STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2026

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

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation for 2 of 8 residents (Resident #1 and #2) reviewed for abuse and neglect, in that; Resident #2 made repeated hateful remarks toward Resident #1 and struck Resident #1 with her wheelchair. Following the incident of being struck by Resident #2's wheelchair, Resident #1 reported increased right shoulder pain lasting approximately one week, exhibited tearfulness and avoidance behaviors, and remained in her room due to fear of encountering Resident #2. Resident #2 continued to be present in common areas for approximately three weeks after Resident #1 expressed fear and concern. An Immediate Jeopardy (IJ) situation was identified on 3/14/2026. While the IJ was removed on 3/15/2026, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for injury, emotional harm, unsafe conditions, and compromised dignity and safety.Findings include: 1.Record review of Resident #1's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: osteoarthritis (a degenerative joint disease caused by the breakdown of cartilage covering the ends of bones), depression (mood disorder causing persistent sadness, loss of interest, and physical symptoms like fatigue or pain that disrupt daily life), anxiety disorder (mental health conditions involving excessive, persistent, and uncontrollable worry or fear that interferes with daily life), Alzheimer's disease (a progressive neurological disorder causing brain shrinkage and cognitive decline), abnormalities of gait and mobility, and age related physical debility . Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. Resident #1 reported feeling down, depressed, or hopeless for several days and exhibited no behavioral symptoms. Resident #1 used a wheelchair for mobility and received a scheduled pain medication regimen with no reported pain. Record review of Resident #1's Care Plan, last revised on 10/24/2025, revealed a care area which addressed increased pain/discomfort and risk for injury related to diagnoses of chronic pain and osteoarthritis. Interventions included encouraging the resident to verbalize feelings of pain/discomfort; assisting with ADLs and providing comfort measures as indicated; encouraging socialization and participation in activities as tolerated; monitoring the effectiveness of pain medications and other interventions and reporting to the MD if ineffective; monitoring for side effects of pain medications and reporting any noted to the MD; observing for signs and symptoms of increased pain/discomfort and assessing for possible causes, implementing interventions such as administering pain medications, treatments, and relaxation modalities, and evaluating for relief; and utilizing a 0-10 numeric pain scale to assess pain level. Further record review of Resident #1 care plan, last revised on 10/24/2025, revealed a focus area which addressed the potential for decline in psychosocial well-being and social isolation, as evidenced by the mood interview. Interventions included encouraging family involvement to support a positive psychosocial outlook; encouraging family to bring familiar items during visits; encouraging (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident to attend activities of choice and facilitating pairing with peers who share similar interests; engaging the resident in reminiscing about past experiences and life prior to residency; and introducing the resident to others to promote social interaction and relationship building. Record review of another care plan area for Resident #1, last revised on 10/25/2025, revealed a focus on the use of psychotropic medications and the resident's risk for adverse reactions and episodes of depressive and anxiety-driven behaviors, as evidenced by a diagnosis of depression with anxiety and the use of antidepressant medications. Interventions included encouraging the resident to verbalize feelings during behavioral episodes; monitoring for signs of depressive behaviors such as spontaneous crying, sad mood/affect, self-imposed isolation, and mood not easily altered; reporting any noted changes to the MD/RP; and documenting findings in the clinical record. Record review of Resident #1's physician order, dated 9/30/2025, revealed an order for cyclobenzaprine HCl oral tablet 10MG to be given by mouth every 8 hours as needed for neck and muscle pain related to other chronic pain. Record review of Resident #1's February and March 2026 MAR revealed order for cyclobenzaprine HCl oral tablet 10MG to be given by mouth every 8 hours as needed for neck and muscle pain was administered once on 2/17/2026 at 11:58 PM with a pain rating of 5/10. Record review of Resident #1's physician order, dated 10/1/2025, revealed an order to monitor resident every shift for Target Behaviors of confusion and depressive features. Record review of Resident #1's February and March 2026 TAR revealed according to order to monitor for target behaviors of confusion and depressive features every shift, no behaviors were noted. Record review of Resident #1's physician order, dated 10/1/2025, revealed an order to observe for pain every shift. Record review of Resident #1's February and March 2026 TAR revealed according to order to monitor for pain every shift, no complaints of pain were noted. Record review of Resident #1's physician order, dated 1/8/2026 and discontinued on 2/23/2026, revealed an order for Acetaminophen Extra Strength Tablet 500 MG to give 2 tablet by mouth two times a day for Arthritis. Record review of Resident #1's physician order, dated 2/23/2026, revealed an order for Acetaminophen Extra Strength Tablet 500 MG to give 2 tablet by mouth two times a day related to unspecified osteoarthritis, unspecified site. Record review of Resident #1's February and March 2026 MAR revealed order for Acetaminophen Extra Strength Tablet 500 MG, 2 tablets by mouth two times a day was administered 2/1/2026 - 3/15/2026 as ordered with a pain level of 0/10. Record review of Concern Report, dated 2/22/2026, revealed concern was received by LVN A from Resident #1 regarding Resident #2. The description of concern was, Several residents complaining that above resident cleans DR (dining room) and takes their plates and cups away before they are finished. Investigation details noted, Spoke with resident and was instructed not to clean the DR anymore. Leave it for the kitchen staff. Resident also arguing with other residents about their plates and drinks. Further review of the report revealed the concern was reported to the social worker . Bottom of the concern report regarding Findings of investigation/resolution was blank as well as whom the investigation results were reported to was blank. Investigator signature and Administrator review signatures were also blank on the report. Record review of Resident #1's Psychological Services progress note, dated 2/23/2026, revealed Resident #1 had a diagnosis of major depressive disorder, her functional and behavioral challenges that were focused on during the session was adjustment difficulty with no new stressors noted. The progress note revealed her progress and plan included in part, .Client appeared stable, relaxed and comfortable throughout the visit . continue routine supportive visit to reinforce emotional well-being. Encourage participation in day room activities and peer interaction. monitor for changes in affect and behavior. Record review of Resident #1's progress note, dated 2/24/2026 at 12:42 PM, revealed a physiatry progress note by NP, noted in part, .Resident #1 reports right shoulder/arm pain today. She states another resident ran into her with a wheelchair accidentally a few days ago. She reports the pain is subsiding. Right shoulder pain: patient states another resident accidentally backed into her with her wheelchair. Patient states pain in right arm is subsiding. She did not want to roll sleeves all the way up to exam skin; likely a contusion as there is tenderness with palpation over right upper arm (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	area; range of motion (ROM) is intact. Can abduct shoulder to about 60 degrees. Pain is improving per patient. If it persists, will get xray. Record review of Resident #1's Quarterly Care Plan Meeting note, provided by the facility after exit on 3/16/2026 at 12:02 PM, documented an effective date of 2/24/2026 at 1:30 PM. Care Plan meeting note reflected Resident #1's RP attended the meeting in person and had a summary noting in part, .The family was able to express their concerns regarding the resident having a verbal disagreement with a peer. Their concerns were addressed by IDT members. Record review of Resident #1's psychiatric subsequent assessment, dated 2/27/2026, noted reason for referral was depression and anxiety and chief complaint noted was, I hear voices sometimes. Resident #1's History of Presenting Illness noted in part, .Depression: Staff reports current symptoms of loss of interest. severity level 4 (moderate). Symptoms occurring for 8 months. Anxiety: Staff reports current symptoms of impaired concentration. symptoms have been occurring for 7 months. Cognitive Impairment: staff reports current symptoms of confusion and reports no current symptoms of forgetfulness.symptoms have been occurring for 11 months. collateral information: Staff denies any complaints/concerns at this time. Further review of progress note revealed Resident #1's psychiatric review of systems noted anxiety symptoms, depressive symptoms and insomnia and her Mental Status Examination noted she had an anxious depressed mood. Record review of Resident #1's Psychological Services progress note, dated 3/2/2026, revealed Resident #1 had a diagnosis of major depressive disorder, her functional and behavioral challenges that were focused on during the session was adjustment difficulty with no new stressors noted. The progress note revealed her progress and plan included in part, .Client presented with a calm and stable demeanor. continue regular supportive check-ins to sustain emotional stability. Encourage involvement in day room programming and peer interactions. Record review of Resident #1's Psychological Services progress note, dated 3/10/2026, revealed Resident #1 had a diagnosis of major depressive disorder, her functional and behavioral challenges that were focused on during the session was adjustment difficulty with a new stressor of recent illness noted. The progress note revealed her progress and plan included in part, .Discussed recent illness involving diarrhea and assessed clients physical status. Reinforced positive shift toward increased social interaction as symptoms improved. client appeared more comfortable and reported feeling better physically. She engaged in conversation and expressed enjoyment in socializing again. The plan also included to encourage continued social engagement and monitor physical recovery . Observation and interview on 3/13/2026 at 5:00 PM, the Administrator identified Resident #1 sitting in the dining room at a table with another resident. Resident #1 said things had generally been going okay at the facility, but she reported having a serious issue with one resident. Resident #1 stated there was another female resident who was always in the dining room messing with everyone. Resident #1 stated she did not know the resident's name but identified her as being present in the dining room at that time, sitting a few tables away. It was noted Resident #2 was seated in the dining room approximately two tables away from Resident #1. Resident #1 stated Resident #2 did not like her, and she did not know why. Resident #1 stated Resident #2 was rude to her and other residents and would say nasty hateful things to everyone. Resident #1 stated she had never done anything to Resident #2 to cause this behavior and said she was terrified of Resident #2 because Resident #2 had hit me with her wheelchair a few weeks earlier. Resident #1 pointed out an area in the dining room, beside a nearby table, and stated that was where she was sitting when she felt a hard crash from behind. Resident #1 stated she could hear Resident #2 talking but could not make out what she was saying. Resident #1 stated she was so scared when it happened, she could not remember who else was around and was in shock from the incident. Resident #1 stated Resident #2 eventually wheeled away, while she remained scared and concerned Resident #2 might return. Resident #1 recalled seeing her RP later that same day and told her what happened. Resident #1 stated she and her RP then spoke to the facility staff about the incident involving Resident #2. Resident #1 stated after the incident of being hit by the wheelchair, if she saw Resident #2 in the hallway or dining room, she would go back to her room because she was afraid to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	be around her and did not know what Resident #2 might do next. Resident #1 stated the way Resident #2 treated her and the other residents was very upsetting. Resident #1 stated her RP and staff tried to tell her that was just how Resident #2 acted because she had issues, but Resident #1 stated she did not feel it was fair that she and the other residents had to tolerate being harassed by Resident #2. Resident #1 stated she did not think Resident #2 should be at the facility. Resident #1 stated she was still scared of Resident #2 but felt somewhat safer now because she made friends at the facility who she felt had her back. Resident #1 stated she was just beginning to return to the dining room while Resident #2 was present due to encouragement from her RP and other residents, but she would rather not have to be around Resident #2. Resident #1 stated after being hit by Resident #2's wheelchair, she experienced severe shoulder pain. Resident #1 stated the wheelchair strike was really hard and hurt really bad. Resident #1 pointed to her right shoulder as the area affected and stated it felt better at the time of the interview; however, after the incident she had pain in her right shoulder for about one week. Resident #1 stated her RP was aware of the shoulder pain and recalled telling her PE teacher (NP) about the incident and her shoulder pain as well. During the interview, another resident sat at a nearby table sneezed loudly. Resident #1 was visibly startled and jumped in her chair. The state surveyor reassured Resident #1 the noise was another resident sneezing. Resident #1 grabbed her chest and stated the noise startled her and she felt more cautious of her surroundings since the incident with Resident #2. 2. Record review of Resident #2's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: dementia with other behavioral disturbances, COPD (progressive lung disease that restricts airflow, causing chronic breathing difficulties, cough, and fatigue), Type II diabetes, lack of coordination, depression, psychotic disorder with hallucinations due to known physiological condition (severe mental health conditions causing a loss of contact with reality, characterized by hallucinations, delusions, and disorganized thinking), insomnia, and muscle weakness . Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 7/15, which indicated severe cognitive impairment. The resident exhibited no behavioral symptoms, utilized a wheelchair or walker for mobility, and was able to independently self-propel her wheelchair. Record review of Resident #2's care plan, initiated on 11/2/2023 and last revised on 3/13/2026, revealed a focus area addressing episodes of inappropriate behaviors and the risk for increased behavioral episodes and related injury. This was evidenced by the resident storing soiled clothing in boxes in her room, collecting and storing facility linens in boxes which resulted in odors in the room, placing paper towels and toilet paper in her pull-up briefs, and moving/dragging and rearranging dining room chairs (added to the care plan on 3/13/2026). Interventions included educating the resident to avoid using paper products as padding in her briefs each shift; explaining that the facility will complete her laundry and discouraging the storage of soiled laundry in her room; reminding and encouraging the resident to allow staff to collect her laundry and linens daily; monitoring and documenting behaviors as they occurred and reporting progress or decline to the MD; observing for early warning signs of behaviors and approaching the resident calmly, calling her by name, and providing reassurance as needed; and providing a psychiatric consult as ordered. Record review of Resident #2's physician order, dated 3/18/2024, revealed to monitor target behavior of confusion or aggression at the end of each shift. Record review of Resident #2's February and March 2026 TAR revealed no behaviors were observed. Record review of Resident #2's progress notes revealed no entries from 2/16/2026 - 3/13/2026. Record review of Resident #2's Psychological Services Progress notes, dated 2/23/2026, 3/1/2026 and 3/9/2026 revealed she had diagnoses which included major depressive disorder and generalized anxiety and her symptoms focused on during the sessions, in part, included anxiety and agitation, and her functional behavioral challenges that were focused on, in part, included verbal or physical aggression. Summary of the notes included no concerns, or distress was noted and to continue to monitor residents mood, responsiveness and emotional stability. Observation and interview conducted on 3/13/2026 at 12:41 PM revealed approximately seven residents seated at tables in the dining room, all of whom appeared (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to have finished their meals. Resident #2 was observed in the dining room, ambulating in her wheelchair by propelling herself with both feet. She was observed moving from table to table, picking up items from tables and the floor while also pulling on chairs and tables. Resident #2 was then observed wheeling over to Resident #3 and attempting to pull on Resident #3's wheelchair. Resident #2 bent over, unlocked the left wheel brake of Resident #3's wheelchair, and pulled the wheelchair backward away from the table. Resident #2 was heard mumbling; however, her statements could not be understood. Resident #3 did not respond verbally during this interaction. No staff were present in the dining room at the time; however, staff were observed passing by in the hallway in front of the dining room and in adjacent office areas. The state surveyor approached Resident #2 while she was leaning on the left side of Resident #3's wheelchair. After introduction, Resident #2 asked the state surveyor what she wanted. Resident #2 was able to state her name and indicated she was cleaning, showing the state surveyor trash in her hand. Resident #2 then instructed the state surveyor to leave so she could continue cleaning. She subsequently wheeled away from Resident #3 and the state surveyor and continued moving around to other tables. 3. Record review of Resident #3's facesheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Type II diabetes, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing it of oxygen), chronic kidney disease (long-term, progressive loss of kidney function), congestive heart failure (a chronic, progressive condition where the heart inefficiently pumps blood, causing fluid buildup in the body). Observation and interview conducted on 3/13/2026 at 12:41 PM revealed during the state surveyor's interview with Resident #2, Resident #3 remained silent. After Resident #2 wheeled away, Resident #3 was able to state her name and reported she was doing okay. Resident #3 stated she did not know what Resident #2 wanted or why her wheelchair had been moved and reported having no complaints. Resident #3 was unable to state whether she knew Resident #2. 4. Record review of Resident #4's facesheet revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: Type II diabetes, hypertension , mononeuropathy (damage or dysfunction of a single peripheral nerve, resulting in localized pain, numbness, tingling, and muscle weakness), anxiety disorder, obsessive compulsive disorder (chronic mental health condition characterized by uncontrollable, recurring thoughts and repetitive behaviors performed to reduce anxiety), and age-related cataracts (progressive clouding of the eye's natural lens). Record review of Resident #4's Annual MDS, dated [DATE], revealed a BIMS score of 13/15, which indicated her cognition was intact. Resident #4 had no behaviors, and she could ambulate with a walker. Interview conducted on 3/13/2026 at 12:00 PM revealed Resident #4 stated there was a resident who moved around the facility taking items, whom she identified as Resident #2. Resident #4 reported approximately one month ago, she was in the dining room near the kitchen door waiting for an item she had requested when Resident #2 approached her in a wheelchair and told her to move out of the way. Resident #4 stated she informed Resident #2 she was waiting for something, however, Resident #2 continued yelling at her to move. Resident #4 reported when she did not move, Resident #2 struck her on the arm with her hand. Resident #4 stated the Director of Nursing (DON) was nearby and believed the DON witnessed the incident. Resident #4 further stated the DON told her Resident #2 was confused and this explained her behavior, which indicated it was part of Resident #2's baseline behaviors. Resident #4 reported she began avoiding Resident #2 whenever she saw her because she felt Resident #2 did not like her and was consistently rude to others. Resident #4 stated it was not fair that other residents had to tolerate Resident #2's behavior due to her confusion. Resident #4 added there was another unit designated for residents with cognitive impairment and suggested Resident #2 should be transferred there and stated she did not understand why this had not occurred. Interview conducted on 3/13/2026 at 4:33 PM, CNA A stated she was familiar with Resident #2 and was aware of behaviors involving physical and verbal aggression toward residents and staff. CNA A reported Resident #1 told her Resident #2 previously hit her. CNA A stated she did not witness the incident; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were typical for Resident #2 due to her diagnoses. The RP further stated Resident #1 continued to express fear of Resident #2 during phone calls and avoided leaving her room due to concern Resident #2 would approach or interfere with her. The RP reported she had to encourage Resident #1 to resume normal activities and reassured her she should not allow Resident #2's behavior to limit her daily routine. The RP stated she continued to observe Resident #2 in the dining room during visits and reported Resident #2 exhibited similar behaviors toward other residents. The RP added prior to the wheelchair incident, Resident #1 reported Resident #2 made inappropriate and hateful remarks toward her and other residents. The RP recalled an incident Resident #1 reported in which Resident #2 approached her table, spoke negatively to another resident, and told both residents to go back to where the hell they came from. The RP was unable to identify who the other resident was but stated she was cognitively impaired and not able to defend herself which was why Resident #1 attempted to defend them by telling Resident #2 to leave them alone. The RP stated she felt Resident #1 trying to defend the other resident sparked Resident #2's rage towards Resident #1. The RP also reported observing Resident #2 staring at Resident #1 in the dining room during visits and described the behavior as appearing hostile and caused her to be concerned. Interview conducted on 3/13/2026 at 6:38 PM, the Administrator stated she had just come back from speaking with Resident #1, and she did tell her an incident occurred involving Resident #2 and her being bumped by Resident #2's wheelchair. The Administrator stated Resident #1 reported feeling safe in the facility; however, Resident #1 expressed she believed the contact with the wheelchair was intentional. Interview conducted on 3/13/2026 at 7:00 PM, the Social Worker stated during the care plan meeting on 2/24/2026, the RP asked about Resident #2 and what actions were being taken to address her behaviors. The Social Worker reported she was only aware of a verbal altercation between Resident #1 and Resident #2 and had not received any reports indicating Resident #1 had been struck or rammed with a wheelchair. The Social Worker stated she explained to the RP, Resident #2 was cognitively impaired, and the actions described were consistent with her behavior. She further indicated to the RP interventions were in place to attempt to prevent Resident #2 from disturbing other residents. The Social Worker explained Resident #2 exhibited behaviors such as attempting to clean the dining room and frequently tried to take other residents' plates while they were still eating, which caused disruptions. She stated, in response, staff should monitor Resident #2 and intervene prior to interaction with other residents. The Social Worker stated redirection was often ineffective, as Resident #2 would resume the behavior shortly after being redirected. The Social Worker further stated Resident #2 could become verbally aggressive when she did not get her way; however, she denied any knowledge of physical aggression. The social worker stated if she was aware of any concerns of abuse, she would have immediately reported it to the Administrator. Interview conducted on 3/13/2026 at 7:13 PM revealed LVN A stated she recalled Resident #1 and the RP approaching her while upset about an altercation with Resident #2 a few weeks ago. LVN A stated she did not witness the incident; however, she was informed Resident #2 attempted to take Resident #1's plate and cup while she was still eating and continued to do so while making hateful remarks. LVN A denied being told Resident #1 was struck by Resident #2 but stated Resident #1 reported Resident #2 bumped her with her wheelchair. LVN A stated she did not read the situation as an allegation of abuse. LVN A reported she spoke with Resident #1 and the RP and explained the behavior was consistent with Resident #2's known behaviors and she would address the situation. LVN A stated she subsequently spoke with Resident #2 and redirected her and instructed her not to take items from residents while they were eating. She reported Resident #2 did not respond well to redirection and wheeled away appearing upset following the intervention. LVN A stated she was aware allegations of abuse were required to be reported to the Abuse Coordinator, identified as the Administrator. LVN A identified some types of abuse to include verbal, physical, and sexual. However, LVN A stated she did not report the incident to the Administrator because she did not believe it was a repeated occurrence or that Resident #2 was specifically targeting Resident #1 and it was just part of Resident #2's behaviors. LVN A believed the situation was resolved through her redirection of Resident #2. LVN A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2026

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement written policies and procedures that to prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 of 8 residents (Resident #1 and #2) reviewed for implementation of the abuse policy. The facility failed to implement its abuse policy by not investigating or reporting allegations of verbal and physical abuse to the facility's Abuse Coordinator after Resident #1 and her RP reported concerns of abuse by Resident #2 to LVN A and CNA A on the weekend of 2/21/2026. The facility failed to assess Resident #1 following the allegation of abuse in accordance with its abuse/neglect policy. Resident #1 subsequently reported shoulder/arm pain and exhibited signs of psychological distress related to the alleged abuse. An Immediate Jeopardy (IJ) situation was identified on 3/14/2026. While the IJ was removed on 3/15/2026, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for abuse to go undetected and unreported, allowing potential continuation of abuse and increasing the risk for serious psychological and physical harm.Findings include: 1.Record review of Resident #1's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: osteoarthritis (a degenerative joint disease caused by the breakdown of cartilage covering the ends of bones), depression (mood disorder causing persistent sadness, loss of interest, and physical symptoms like fatigue or pain that disrupt daily life), anxiety disorder (mental health conditions involving excessive, persistent, and uncontrollable worry or fear that interferes with daily life), Alzheimer's disease (a progressive neurological disorder causing brain shrinkage and cognitive decline), abnormalities of gait and mobility, and age related physical debility . Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. Resident #1 reported feeling down, depressed, or hopeless for several days and exhibited no behavioral symptoms. Resident #1 used a wheelchair for mobility and received a scheduled pain medication regimen with no reported pain. Record review of Resident #1's Care Plan, last revised on 10/24/2025, revealed a care area which addressed increased pain/discomfort and risk for injury related to diagnoses of chronic pain and osteoarthritis. Interventions included encouraging the resident to verbalize feelings of pain/discomfort; assisting with ADLs and providing comfort measures as indicated; encouraging socialization and participation in activities as tolerated; monitoring the effectiveness of pain medications and other interventions and reporting to the MD if ineffective; monitoring for side effects of pain medications and reporting any noted to the MD; observing for signs and symptoms of increased pain/discomfort and assessing for possible causes, implementing interventions such as administering pain medications, treatments, and relaxation modalities, and evaluating for relief; and utilizing a 0-10 numeric pain scale to assess pain level. Further record review of Resident #1 care plan, last revised on 10/24/2025, revealed a focus area which addressed the potential for decline in psychosocial well-being and social isolation, as evidenced by the mood interview. Interventions included encouraging family involvement to support a positive psychosocial outlook; encouraging family to bring familiar items during visits; encouraging the resident to attend activities of choice and facilitating pairing with peers who share similar interests; engaging the resident in reminiscing about past experiences and life prior to residency; and introducing the resident to others to promote social interaction and relationship building. Record review of another care plan area for Resident #1, last revised on 10/25/2025, revealed a focus on the use of psychotropic medications and the resident's risk for adverse reactions and episodes of depressive and anxiety-driven behaviors, as evidenced by a diagnosis of depression with anxiety and the use of antidepressant medications. Interventions included encouraging the resident to verbalize feelings during behavioral episodes; monitoring for signs of depressive behaviors such as (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	spontaneous crying, sad mood/affect, self-imposed isolation, and mood not easily altered; reporting any noted changes to the MD/RP; and documenting findings in the clinical record. Record review of Resident #1's physician order, dated 9/30/2025, revealed an order for cyclobenzaprine HCl oral tablet 10MG to be given by mouth every 8 hours as needed for neck and muscle pain related to other chronic pain. Record review of Resident #1's February and March 2026 MAR revealed order for cyclobenzaprine HCl oral tablet 10MG to be given by mouth every 8 hours as needed for neck and muscle pain was administered once on 2/17/2026 at 11:58 PM with a pain rating of 5/10. Record review of Resident #1's physician order, dated 10/1/2025, revealed an order to monitor resident every shift for Target Behaviors of confusion and depressive features. Record review of Resident #1's February and March 2026 TAR revealed according to order to monitor for target behaviors of confusion and depressive features every shift, no behaviors were noted. Record review of Resident #1's physician order, dated 10/1/2025, revealed an order to observe for pain every shift. Record review of Resident #1's February and March 2026 TAR revealed according to order to monitor for pain every shift, no complaints of pain were noted. Record review of Resident #1's physician order, dated 1/8/2026 and discontinued on 2/23/2026, revealed an order for Acetaminophen Extra Strength Tablet 500 MG to give 2 tablet by mouth two times a day for Arthritis. Record review of Resident #1's physician order, dated 2/23/2026, revealed an order for Acetaminophen Extra Strength Tablet 500 MG to give 2 tablet by mouth two times a day related to unspecified osteoarthritis, unspecified site. Record review of Resident #1's February and March 2026 MAR revealed order for Acetaminophen Extra Strength Tablet 500 MG, 2 tablets by mouth two times a day was administered 2/1/2026 - 3/15/2026 as ordered with a pain level of 0/10. Record review of Concern Report, dated 2/22/2026, revealed concern was received by LVN A from Resident #1 regarding Resident #2. The description of concern was, Several residents complaining that above resident cleans DR (dining room) and takes their plates and cups away before they are finished. Investigation details noted, Spoke with resident and was instructed not to clean the DR anymore. Leave it for the kitchen staff. Resident also arguing with other residents about their plates and drinks. Further review of the report revealed the concern was reported to the social worker . Bottom of the concern report regarding Findings of investigation/resolution was blank as well as whom the investigation results were reported to was blank. Investigator signature and Administrator review signatures were also blank on the report. Record review of Resident #1's Psychological Services progress note, dated 2/23/2026, revealed Resident #1 had a diagnosis of major depressive disorder, her functional and behavioral challenges that were focused on during the session was adjustment difficulty with no new stressors noted. The progress note revealed her progress and plan included in part, .Client appeared stable, relaxed and comfortable throughout the visit . continue routine supportive visit to reinforce emotional well-being. Encourage participation in day room activities and peer interaction. monitor for changes in affect and behavior. Record review of Resident #1's progress note, dated 2/24/2026 at 12:42 PM, revealed a physiatry progress note by NP, noted in part, .Resident #1 reports right shoulder/arm pain today. She states another resident ran into her with a wheelchair accidentally a few days ago. She reports the pain is subsiding. Right shoulder pain: patient states another resident accidentally backed into her with her wheelchair. Patient states pain in right arm is subsiding. She did not want to roll sleeves all the way up to exam skin; likely a contusion as there is tenderness with palpation over right upper arm area; range of motion (ROM) is intact. Can abduct shoulder to about 60 degrees. Pain is improving per patient. If it persists, will get xray. Record review of Resident #1's Quarterly Care Plan Meeting note, provided by the facility after exit on 3/16/2026 at 12:02 PM, documented an effective date of 2/24/2026 at 1:30 PM. Care Plan meeting note reflected Resident #1's RP attended the meeting in person and had a summary noting in part, .The family was able to express their concerns regarding the resident having a verbal disagreement with a peer. Their concerns were addressed by IDT members. Record review of Resident #1's psychiatric subsequent assessment, dated 2/27/2026, noted reason for referral was depression and anxiety and chief complaint noted was, I hear voices (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sometimes. Resident #1's History of Presenting Illness noted in part, .Depression: Staff reports current symptoms of loss of interest. severity level 4 (moderate). Symptoms occurring for 8 months. Anxiety: Staff reports current symptoms of impaired concentration. symptoms have been occurring for 7 months. Cognitive Impairment: staff reports current symptoms of confusion and reports no current symptoms of forgetfulness.symptoms have been occurring for 11 months. collateral information: Staff denies any complaints/concerns at this time. Further review of progress note revealed Resident #1's psychiatric review of systems noted anxiety symptoms, depressive symptoms and insomnia and her Mental Status Examination noted she had an anxious depressed mood. Record review of Resident #1's Psychological Services progress note, dated 3/2/2026, revealed Resident #1 had a diagnosis of major depressive disorder, her functional and behavioral challenges that were focused on during the session was adjustment difficulty with no new stressors noted. The progress note revealed her progress and plan included in part, .Client presented with a calm and stable demeanor. continue regular supportive check-ins to sustain emotional stability. Encourage involvement in day room programming and peer interactions. Record review of Resident #1's Psychological Services progress note, dated 3/10/2026, revealed Resident #1 had a diagnosis of major depressive disorder, her functional and behavioral challenges that were focused on during the session was adjustment difficulty with a new stressor of recent illness noted. The progress note revealed her progress and plan included in part, .Discussed recent illness involving diarrhea and assessed clients physical status. Reinforced positive shift toward increased social interaction as symptoms improved. client appeared more comfortable and reported feeling better physically. She engaged in conversation and expressed enjoyment in socializing again. The plan also included to encourage continued social engagement and monitor physical recovery . Observation and interview on 3/13/2026 at 5:00 PM, the Administrator identified Resident #1 sitting in the dining room at a table with another resident. Resident #1 said things had generally been going okay at the facility, but she reported having a serious issue with one resident. Resident #1 stated there was another female resident who was always in the dining room messing with everyone. Resident #1 stated she did not know the resident's name but identified her as being present in the dining room at that time, sitting a few tables away. It was noted Resident #2 was seated in the dining room approximately two tables away from Resident #1. Resident #1 stated Resident #2 did not like her, and she did not know why. Resident #1 stated Resident #2 was rude to her and other residents and would say nasty hateful things to everyone. Resident #1 stated she had never done anything to Resident #2 to cause this behavior and said she was terrified of Resident #2 because Resident #2 had hit me with her wheelchair a few weeks earlier. Resident #1 pointed out an area in the dining room, beside a nearby table, and stated that was where she was sitting when she felt a hard crash from behind. Resident #1 stated she could hear Resident #2 talking but could not make out what she was saying. Resident #1 stated she was so scared when it happened, she could not remember who else was around and was in shock from the incident. Resident #1 stated Resident #2 eventually wheeled away, while she remained scared and concerned Resident #2 might return. Resident #1 recalled seeing her RP later that same day and told her what happened. Resident #1 stated she and her RP then spoke to the facility staff about the incident involving Resident #2. Resident #1 stated after the incident of being hit by the wheelchair, if she saw Resident #2 in the hallway or dining room, she would go back to her room because she was afraid to be around her and did not know what Resident #2 might do next. Resident #1 stated the way Resident #2 treated her and the other residents was very upsetting. Resident #1 stated her RP and staff tried to tell her that was just how Resident #2 acted because she had issues, but Resident #1 stated she did not feel it was fair that she and the other residents had to tolerate being harassed by Resident #2. Resident #1 stated she did not think Resident #2 should be at the facility. Resident #1 stated she was still scared of Resident #2 but felt somewhat safer now because she made friends at the facility who she felt had her back. Resident #1 stated she was just beginning to return to the dining room while Resident #2 was present due to encouragement from her RP and other residents, but she would rather (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not have to be around Resident #2. Resident #1 stated after being hit by Resident #2's wheelchair, she experienced severe shoulder pain. Resident #1 stated the wheelchair strike was really hard and hurt really bad. Resident #1 pointed to her right shoulder as the area affected and stated it felt better at the time of the interview; however, after the incident she had pain in her right shoulder for about one week. Resident #1 stated her RP was aware of the shoulder pain and recalled telling her PE teacher (NP) about the incident and her shoulder pain as well. During the interview, another resident sat at a nearby table sneezed loudly. Resident #1 was visibly startled and jumped in her chair. The state surveyor reassured Resident #1 the noise was another resident sneezing. Resident #1 grabbed her chest and stated the noise startled her and she felt more cautious of her surroundings since the incident with Resident #2. 2. Record review of Resident #2's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: dementia with other behavioral disturbances, COPD (progressive lung disease that restricts airflow, causing chronic breathing difficulties, cough, and fatigue), Type II diabetes, lack of coordination, depression, psychotic disorder with hallucinations due to known physiological condition (severe mental health conditions causing a loss of contact with reality, characterized by hallucinations, delusions, and disorganized thinking), insomnia, and muscle weakness . Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 7/15, which indicated severe cognitive impairment. The resident exhibited no behavioral symptoms, utilized a wheelchair or walker for mobility, and was able to independently self-propel her wheelchair. Record review of Resident #2's care plan, initiated on 11/2/2023 and last revised on 3/13/2026, revealed a focus area addressing episodes of inappropriate behaviors and the risk for increased behavioral episodes and related injury. This was evidenced by the resident storing soiled clothing in boxes in her room, collecting and storing facility linens in boxes which resulted in odors in the room, placing paper towels and toilet paper in her pull-up briefs, and moving/dragging and rearranging dining room chairs (added to the care plan on 3/13/2026). Interventions included educating the resident to avoid using paper products as padding in her briefs each shift; explaining that the facility will complete her laundry and discouraging the storage of soiled laundry in her room; reminding and encouraging the resident to allow staff to collect her laundry and linens daily; monitoring and documenting behaviors as they occurred and reporting progress or decline to the MD; observing for early warning signs of behaviors and approaching the resident calmly, calling her by name, and providing reassurance as needed; and providing a psychiatric consult as ordered. Record review of Resident #2's physician order, dated 3/18/2024, revealed to monitor target behavior of confusion or aggression at the end of each shift. Record review of Resident #2's February and March 2026 TAR revealed no behaviors were observed. Record review of Resident #2's progress notes revealed no entries from 2/16/2026 - 3/13/2026. Record review of Resident #2's Psychological Services Progress notes, dated 2/23/2026, 3/1/2026 and 3/9/2026 revealed she had diagnoses which included major depressive disorder and generalized anxiety and her symptoms focused on during the sessions, in part, included anxiety and agitation, and her functional behavioral challenges that were focused on, in part, included verbal or physical aggression. Summary of the notes included no concerns, or distress was noted and to continue to monitor residents mood, responsiveness and emotional stability. Observation and interview conducted on 3/13/2026 at 12:41 PM revealed approximately seven residents seated at tables in the dining room, all of whom appeared to have finished their meals. Resident #2 was observed in the dining room, ambulating in her wheelchair by propelling herself with both feet. She was observed moving from table to table, picking up items from tables and the floor while also pulling on chairs and tables. Resident #2 was then observed wheeling over to Resident #3 and attempting to pull on Resident #3's wheelchair. Resident #2 bent over, unlocked the left wheel brake of Resident #3's wheelchair, and pulled the wheelchair backward away from the table. Resident #2 was heard mumbling; however, her statements could not be understood. Resident #3 did not respond verbally during this interaction. No staff were present in the dining room at the time; however, staff were observed passing by in the hallway in front of the (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dining room and in adjacent office areas. The state surveyor approached Resident #2 while she was leaning on the left side of Resident #3's wheelchair. After introduction, Resident #2 asked the state surveyor what she wanted. Resident #2 was able to state her name and indicated she was cleaning, showing the state surveyor trash in her hand. Resident #2 then instructed the state surveyor to leave so she could continue cleaning. She subsequently wheeled away from Resident #3 and the state surveyor and continued moving around to other tables. Interview conducted on 3/13/2026 at 4:33 PM, CNA A stated she was familiar with Resident #2 and was aware of behaviors involving physical and verbal aggression toward residents and staff. CNA A reported that Resident #1 had told her that Resident #2 had previously hit her. CNA A stated she did not witness the incident; however, she recalled an occasion when she was escorting Resident #1 to the dining room and, upon seeing Resident #2, Resident #1 became tearful and stated she did not want to enter the dining room due to fear of Resident #2. CNA A reported she asked Resident #1 why she was avoiding Resident #2, and Resident #1 stated that Resident #2 had hit her. CNA A was re-interviewed on 3/13/2026 at 5:20 PM and stated that Resident #1 first reported the incident to her a few weeks ago. CNA A further stated that Resident #1 continued to express concerns about Resident #2 whenever she encountered her, became visibly upset at the sight of Resident #2, and preferred to remain in her room to avoid contact. CNA A reported she had received multiple in-services on abuse and neglect and understood that all allegations of abuse should be reported to the Administrator, who serves as the Abuse Coordinator. CNA A stated she did not report Resident #1's allegations because Resident #1 indicated that the nurse and social worker were already aware, and she assumed the issue was being addressed. CNA A further stated that, in response to Resident #2's behaviors, staff attempted to monitor her in the dining room to prevent her from disturbing other residents; however, Resident #2 does not respond well to redirection. Interview conducted on 3/13/2026 at 4:50 PM, the Administrator stated no concerns had been reported to her regarding Resident #2 exhibiting aggressive behaviors. The Administrator reported she was aware that Resident #2 frequently attempted to clean the dining room and would take trays from residents before they had finished eating; however, she had not received any reports of aggressive behavior during these incidents. The Administrator further stated she was not aware of any incidents involving Resident #1 and Resident #2 and indicated staff were trained to report all abuse concerns directly to her so an investigation could be conducted and if she was not available for them to report to the DON. The Administrator stated staff received in-service training multiple times per month on abuse and neglect, which included her role as the Abuse Coordinator, identification of different types of abuse, and the requirement to report all abuse concerns to her. Phone interview conducted on 3/13/2026 at 5:11 PM revealed that the Director of Nursing (DON) stated she had not received any reports of Resident #2 exhibiting aggressive behavior toward any resident. The DON further stated if any allegations of abuse, whether verbal or physical, were reported to her, she would notify the Administrator to initiate an investigation and ensure appropriate reporting. The DON added the staff were trained to report any allegation or witness of abuse to her or the Administrator so it could be promptly addressed and investigated. The DON said the priority in abuse and neglect allegations is to ensure resident safety first which included assessing residents for injuries and reporting immediately after ensuring residents involved are okay and safe. Phone interview conducted on 3/13/2026 at 6:06 PM, Resident #1's responsible party (RP) stated there was a significant concern involving Resident #2 and reported that Resident #1 was fearful of Resident #2. The RP stated she visited the facility on either 2/21/2026 or 2/22/2026, at which time Resident #1 reported that, just minutes prior to her arrival, Resident #2 had rammed her with a wheelchair in the dining room. The RP stated Resident #1 was upset and crying following the incident. The RP reported that this caused her to become upset and tearful as well due to concerns for Resident #1's safety, and she made staff aware of the situation. The RP stated that several CNAs were present and appeared aware of the incident. She reported speaking with LVN A regarding Resident #2's aggressive behavior and asked what actions would be taken to ensure Resident #1's safety. The RP stated she (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	did not recall any staff assessing Resident #1 at that time. She reported observing a bruise developing on Resident #1's elbow. The RP stated she was later informed that staff assessed Resident #1's shoulder due to complaints of pain; however, she was told there was no bruising noted to the shoulder and was not informed of any assessment of the elbow. The RP stated she believed the elbow was the point of impact and that the pain radiated to the shoulder. The RP further reported Resident #1's right shoulder bothered her for about a week after the incident. The RP reported that a care plan meeting was held on 2/24/2026 with approximately three staff members, including a social worker. She stated she asked what actions were being taken regarding Resident #2 to ensure Resident #1's safety and was informed that the situation was being handled and that the behaviors described were typical for Resident #2 due to her diagnoses. The RP further stated that Resident #1 continued to express fear of Resident #2 during phone calls and avoided leaving her room due to concern that Resident #2 would approach or interfere with her. The RP reported she had to encourage Resident #1 to resume normal activities and reassured her that she should not allow Resident #2's behavior to limit her daily routine. The RP stated she continued to observe Resident #2 in the dining room during visits and reported that Resident #2 exhibited similar behaviors toward other residents. The RP added that prior to the wheelchair incident, Resident #1 had reported that Resident #2 made inappropriate and hateful remarks toward her and other residents. The RP recalled an incident Resident #1 reported in which Resident #2 approached her table, spoke negatively to another resident, and told both residents to go back to where the hell they came from. The RP was unable to identify the other resident involved. The RP also reported observing Resident #2 staring at Resident #1 in the dining room during visits and described the behavior as appearing hostile and caused her to be concerned. Interview conducted on 3/13/2026 at 6:38 PM revealed that the Administrator stated she spoke with Resident #1, who reported that an incident had occurred involving Resident #2 and that she was bumped by Resident #2's wheelchair. The Administrator stated that Resident #1 reported feeling safe in the facility; however, Resident #1 expressed that she believed the contact with the wheelchair was intentional. Interview conducted on 3/13/2026 at 7:00 PM, the Social Worker stated during the care plan meeting on 2/24/2026, the RP asked about Resident #2 and what actions were being taken to address her behaviors. The Social Worker reported she was only aware of a verbal altercation between Resident #1 and Resident #2 and had not received any reports indicating Resident #1 had been struck or rammed with a wheelchair. The Social Worker stated she explained to the RP, Resident #2 was cognitively impaired, and the actions described were consistent with her behavior. She further indicated to the RP interventions were in place to attempt to prevent Resident #2 from disturbing other residents. The Social Worker explained Resident #2 exhibited behaviors such as attempting to clean the dining room and frequently tried to take other residents' plates while they were still eating, which caused disruptions. She stated, in response, staff should monitor Resident #2 and intervene prior to interaction with other residents. The Social Worker stated redirection was often ineffective, as Resident #2 would resume the behavior shortly after being redirected. The Social Worker further stated Resident #2 could become verbally aggressive when she did not get her way; however, she denied any knowledge of physical aggression. The social worker stated she had been in-serviced on abuse and neglect and if she was aware of any concerns of abuse, she would have immediately reported it to the Administrator. Interview conducted on 3/13/2026 at 7:13 PM revealed LVN A stated she recalled Resident #1 and the RP approaching her while upset about an altercation with Resident #2 a few weeks ago. LVN A stated she did not witness the incident; however, she was informed Resident #2 attempted to take Resident #1's plate and cup while she was still eating and continued to do so while making hateful remarks. LVN A denied being told Resident #1 was struck by Resident #2 but stated Resident #1 reported Resident #2 bumped her with her wheelchair. LVN A stated she did not read the situation as an allegation of abuse. LVN A reported she spoke with Resident #1 and the RP and explained the behavior was consistent with Resident #2's known behaviors and she would address the situation. LVN A stated she subsequently spoke with Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2026

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

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#2 and redirected her and instructed her not to take items from residents while they were eating. She reported Resident #2 did not respond well to redirection and wheeled away appearing upset following the intervention. LVN A stated she was aware allegations of abuse were required to be reported to the Abuse Coordinator, identified as the Administrator. LVN A identified some types of abuse to include verbal, physical, and sexual. However, LVN A stated she did not report the incident to the Administrator because she did not believe it was a repeated occurrence or that Resident #2 was specifically targeting Resident #1 and it was just part of Resident #2's behaviors. LVN A believed the situation was resolved through her redirection of Resident #2. LVN A denied completing an assessment of Resident #1 following the allegation due to her not seeing a concern for abuse and stated she was not informed Resident #1 experienced pain related to the incident otherwise she would of assessed her. LVN A reported, in response to Resident #2's behaviors, staff monitored her during meals to prevent her from taking items from other residents. She further stated recently Resident #2 had not been observed taking items from residents' plates but developed a fixation on a bookcase in the hallway and did not want other residents to touch it. LVN A stated she also redirected Resident #2 regarding this behavior, and Resident #2 responded with signs of frustration when redirected. LVN A stated she was aware that all allegations of abuse are required to be reported to the Abuse Coordinator, identified as the Administrator. However, LVN A stated she did not report the incident because she did not believe it was a repeated occurrence or that Resident #2 was specifically targeting Resident #1, and she believed the situation had been resolved through redirection. LVN A denied completing an assessment of Resident #1 following the allegation and stated she was not informed that Resident #1 experienced pain related to the incident. LVN A reported that, in response to Resident #2's behaviors, staff monitor her during meals to prevent her from taking items from other residents. She further stated that recently Resident #2 had not been observed taking items from residents' plates but had developed a fixation on a bookcase in the hallway and did not want other residents to touch it. LVN A stated she also redirected Resident #2 regarding this behavior, and Resident #2 responded with signs of frustration when redirected. Interview on 3/23/2026 at 1:28 PM, the NP stated he authored Resident #1's physiatry progress note, dated 2/24/2026, and recalled Resident #1 reporting right shoulder pain. The NP stated he had a brief discussion with Resident #1 regarding the pain and recalled her reporting another resident had run into her with a wheelchair that may have initiated the pain. The NP stated Resident #1 did not indicate whether she believed the incident was intentional and he interpreted the event as accidental. The NP further stated he did not explore the incident in detail, as Resident #1 reported the pain was subsiding and not severe. He did attempt to assess Resident #1's shoulder but she did not want him to visualize the skin area, so he was just able to palpate the area in which she expressed minor pain when he did. NP stated no orders for x-rays were ordered at that time because Resident #1 expressed the pain was already getting better and made no further complaints about it that he was aware of. Record review of the facility Abuse, Neglect, and Exploitation (ANE) Prohibition policy revised 10/2024 revealed in part, .The facility administrator serves as the Abuse Prevention Coordinator. In the temporary absence of Administrator, appointed designee may temporarily serve as the Abuse Prevention Coordinator. Abuse - the willful infliction of injury, unreasonable confinement, intimi