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	11/18/2025

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 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. (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
	676040	A. Building B. Wing	11/18/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for two (Resident #1 and Resident #2) of fifteen residents reviewed for dignity. 1. The facility failed to ensure CNA H did not stand while assisting Resident #1 with lunch on 11/17/2025. 2. The facility failed to provide a privacy bag for Resident #2s catheter bag (collects urine from the urinary bladder) on 11/17/2025. These failures could place the residents at risk of not having their right to a dignified existence maintained.Findings included: 1. Record review of Resident #1's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting (loss of muscle leading to its shrinking and weakening) and atrophy (decrease in size of a body part). Record review of Resident #1's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 10/11/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 14. The Comprehensive MDS Assessment indicated that the resident was dependent on staff for eating. Record review of Resident #1's Comprehensive Care Plan, dated 10/09/2025, reflected the resident had ADL self-care deficits and one of the interventions was to provide assistance for eating. Observation on 11/17/2025 at 12:04 PM revealed Resident #1 was sitting in his wheelchair in-front of the nurse's station. It was observed that CNA H was pushing a food cart along with CNA G. Both of them stopped in front of the nurse's station and then CNA G grabbed a tray from the food cart and went inside a resident's room. While waiting for CNA G, CNA H started feeding Resident #1 while he was still sitting in front of the nurse's station. She was standing up while feeding the resident. CNA G then told her to usher the resident to the dining area to continue feeding the resident. In an interview on 11/17/2025 at 12:09 PM, LVN C stated she did not notice that CNA H started feeding Resident #1 while he was still in the hallway and was standing up while feeding the resident. She said she should have pushed the resident's wheelchair in the dining area and fed the resident in the dining area instead of feeding the resident in the hallway. She said when assisting a resident during meals, the staff should also be sitting down to provide dignity to the resident. In an interview on 11/17/2025 at 1:03 PM, CNA H stated she should be sitting down when assisting with residents' meals. She said she started feeding Resident #1 in the hallway while waiting for CNA G. She said she was standing up while she was assisting the resident with lunch in the hallway. She said, when assisting somebody during meal times, she should sit down so she would be face to face with the resident. She said standing up in front of the resident was not a way of showing respect and dignity and as if she was in a hurry. She said she did not know what she was thinking. She said CNA G stopped her and told her to bring the resident to the dining area and that she should be sitting down when feeding the resident. In an interview on 11/17/2025 at 1:44 PM, Resident #1 did not reply when asked if it was okay for him that the staff was standing up while assisting him during lunchtime. 2. Record review of Resident #2's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic kidney disease. Record review of Resident #2's Comprehensive MDS Assessment, dated 11/13/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to flow in the catheter bag). Review of Resident #2's Comprehensive Care Plan, dated 11/14/2025, reflected that the resident had a Foley catheter (device used to help drain urine from bladder) and one of the interventions was to provide a catheter bag. Review of Resident #2's Physician Order, dated 11/08/2025, reflected (Specify type . indwelling urinary catheter (device used to help drain urine from bladder): 16 Fr (French: unit of measurement for catheter sizes) with . cc normal saline balloon using a closed drainage system. Change monthly and as needed. every night shift starting on the 10th and ending on the 11th every month. In an observation and interview on 11/17/2025 at 10:39 AM Resident #2 was in her wheelchair at her doorway. She said she was waiting for somebody to push her wheelchair to the activity area. It was observed that the resident had a catheter hooked beneath her wheelchair. The catheter bag, with urine inside, did not have a privacy bag. The resident stated she had a catheter because she had a kidney problem. She said she was transferred by an aide to her wheelchair but did not notice if her catheter was inside a privacy bag. She said she was about to go out of her room and it would be nice if her urine bag

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	11/18/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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	11/18/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for five (Resident #3, Resident #4, Resident #5, Resident #13, and Resident #14) of twenty-one residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #3, Resident #4, Resident #5, Resident #13 and Resident #14's rooms was in a position that was accessible to the resident on 11/17/2025.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #3 Record review of Resident #3's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and lack of coordination. Record review of Resident #3's Comprehensive MDS Assessment, dated 08/28/2025, reflected the resident had a severe impairment (the resident required significant assistance and support in daily life) in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated that the resident was dependent on staff for transfers and bed mobility. Record review of Resident #3's Comprehensive Care Plan, dated 09/29/2025, reflected the resident was at risk for falls and one of the interventions was to ensure the call light was within reach. Observation and interview on 11/17/2025 at 9:05 AM revealed Resident #3 was in her bed, awake. It was observed that the resident's call light was on top of the resident's side table and was not within reach. When asked about what she used when she needed to call the staff, the resident did not answer. During an interview and observation on 11/17/2025 at 9:10 AM, LVN C stated call lights should always be within reach of the resident so the residents would be able to call the staff if they needed assistance. She went inside Resident #3's room and saw the call light on top of the side table. She took the call light from the side table and placed it where the resident could reach it. She said she would tell the CNA assigned to the hall to make sure that residents' call lights were within reach. She called CNA H and talked to her regarding the call light. She said the call lights were for all the residents and all the staff were responsible in making sure they were within reach. In an interview on 11/18/2025 at 1:03 PM, CNA H stated that the call lights should always be with the residents. She said she must have forgotten to put the call light at the side of the resident when she went to check on Resident #3 during her morning round. Resident #4 Review of Resident #4's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting and atrophy. Review of Resident #4's Comprehensive MDS Assessment, dated 09/08/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated that the resident required assistance for bed mobility and transfer. Review of Resident #4's Comprehensive Care Plan, dated 09/26/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach. Observation and interview on 11/17/2025 at 9:20 AM revealed Resident #4 was in her bed with eyes closed. It was observed that the resident's call light was in the trash can and the cord of the call light was between the frame of the bed and the mattress. The cord was not visible. Observation and interview on 11/17/2025 at 9:41 AM, RN B stated the call lights were used by the resident to call the staff if they needed something or if they needed assistance. She said without the call lights, the residents might fall if they tried to do things by themselves. She said the call lights were for all the residents, whether independent or dependent residents. She went inside Resident's #4's room and saw the call light was not within reach of the resident. She took the call light, cleaned it, and placed it where the resident could reach it. In an interview on 11/17/2025 at 9:46 AM, CNA I stated she did not notice Resident #4's call light was not with the resident. She said the call lights were there so the resident could use them to call the staff. She said it did not matter if the residents were using them or not, but the important thing was it was within reach of the residents. Resident #5 Review of Resident #5's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and repeated falls. Review of Resident #5's Quarterly MDS Assessment, dated 08/26/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 04. The Quarterly MDS Assessment indicated that the resident required maximal assistance for toileting, bed mobility, and transfer. Review of Resident #5's Comprehensive Care Plan, dated 09/29/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach. Observation and interview on 11/17/2025 at 9:52 AM revealed Resident #5 was in her bed

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	11/18/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (continued on next page)

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	11/18/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the residents' right to personal privacy and confidentiality of his or her personal and medical records for two (Resident #6 and Resident #7) of residents reviewed for privacy and confidentiality. 1. The facility failed to ensure MA D did not leave Resident #6's medical information at the side of the medication cart unattended on 11/17/2025. 2. The facility failed to ensure MA E did not leave Resident #7's medical information on top of the medication cart unattended on 11/17/2025.Findings included: 1. Record review of Resident #6's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #6's Comprehensive MDS Assessment, dated 09/30/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had chronic obstructive pulmonary disease. Record review of Resident #6's Comprehensive Care Plan, dated 09/27/2025, reflected the resident had asthma (lung disorder caused by narrowing of the airways) and one of the interventions was to give medications as ordered. Record review of Resident #6's Physician Order, dated 05/06/2025, reflected Montelukast Sodium Oral Tablet 10 MG (Montelukast Sodium) Give 1 tablet by mouth one time a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Observation on 11/17/2025 at 8:57 AM revealed MA D was passing medications down the hall. It was observed that a blister pack was at the side of the medication cart where the plastic cups and small paper cups were stored. The blister pack was facing the hallway and Resident #6's medical information was visible to passers-by. On the blister pack was Resident #6's name, the name of the medication, the prescription number of the medication, the dose and the frequency of the medication, the physician's order, the diagnosis indicating why the medication was being administered, and the name of the pharmacy. Observation on 11/17/2025 at 9:01 AM revealed MA D went inside a resident's room to administer medications. She left the medication cart outside the resident's room with the blister pack still at the side of the medication cart and Resident #6's information still visible. Observation on 11/17/2025 at 9:12 AM revealed MA D took resident #6's blister pack and put them inside the drawer of the medication cart when asked about the blister packs. In an interview on 11/17/2025 at 12:40 PM, MA D stated she should have secured Resident #6's empty blister pack until she got a chance to re-order it or she should have just flipped it so the back of the blister pack would be the one showing. She said since the blister pack had the resident's medical information, then it could be considered as a HIPAA violation because that information was confidential. 2. Record review of Resident #7's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypothyroidism (a condition wherein the thyroid gland did not produce enough thyroid hormones). Record review of Resident #7's Comprehensive MDS Assessment, dated 10/16/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had hypothyroidism. Record review of Resident #7's Comprehensive Care Plan, dated 10/07/2025, reflected the resident had hypothyroidism and one of the interventions was to observe for edema (swelling caused by fluid trapped in the tissues of the body). Record review of Resident #7's Physician Order, dated 10/08/2019, reflected Lasix Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for Edema. Observation on 11/17/2025 at 9:23 AM revealed a cart was parked on a hallway going to the memory care unit. On top of the cart was a blister pack and on the blister pack was Resident #7's name, the name of the medication, the prescription number of the medication, the dose, the frequency, the physician's order, the diagnosis indicating why the medication was being administered, and the name of the pharmacy. It was observed that nobody was attending the cart and the cart was facing the hallway. During an interview on 11/17/2025 at 9:25 AM, MA E stated she was not with her medication cart because she was administering a resident's medication. She said she should have put the blister pack inside the medications cart before leaving her cart because Resident #7's medical medication was on the blister pack. She said she would be mindful that no information about the resident would be left on top of the cart because it was a HIPAA violation. In an interview on 11/18/2025 at 8:40 AM, the DON stated personal and medical information about a resident should not be exposed for everybody to see because it was confidential. She said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's

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	11/18/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews and record reviews, the facility failed to provide a safe, sanitary, and homelike environment including but not limited to treatment and support for daily living safely when one of one sit-to-stand transfer chair was reviewed for environment.The facility failed to ensure the sit-to-stand transfer chair was thoroughly cleaned and sanitized.This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included:An observation and interview on 11/17/2025 at 10:18 AM revealed CNA J pushing a sit-to-stand transfer chair in the hallway near nurses' station 1. There was no resident in the chair. There was dirt and dried food particles on the footrest of the chair. The base appeared to be covered in dust that had accumulated causing it to appear several shades darker than the cream upper portion of the chair. CNA J stated she was not sure who was responsible for cleaning it. ADON A was sitting at nurses' station 1 and stated she would put in a maintenance order to have it cleaned. She stated it was important to ensure resident equipment was cleaned. During an interview on 11/17/2025 at 12:16 PM, the DON stated the DOS was responsible for ensuring the sit-to-stand was cleaned. The DON stated there was no set cleaning schedule, but she was going to create one to ensure it was routinely cleaned and sanitized. She stated the sit-to-stand transfer chair was used for different residents and should also be wiped down after each use. During an interview on 11/18/25 at 10:32 AM, ADON A stated she had taken the sit-and-stand and cleaned it herself after it was brought to her attention. She stated it looked like there was a wad of hair and food and dirt particles on the footrest. She stated it became gummy when she sprayed it with cleaner, so she knew it was not only food. She stated dust had accumulated all over the sit-to-stand. ADON A stated she spoke with the DON and there would be a cleaning log created to ensure it was routinely cleaned. During an interview on 11/18/25 at 11:41 AM, the DOS stated he had been in the role since August of this year and was over maintenance, laundry, and housekeeping. He stated the housekeeping staff would be responsible for cleaning the equipment used to transfer residents. He stated it was important to ensure equipment used by residents was routinely cleaned and sanitized. He stated he spoke with the DON, and they were creating a cleaning log to ensure it was routinely cleaned.During an interview on 11/18/2025 at 1:58 PM, the Administrator stated she was currently the interim administrator, and it would soon be a permanent position. She stated there was usually a schedule for nursing or maintenance staff to clean equipment used for residents routinely and in between as needed. She stated she spoke with the DON and DOS, and a schedule was being created to ensure wheelchairs, mechanical lifts, and sit-to-stand transfer chairs were routinely cleaned and sanitized. She stated it was important to prevent cross contamination and the spread of germs between residents. Record review of the facility's policy Infection Control: Cleaning and Disinfecting Resident Care Equipment, revised June 2024, reflected Equipment will be maintained and kept clean or disinfected in accordance with acceptable policies. Manufacturers' recommendations will be followed when cleaning or disinfecting medical equipment.

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	11/18/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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	11/18/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding (delivery of food through feeding tube) for one (Resident #8) of one resident reviewed for feeding tube. The facility failed to ensure LVN C checked Resident #8's gastric residual (volume of liquid and food remaining in the stomach) before administering medications via g-tube on 11/17/2025. This failure could place residents with g-tubes at risk for aspiration.Findings included: Record review of Resident #8's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support). Record review of Resident #8's Comprehensive MDS Assessment, dated 10/24/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #8's Quarterly Care Plan, dated 09/28/2025, reflected the resident was at risk for aspiration related to g-tube and one of the interventions was to check gastric residual. Record review of Resident #8's Physician Order, dated 03/23/2025, reflected *Enteral Feeding- Check Residual* -Every Shift and With S/S of intolerance. Document Residual in CCs. every shift A) If Residual is < 200 reinsert contents and continue feeding B) If residual is > 200 Discard Contents, Hold Feeding and Notify MD for further orders. Observation on 11/17/2025 at 2:15 PM revealed LVN C was about to give Resident #8's medication via g-tube. LVN C sanitized her hands and started to prepare and crush the medications. After crushing the medication, she went inside the room and placed the medications on the resident's overbed table. She then incorporated some water into the medications to dissolve them. She also had a plastic glass with water in it. She took a 60 ml piston syringe from the resident's side table and placed it also on the overbed table. She raised the bed, lifted the resident's gown to expose the g-tube site, and disconnected the g-tube from the formula. After disconnecting the g-tube, she pulled the plunger of the syringe, attached the syringe to the g-tube, and flushed the g-tube. After flushing the g-tube, she poured the dissolved medications in it, flushing in between each medication. She did not check the residual before flushing and administering the medication. After pouring the last medication, she flushed the g-tube, detached the syringe, connected the g-tube to the formula, and cleaned the table and the syringe. In an interview on 11/17/2025 at 2:47 PM, LVN C stated she forgot to check the Resident #8's gastric residual before administering her medications. She said the right procedure was to check the residual before administering the medications to check if the stomach was not too full and could accommodate the medications and fluid to be introduced. She said the gastric residual should be checked to prevent aspiration. She said she knew she needed to check the residual, but failed to do so because she was nervous. In an interview on 11/18/2025 at 8:40 AM, the DON stated the gastric residual should be checked before administering medications to prevent aspiration and also to assess if the resident's stomach was emptying properly. She said the expectation was for the staff to follow the right procedure for medication administration via g-tube. She said she would do an in-service about enteral feeding. In an interview on 11/18/2025 at 10:31 AM, ADON A stated the residual should be checked before giving medications to prevent aspiration and also to assess if the rate of the formula ,and the fluid used to flush the medication, should be modified. She said the expectation was for the staff to check for gastric residual every time they administered medications. She said she would coordinate with the DON to do an in-service about enteral feeding. In an interview on 11/18/2025 at 1:20 PM, the Administrator stated the expectation was for the staff to follow the right procedure for administering medications via g-tube. She said she was not a clinician and would let the DON take the lead in educating the staff about the issue. Record review of the facility's policy entitled Enteral Feeding Policies and Procedures revised 09/2023 reflected Policy: The facility will provide adequate care for residents with enteral feeding tubes to prevent complications . Residual Check . Check residual every shift and with signs/symptoms of intolerance.

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	11/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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	11/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #9 and Resident #10) of ten residents reviewed for respiratory care. 1. The facility failed to ensure Resident #9 's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was stored properly when not in use on 11/17/2025. 2. The facility failed to ensure Resident #10's breathing mask was stored properly when not in use on 11/17/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: 1. Record review of Resident #9's face sheet, dated 11/17/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with respiratory disorder. Record review of Resident #9's Quarterly MDS Assessment, dated 11/13/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #9's Comprehensive Care Plan, dated 11/10/2025, reflected the resident required supplemental oxygen and one of the interventions was provide oxygen therapy as ordered. Record review of Resident #9's Physician's Order, dated 10/22/2025, reflected Oxygen @ 2-4 LPM via nasal cannula continuously. Monitor O2 sat. every shift. Observation on 11/17/2025 at 9:02 AM revealed Resident #9 was in his bed with eyes closed. It was observed that an oxygen concentrator was at the bedside with a nasal cannula connected to it. The nasal cannula was inside the trash can and was not bagged. Observation and interview on 11/17/2025 at 1:22 PM revealed Resident #9 only shrugged his shoulders when asked who removed his nasal cannula earlier that day. 2. Record review of Resident #10's face sheet, dated 11/17/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection). Record review of Resident #10's Quarterly MDS Assessment, dated 09/16/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident had respiratory disorders. Record review of Resident #10's Comprehensive Care Plan, dated 09/29/2025, reflected the resident had respiratory illness and one of the interventions was to follow orders to treat respiratory illnesses. Record review of Resident #10's Physician's Order, dated 10/17/2025, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally four times a day related to PNEUMONIA, UNSPECIFIED ORGANISM for 5 Days AND 1 vial inhale orally every 6 hours as needed for Wheezing related to PNEUMONIA, UNSPECIFIED ORGANISM. Observation and interview on 08/12/2025 at 9:03 AM revealed Resident #10 was in his bed, awake. It was observed the nebulization machine was on top of the resident's side table with a breathing mask connected to it. The breathing mask was not bagged. The resident said he would only use it when he needed it. He said he did not know when was the last time he used it. In an observation and interview with LVN C on 11/17/2025 at 9:10 AM, LVN C stated the nasal cannula should not be in the trash can and the breathing mask should be inside the bag to prevent cross contamination and respiratory infection. She went inside Resident #9's room and saw the nasal cannula that was inside the trash can. She disconnected the nasal cannula and threw it on the trash can. She said she would get a new one for the Resident #9. She then went to Resident #10's room and saw the breathing mask was not bagged. She disconnected and threw it on the trash can. She said she would just get a new one when Resident #10 needed a breathing treatment, because his breathing treatment was as needed. She said she did not notice during her morning round that the nasal cannula and the breathing mask were not bagged. She said she was responsible for bagging them when the residents were not using them. In an interview on 11/18/2025 at 8:40 AM, the DON stated the staff were responsible in making sure the nasal cannula and the breathing masks were bagged when not in use to prevent cross contamination and respiratory infection. She said it was her responsibility to check if the staff were compliant. She said she would do an in-service about bagging the nasal cannula and the breathing mask when not in use and would randomly monitor the staff if they were bagging them when not in use. In an interview on 11/18/2025 at 10:31 AM, ADON A stated the nasal cannula and the breathing mask should be stored properly to prevent cross contamination and respiratory infections. She said whoever administered the breathing treatment was responsible for cleaning it and storing it in a plastic bag. She said the nasal cannula should not be on the

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	11/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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	11/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the medications for two (Residents #6 and #11) of twelve residents were stored properly in locked compartments or provided a safe and secured storage with limited access. 1. The facility failed to ensure there were no nystatin powder (antifungal medication) and barrier ointment inside Resident #6's room on 11/17/2025. 2. The facility failed to ensure a tube of zinc oxide (cream used to treat skin irritations, diaper rash, and other skin conditions) was not left inside Resident #11's room on 11/17/2025. These failures could place the residents at risk of accidental overdose or misuse of medications. Findings included: 1. Record review of Resident #6's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obesity (excessive accumulation of body fats) and muscle weakness. Record review of Resident #6's Comprehensive MDS Assessment, dated 09/30/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was incontinent (uncontrolled) for bladder and bowel. Record review of Resident #6's Comprehensive Care Plan, dated 09/27/2025, reflected the resident had urinary and bowel incontinence and one of the interventions was to apply barrier cream after each episode of incontinence. In an observation and interview on 11/17/2025 at 8:46 AM revealed Resident #6 was in his bed, awake. It was observed that that there were three plastic bottles of nystatin powder in a basket at the resident's sink located inside the room. The resident said he used to use it when he would have rashes because of the brief. He said the medications had always been there with his shampoo and IV (intravenous: administering fluids or medications directly into a vein) paraphernalia so for sure the staff saw the medications in his basket. 2. Record review of Resident #11's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #11's Quarterly MDS Assessment, dated 09/08/2025, reflected the resident's cognition was intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was always incontinent for bladder and bowel. Record review of Resident #11's Comprehensive Care Plan, dated 09/26/2025, reflected the resident had urinary and bowel incontinence and of the interventions was to apply barrier cream after each episode of incontinence. Observation on 11/17/2025 at 9:01 AM revealed Resident #11 was not inside her room. A tube of barrier ointment was observed on top of the resident's table located at the foot portion of her bed. The container of barrier ointment was visible from the hallway. In an observation and interview on 11/17/2025 at 9:10, LVN C stated there should not be any medications inside the residents' rooms because the residents might misuse them or mistakenly use them as a toothpaste. She went inside Resident #6's room and saw the tube of barrier cream. She said the aides would use it after incontinent care. She said the barrier ointment had zinc oxide in it and was also used to prevent skin issues; making it a form of medication. She took the barrier ointment and said it should be inside the cart. She then went inside Resident #11's room and saw the three bottles of nystatin powder and the tube of barrier cream. She said she was not aware there were medications inside Resident #11's room. She took the medication and said she would ask Resident #11 about it to know if she needed to get an order for the nystatin. In an interview on 11/18/2025 at 8:40 AM, the DON stated the barrier ointment, and the nystatin powder should not be inside the room. She said the barrier ointment could be placed in the drawer where the staff would put the briefs and the wipes used for incontinent care. She said it could also be placed in the carts, as long as the barrier ointment was not accessible to the residents. She said confused residents might ingest it and suffer adverse reactions especially if somebody who accidentally ingested the medications was allergic to the medications. She said the nystatin powder should not be inside the room, and she was not sure why nobody noticed it. She said the resident might misuse it or other residents might get a hold of it and put them in their mouth or eyes. She said the expectation was the medicated ointment and the nystatin powder be placed inside the carts to secure it, and that the staff would check the residents' room for medications. She said she would do an in-service making sure no medications were accessible to the residents. In an interview on 11/18/2025 at 10:31 AM, ADON A stated zinc oxide and the nystatin powder should not be left or stored inside the residents' rooms because the residents might administer or use them incorrectly that could result in adverse reactions. She said the medicated ointments should be stored in the cart because it had chemicals that could be toxic when consumed. She said she was not sure why nobody saw the nystatin powder inside the basket

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	11/18/2025

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 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 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 four (Resident #5, Resident #8, Resident #12, and Resident #13) of fifteen residents reviewed for infection control. 1. The facility failed to ensure CNA F and CNA G performed hand hygiene and changed their gloves during Resident #5's incontinent care on 11/17/2025.2. The facility failed to ensure LVN C wore a gown while administering Resident #8's medication via g-tube, who had an order for enhanced barrier protection, on 11/17/2025. 3. The facility failed to ensure CNA I performed hand hygiene during Resident #12's incontinent care on 11/17/2025.4. The facility failed to ensure CNA J changed gloves and washed her hands while providing incontinent care for Resident #13 on 11/17/2025.These failures could place residents at risk of cross-contamination and development of infections.Findings include: 1. Review of Resident #5's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with overactive bladder (a bladder control problem which leads to a sudden urge to urinate). Review of Resident #5's Quarterly MDS Assessment, dated 08/26/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 04. The Quarterly MDS Assessment indicated that the resident had urinary and bowel incontinence. Review of Resident #5's Comprehensive Care Plan, dated 09/29/2025, reflected the resident had bowel and bladder incontinence and one of the interventions was to change promptly. Observation on 11/17/2025 at 9:45 AM revealed CNA F and CNA G were about to do Resident #5's incontinent care. Both CNAs put on a pair of gloves, but did not wash their hands before putting on the pairs of gloves. CNA G was observed taking the gloves that she wore from her pocket. CNA F took a brief and placed it on the resident's side. CNA G unfastened the brief and pushed it in the middle of the resident's legs. She then cleaned the resident's perineal area using the front to back technique. After cleaning the perineal area, she assisted the resident to turn towards the wall and cleaned the resident's bottom. After cleaning the resident's bottom, she took the brief from the side of the resident and placed it under the resident. CNA G then rolled back the resident and fixed the brief. She did not change her gloves throughout the process of incontinent care. In an interview on 11/17/2025 at 10:01 AM, CNA F stated their hands should be washed before incontinent care to make sure their hands were clean before touching the gloves that would be used for incontinent care. She said washing hands before any care was done to prevent infection. (continued on next page)

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	11/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/17/2025 at 10:04 AM, CNA G stated she washed her hands after taking care of a resident before going to Resident #5's room. She said she should have washed her hands again before performing the resident incontinent care, because she touched a lot of thing on her way to Resident #5's room. She said she did have some gloves in the pocket of her scrub pants, and she should not be doing that because her pockets might be dirty rendering the gloves used for incontinent care dirty. She said she should have changed her gloves after cleaning the resident's bottom and before touching the new briefs to prevent using dirty gloves. She said using soiled gloves could cause transfer of germs to the new brief. She said her hands should also be sanitized if she changed her gloves. She said she would be mindful the next time she did incontinent care. 2. Record review of Resident #8's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status. Record review of Resident #8's Comprehensive MDS Assessment, dated 10/24/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #8's Quarterly Care Plan, dated 09/28/2025, reflected the resident required enhanced barrier protection and one of the interventions was to monitor the resident for signs and symptoms of infection. Record review of Resident #8's Physician Order, dated 04/01/2024, reflected Enhanced Barrier Precautions - PPE: Gloves/Gown during high-contact resident care activities. every shift. Observation on 11/17/2025 at 2:15 PM revealed LVN C was about to administer Resident #8's medication via g-tube. She prepared her medications and went inside the resident's room. She washed her hands and then closed the door. She did not wear a gown before giving the resident's medication via g-tube. It was observed that there was sign outside the door that EBP was required because the resident had a g-tube. In an interview on 11/17/2025 at 2:47 PM, LVN C stated Resident #8 had a g-tube and EBP was required. She said she did not know why she forgot to wear a gown when she administered the resident's medication. She said the gown was needed basically to prevent transmission of microorganisms from one resident to another. She said she would wear a gown the next time she cared for residents with g-tube. 3. Record review of Resident #12's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hypertensive encephalopathy (a brain dysfunction due to a rapid increase in blood pressure). Record review of Resident #12's Comprehensive MDS Assessment, dated 10/15/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #12's Comprehensive Care Plan, dated 10/08/2025, reflected that the resident was incontinent for bladder and bowel, and one of the interventions was to perform routine rounding to include incontinence care and brief changes. (continued on next page)

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	11/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 11/17/2025 at 11:11 AM revealed CNA I was about to do Resident #12's incontinent care. She washed her hands and put on a pair of gloves. She pulled the gloves that she wore from her pocket. She unfastened the brief and pushed it between the resident's legs. She cleaned the perineal area using a front to back technique. She rolled the resident to her side and cleaned the resident's bottom. Before cleaning the resident's bottom, she took off her gloves, pulled a pair form her pocket, and put on the gloves. She did not sanitize her hands. After cleaning the bottom, she took off her gloves, pulled a pair from her pocket, and put I on. She did not sanitize her hands before putting on the new pair of gloves. She took the brief and placed it under the resident. She rolled back the resident and fixed the brief. In an interview on 11/17/2025 at 11:29 AM, CNA I stated she should have sanitized her hands when she changed her gloves to make sure her hands were clean before touching the new pair of gloves. She said she needed to sanitize her hands in between changing of gloves to prevent cross contamination, and eventually infection. She said she did put some gloves in her pockets to have easy access to them. She said she was not sure if her pocket was clean. She said because she would put her keys and cell phone in her pocket, she would not put gloves inside her pocket again, and would just get them from the box to make sure she was using clean gloves. In an interview on 11/18/2025 at 8:40 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care. She said gloves should be changed after cleaning the resident's bottom and before touching the new brief. She said the hands should be sanitized in between changing of gloves. She said staff should not be put gloves inside staff pockets because they put their cell phones and keys in their pockets rendering the pockets not clean. She said the staff would also put their hands in their pocket and nobody would know what they touched before putting their hands in the pockets. She said if a resident had a g-tube, the staff should wear a gown every time the staff had contact with the resident. She said the procedures mentioned should be in place to prevent cross contamination and to prevent the spread of infection. She said every resident that needed EBP had a sign outside to remind the staff that they needed to wear gowns and gloves every time they had contact with the resident. She said she already initiated an in-service about infection control and would closely monitor staffs' adherence to the policy of infection control. In an interview on 11/18/2025 at 10:31 AM, ADON A stated the staff should be mindful that they were not causing any spread of infection in the facility and one way to do that was to do hand hygiene before, during, and after any care. She said the staff should also change their gloves after touching a soiled brief or after cleaning the resident's bottom. She said the staff should sanitize their hands when they were changing their gloves. She said the staff should not put their gloves inside their pockets because they put their car keys, money, snacks, and dirty hands in their pockets. She said another way to prevent the spread of infection was to practice EBP when needed. She said residents with a g-tube required gown to protect the resident and also the staff if the resident had any microorganism that could cling to them. She said she would coordinate with the DON to do an in-service again about infection control. She said the staff would be re-trained and would spot check them. (continued on next page)

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	11/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/18/2025 at 1:20 PM, the Administrator stated the staff should be mindful of what they were doing to ensure that there was no cross contamination or spread of infection. She said after touching something soiled, the staff should change their gloves and sanitize the hands in between changing of gloves. She said she was not a clinician, but she knew that if there was a sign for EBP, then the staff should wear a gown in addition to the gloves. She said the gloves should not be in the pockets. She said the concerns discussed would all contribute to the development and spread of infection. She said she would coordinate with the DON about the issue. 4. Record review of Resident #13's Face Sheet, dated 11/18/2025, reflected the resident was a [AGE] year-old female who admitted on [DATE]. Resident #13 had diagnoses which included Alzheimer's disease (progressive cognitive decline, memory loss, and behavioral changes) and muscle wasting and atrophy. Record review of Resident #13's Quarterly MDS Assessment, dated 10/16/2025, reflected severe cognitive impairment with a BIMS score of 05. Section GG (functional abilities) reflected Resident #13 required assistance with self-care needs. Section H (bowel and bladder) indicated she was frequently incontinent of bowel and bladder. Record review of Resident #13's Comprehensive Care Plan, dated 09/29/2025, reflected the resident had bowel and bladder incontinence and was at risk for skin breakdown and infection. One intervention was to provide incontinent care after each incontinent episode and as needed. During an observation and interview on 11/17/2025 at 9:31 AM, CNA J provided incontinence care for Resident #13. CNA J had supplies on the bedside table. She pulled the curtain around the bed to provide privacy. CNA J put on clean gloves and helped the resident roll to her right side. CNA J removed the brief revealing loose stool on the resident's bottom and brief. CNA J dropped the soiled brief into the waste basket. She removed the package of wipes from the bedside table and placed it on the bed near her. CNA J cleaned the resident's bottom and dropped the wipes into the waste basket. CNA J did not remove the gloves. She removed the linens and dropped them into a plastic bag. She secured the fitted sheet on each end on her side of the bed. CNA J moved to the other side of the bed and assisted the resident to roll to her left side. CNA J secured the fitted sheet on each end and placed a clean brief under Resident #13 and the resident rolled to her back. CNA J used her gloved hands to push the end of the bed against the wall and moved to the other side of the bed. CNA J pulled more wipes from the package and cleaned the front of the resident, pulled up the front of the brief, and secured the tabs. She pulled the resident's gown down to cover her, placed the pillow under the resident's head, and covered her with a clean sheet. CNA J did not remove her gloves before carrying the bag of soiled linen and the package of wipes to the shower room in the hall. CNA J came out of the shower room and used hand sanitizer from a pump on the wall to clean her hands. When asked about the package of wipes, she stated she put them in the shower room so could find them quickly when she needed them. CNA J stated she should have changed her gloves and washed her hands or used hand sanitizer while providing incontinent care. She stated she should have removed her gloves and used hand sanitizer or washed her hands before leaving the resident's room. CNA J stated she should not have used the same package of wipes in different residents' rooms. She stated hand hygiene was important for infection control and to prevent spreading germs. During an interview on 11/17/2025 at 9:56 AM, ADON K stated CNA J should have used hand hygiene and changed gloves for infection control and to prevent spreading infection to other residents. She stated CNA J should not take the same package of wipes into different residents' rooms. (continued on next page)

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	11/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/18/25 at 12:16 PM, the DON stated she spoke with CNA J about changing gloves and using hand hygiene when providing incontinent care. The DON stated she reminded CNA J packages of wipes could not be carried in and out of a resident's room. She stated CNA J should have washed her hands or used hand sanitizer before putting on gloves and after removing gloves. The DON stated it was important to use proper hand hygiene with incontinence care. She stated the risk to residents was the spread of germs and infection. She stated the facility had started in-servicing staff members. During an interview on 11/18/25 at 12:27 PM, LVN L stated CNA J should have changed her gloves and used hand sanitizer or washed her hands when providing incontinence care. She stated CNA J should not have taken the package of wipes in and out of Resident #13's room. She stated it was important to prevent cross contamination and the spread of infection. She stated the facility was already in-servicing staff. Review of the facility's policy Hand Hygiene, revised 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 fluids, surface, or contaminated equipment Record review of the facility's policy entitled Enhanced Barrier Precautions Policies and Procedures revised March 2024 reflected Policy: Enhanced Barrier Precautions is an infection control intervention designed to reduce the transmission of multidrug-resistant organisms and employs targeted gown and glove use during high-contact resident care activities for targeted residents . EBP are indicated for residents with any of the following . indwelling medical devices . feeding tubes. Policy and procedure for infection control was requested via email to the DON and Administrator on 11/18/2025 at 10:30 AM but was not provided prior to exit.

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	11/18/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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	11/18/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the call light system was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities for fourteen (Resident #4, #12, #15 #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, and #26) of twenty-six residents reviewed for resident call system. 1. The facility failed to ensure the call light system in Resident #4's restroom was functioning on 11/17/2025. 2. The facility failed to ensure the call light system in Resident #15 and Resident #16's restroom was functioning on 11/17/2025. 3. The facility failed to ensure the call light system in Resident #17 and Resident #18's restroom was functioning on 11/17/2025. 4. The facility failed to ensure the call light system in Resident #19 and Resident #20's restroom was functioning on 11/17/2025. 5. The facility failed to ensure the call light system in Resident #12 and Resident #21's restroom was functioning on 11/17/2025. 6. The facility failed to ensure the call light system in Resident #22 and Resident #23's restroom was functioning on 11/17/2025. 7. The facility failed to ensure the call light system in Resident #24 and Resident #25's restroom was functioning on 11/17/2025. 8. The facility failed to ensure the call light system in Resident #26's restroom was functioning on 11/17/2025. This failure could place the residents at the memory care unit at risk of not having a means of directly contacting the staff to obtain assistance for activities of daily living or help in the event of an emergency.Findings included: 1. Resident #4 Review of Resident #4's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with unsteadiness of feet and difficulty in walking. Review of Resident #4's Comprehensive MDS Assessment, dated 09/08/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated that the resident used a walker, required assistance for bed mobility, transfer, hygiene, shower, and dressing. Review of Resident #4's Comprehensive Care Plan, dated 09/26/2025, reflected the resident was at risk for falls and incontinent for bladder and bowel. The interventions were to be sure the resident's call light was within reach and assist the resident to use the toilet regularly. 2. Resident # 15 Review of Resident #15's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with cerebrovascular disease (blood supply to the brain was interrupted). Review of Resident #15's Comprehensive MDS Assessment, dated 10/08/2025, reflected the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated that the resident used a cane, was independent for eating, bed mobility, transfers, and walking 10 feet. Review of Resident #15's Comprehensive Care Plan, dated 10/24/2025, reflected the resident was at risk for falls, had ADL self-care deficits, and was incontinent for bladder and bladder. The interventions were to be sure the resident's call light was within reach, assist the resident to use the toilet, and provide limited assistance for toileting. Resident #16 Review of Resident #16's Face Sheet, dated 11/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with fracture to right patella (knee bone) and frequency of micturition (refers to the need to urinate many times during the day or night). Review of Resident #16's Comprehensive MDS Assessment, dated 10/13/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated that the resident used a walker, needed supervision for toileting and dressing. The resident was independent for bed mobility, and walking for 10 feet. Review of Resident #16's Comprehensive Care Plan, dated 10/20/2025, reflected the resident was at risk for falls, was incontinent, and had ADL self-care deficits. The interventions were to be sure the resident's call light was within reach, encourage independent function, and assist the resident to the toilet. 3. Resident #17 Review of Resident #17's Face Sheet, dated 11/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertensive retinopathy (eye condition caused by high blood pressure) and visual loss. Review of Resident #17's Comprehensive MDS Assessment, dated 09/08/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated that the resident was not using any adaptive device and was independent for bed mobility, toilet transfer, and could walk for 150 feet. Review of Resident #17's Comprehensive Care Plan, dated 09/26/2025, reflected the resident was at risk for falls and had an ADL self-care deficit. The interventions were to be sure the resident's call light was within reach and to provide assistance for toileting