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 04/20/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote and facilitate resident self-determination through support of resident choice to including but not limited to the residents right to make choices about aspects of his or her life in the facility that are significant to the resident, healthcare and providers of healthcare services consistent with his or her interest, assessments, and plan of care and other applicable provisions of this part for 3 of 9 residents (Residents #1, #2 and #3) reviewed for resident rights. The facility failed to support Resident #3 choice to use Medical Transportation B for transportation to and from medical appointments. The facility failed to support Residents #1 and #2's choice to use Medical Transportation B for transportation to and from medical appointments when their family members requested it. This failure could place residents at risk of loss of self-determination resulting in loss of independence, frustration or sadness, and diminished quality of life.Findings included:Resident #3 Record review of Resident #3's admission Record generated on [DATE] revealed she was admitted to the facility on [DATE] with diagnoses of type II diabetes, (a chronic, non-insulin-dependent condition where the body develops insulin resistance or fails to produce enough insulin, causing high blood sugar levels), heart failure (a chronic, progressive condition where the heart muscle cannot pump blood efficiently, leading to fluid buildup in the lungs and body, fatigue, and shortness of breath), chronic angle closure glaucoma (a slow-progressing, often asymptomatic eye disease where the iris gradually blocks the eye's drainage, causing high pressure and permanent damage to the optic nerve), chronic obstructive pulmonary disease (a progressive, incurable lung disease causing chronic airflow obstruction, breathlessness, and cough), and end stage renal disease (the final, permanent stage of chronic kidney disease, occurring when kidney function drops below 10-15% and they can no longer support life). She was [AGE] years of age. Record review of Resident #3's Care Plan dated [DATE] revealed she received dialysis three times a week at an offsite dialysis clinic. The transportation company was listed as Medical Transportation A. Record review of Resident #3's admission MDS assessment dated [DATE] revealed she had the ability to express ideas and wants and had the ability to understand others. She had a BIMS of 11, indicating she had moderate cognitive impairment. In an interview on [DATE] at 11:47am, Resident #3 stated she told two staff members that she wanted to use Medical Transportation B and they said no. Resident #3 said the staff members told her Medical Transportation B could not come on the premises. She said there was nothing wrong with Medical Transportation A, but .you get used to who you get used to.Resident #1Record review of Resident #1's admission Record generated on [DATE] revealed he was admitted to the facility on [DATE] with diagnoses of cerebral infarction (a medical emergency caused by blocked blood flow to the brain, leading to tissue death), dysphagia (difficulty swallowing) and end state regnal disease. He was [AGE] years of age. Family Member D was listed as Resident #1's emergency contact and responsible party. Record review of Resident #1's Care Plan dated [DATE] revealed he received dialysis three times a week at an offsite dialysis clinic. Record review of Resident #1's Care Plan dated [DATE] revealed he had a communication problem related to an impaired ability to make self- understood and an impaired ability to understand others. Record (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: 676040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2026
NAME OF PROVIDER OR SUPPLIER Paradigm at the Prairies		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #1's Nursing Progress Note dated [DATE] at 11:32am, written by the DON read, Spoke with (Family Member D) regarding transportation to and from dialysis. [Family Member D] was assured that the facility has set the resident up has (sic) safe and reliable transportation via stretcher through [Medical Transportation A] for dialysis visits. [Family Member D] states as long as we get him there that is al that she is worried about. Again, reassured the (family member) that transportation was already set up. In an observation and attempted interview on [DATE] at 10:35am, Resident #1 was in his room in bed. He could respond to yes and no questions, however he did respond to questions regarding dialysis or medical appointments. In a telephone interview on [DATE] at 5:00pm, Family Member D said Resident #1 used Medical Transportation A for transportation to and from dialysis. Family Member D said Resident #1 used Medical Transportation B when he was at home. I asked if they could use (Medical Transportation B) and they said no. She said the DON told her Medical Transportation A had a contract with the facility and they did not have a contract with Medical Transportation B and they did not allow Medical Transportation B in their facility. Family Member D said, Why can't I use who I want to use? I really have no choice. Resident #2 Record review of Resident #2's admission Record generated on [DATE] revealed he was admitted to the facility on [DATE] with diagnoses of traumatic amputation of left lower leg, encephalopathy (any disease, damage, or malfunction that affects brain structure and function, leading to altered mental states like confusion, dementia, seizures, or coma), end stage renal disease, type II diabetes, and chronic obstructive pulmonary disease. He was [AGE] years of age. Family Member C was listed as Resident #2's emergency contact and healthcare power of attorney. Resident #2 expired on [DATE]. Record review of Resident #2's Care Plan dated [DATE] revealed he received dialysis three times a week at an offsite dialysis clinic. The transportation company was listed as Medical Transportation A. Record review of Resident #2's Care Plan dated [DATE] revealed Resident #2 had impaired cognitive function or impaired thought processes. Interventions included communicating with the resident, family and caregivers regarding resident's capabilities and needs, and keeping the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. In a telephone interview on [DATE] at 3:54pm, Family Member C said Resident #2 required transportation to and from dialysis and scheduled medical appointments. Family Member C said they preferred to use Medical Transportation B. Family Member C said she asked facility staff if they could call Medical Transportation B to see if they had availability for his appointments. Family Member C said facility staff told her Medical Transportation B was not allowed to come into the facility because the nursing facility's parent company would not allow it. She could not recall the facility staff members' names. Family Member C said Resident #2 had been using Medical Transportation B three times a week for years when he lived at home. Family Member C said, They know (Resident #2), and the less change possible would be beneficial to him. In a telephone interview on [DATE] at 4:55pm, the Administrator of Medical Transportation B said any time their patients were placed at the facility, they were not allowed to provide transportation. She said they provided services in the area for 18 years. She said their patients were like family. She said if a patient was established with their company, then it would be easy to continue transportation at the nursing home. She said she had spoken to the Administrator and the DON at the facility, and they told her they only use Medical Transportation A. In an interview on [DATE] at 6:15pm, ADON A 6:15pm said some of the resident's family members and or residents had set up transportation on their own. She said it was important for residents to be able to request their own ambulance company because it would be their right to choose. In an interview on [DATE] at 6:45pm, the Administrator said Resident #3 requested to use another ambulance service when she admitted to the facility. She could not recall other requests from other residents. She said when Resident #3 asked to use Medical Transportation B, the Administrator told Resident #3 that Medical Transportation B did not pick up any residents from their facility. She did not believe that they serviced their area. She said they used Medical Transportation A because it was the only one in town. In an interview on [DATE] at 2:25pm, the DON said Medical Transportation (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 04/20/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A was local to their area. She said a year ago, they used Medical Transportation B, but there was legal action involved. She could not recall the outcome of the legal action. When asked why it would be important for residents to choose their own transportation company, she said it was because of resident rights. Record review of facility Education regarding Resident Rights, Dignity and Privacy (undated) read, Resident Rights: Legal rights protected under federal law. These rights ensure that residents in Medicare- and Medicaid-certified nursing facility are treated with dignity and respect. Resident Rights. Right to Make Independent Choices. Choose personal scheduled, activities, clothing, and visitors. Manage your own finances or choose someone to do it for you. Record review of the Resident admission Agreement dated [DATE] read, Transportation. The Resident/Responsible Party is generally responsible for transporting the Resident to and from medical appointments, dental appointments, and any other off-siteappointments. The Facility may, upon request of the Resident/Responsible Party, transport or arrange for the transport of non-Medicaid residents to their medical and health care providers at the Facility's standard rates for such services.

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 04/20/2026
NAME OF PROVIDER OR SUPPLIER Paradigm at the Prairies		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide written notice as soon as practicable before transfer or discharge to resident and resident's representative and the reason for the move in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman 1 of 2 resident (CR #10) reviewed for transfer and discharge rights.-The facility failed to provide a written notice of transfer to CR #10, CR #10's representative and the long-term care ombudsman as soon as practicable when CR #10 was transferred to another nursing facility on 3/5/26. This failure placed residents at risk of not receiving an advocate who can inform them of their options, rights, and the added protection from being inappropriately transferred or discharged .Findings included: Record review of CR #10's admission Record generated on 4/16/26 revealed he was admitted to the facility on [DATE] with diagnoses of dementia (a general term for a progressive decline in cognitive function-memory, thinking, and behavior-that interferes with daily life), malignant neoplasm of the prostate (a cancerous tumor forming in the prostate gland's epithelial tissue), anxiety disorder (the body's natural reaction to stress, causing persistent, excessive worry and physical symptoms like rapid heart rate, sweating, and tension), and psychosis (a mental health symptom, not a specific illness, characterized by a disconnection from reality, including hallucinations {seeing, hearing things} and delusions [false, firm beliefs]. He was [AGE] years of age. Guardian E was listed as his emergency contact. He was discharged on 3/5/26. Record review of CR #10's Care Plan dated 8/23/24 revealed he had impaired cognition with short term memory loss and impaired decision making. The care plan indicated he had a legal guardian. Interventions included contacting his legal guardian for all changes and/or decision making. Record review of CR #10's Nurse Progress Note dated 3/5/26 at 9:09am revealed CR #10 was transferred to a sister facility (other nursing facility). Record review of CR #10's electronic medical record on 4/16/26 at 4:34pm indicated no record of a discharge notice or transfer notice. Record review of a Provider Investigation Report dated 3/9/26 read, [CR #10] was propelling down the hallway.he saw [Resident #4] and propelled himself to [Resident #4] and immediately hit him, once in the chest and again in the left arm. These two gentleman had previously been involved in a resident -to- resident alteration on 2/20/26, an altercation initiated by [Resident #4] and received by [CR #10].Since the initial incident, the facility has been actively seeking alternate placement for [Resident #4].[CR #10]. has been transferred temporarily to a sister facility until we can secure alternate placement for [Resident #4]. In a telephone interview on 4/16/26 at 4:38pm, Guardian E said a facility staff member called to inform her that CR #10 was going to be moved to another nursing facility because of an incident that happened. Guardian E said they informed her it was not CR #10's fault, but they were going to move him. Guardian E said they did not give written discharge notice or give her an option of which facility he would go to. She said she agreed to the transfer plan. In an interview on 4/16/26 at 6:45pm, the Administrator said after the incident between CR #10 and Resident #4, she called Guardian E. She said she informed Guardian E that they placed CR #10 at a sister facility, but they were not kicking him out. She said they were trying to get him to a safe place. She said Guardian E understood. She said they did not complete a written transfer or discharge notice. She said she was thinking about safety first.Record review of the facility's Discharge/Transfer policy and procedure dated 6/2025 read, Involuntary discharges.The Facility must provide a discharge notice as soon as practicable.if: The safety of an individual in the facility would be endangered. The Facility should provide as much specific information as possible in the discharge notice to notify the resident why he or she is being discharged and how the discharge meets discharge criteria.

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 04/20/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population for 1 of 3 nursing stations (Station 3) reviewed for sufficient staff.The facility failed to have sufficient staff to ensure staff were always present in the locked memory care unit that housed 14 residents with dementia. This failure could place residents at risk of decreased supervision, accidents, abuse and injuries.Findings included:Record review of the facility's Daily Census dated 4/15/26 revealed there were 14 residents residing on the memory care unit and 13 residents residing on Station 3. Record review of the facility's Resident Matrix dated 4/16/26 revealed 13 of 14 residents residing on the memory care unit had a diagnosis of dementia or Alzheimer's disease. In an observation and interview on 4/16/26 at 1:10pm, Family Member F was visiting a resident in the memory care unit. Family Member F said her family member was in the memory care unit due to dementia. She said the care she received on night shift and weekends was poor quality. Family Member F said they do not check on her enough at night and they leave her in the common area too late. Family Member F said one Saturday night when she visited there were no staff in the memory care unit. In an interview on 4/16/26 at 5:54pm, Medication Aide U, she said she worked during the day shift. She said she covered Station 3 and the memory care unit. She said she had to leave the memory care unit to pass medications on Station 3, leaving one CNA on the unit. She said some of the memory care residents acted out. She said the nurse and other aides could help, but they aide had assignments, including showers and rounds. She said they could not always supervise the residents in the memory care unit. Facility administration had not advised her on what to do when the other aide/nurse was busy and she had to leave the unit, leaving the residents without supervision. In an interview on 4/16/26 at 5:57pm, LVN R said she primarily worked on the day shift. When asked if there were enough staff to meet the residents' needs, she said there were not enough staff on the floor at night, and they were constantly running back and forth. She said during the day shift, they had one CNA and one medication aide for Station 3 and the memory care unit. She said at night, there was only one CNA assigned to Station 3 and the memory care unit. She said some residents were dependent on staff on Station 3. She said the CNA had to leave the memory care unit to care for residents on the other side of the locked unit in Station 3. In an observation on 4/16/26 at 5:58pm, the memory care unit was noted to be one hallway with a locked glass door on one end and a common area with a couch and dining tables on the other end. You could see through the glass door and see the hallway where Station 3 residents resided. There were 5 residents in the common area. Resident #5 stood up from a chair at a dining room table, walked to a medication cart and grabbed a blood pressure cuff, then sat back down in the same chair. Three residents were walking down the hallway and entering resident rooms. CNA W stated to one resident that she entered the wrong room and to go to her room. In an interview on 4/16/26 at 6:00pm, CNA W said the memory care unit needed to be staffed with two CNAs. She felt like she had to rush when the residents needed help. Many of the memory care residents are moving the whole day. She said when one resident got up, they all got up to follow at times. She said it could get a little busy on the memory care unit.In an interview on 4/16/26 at 6:25pm, ADON B said there should be two people at all times in the memory care unit. She said during the day, it was usually a medication aide and a CNA. If the medication aide or the CNA had to step out, then the nurse, another CNA or activity personnel are on the floor. She said at night there was one staff member. She said the resident's needs were met by the staff. In an interview on 4/16/26 at 6:45pm, the Administrator stated Family Member F brought staffing concerns to her and reported that she visited one night and there were no staff on the memory care unit. The (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 04/20/2026
NAME OF PROVIDER OR SUPPLIER: Paradigm at the Prairies		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator told Family Member F that just because you did not see the staff did not mean they were not there. The Administrator said she interviewed a few staff members and the Administrator determined there was someone on the memory care unit the night Family Member F reported there were no staff on the hall. She said when they review staffing ratios, they look at PPD (a key healthcare metric, primarily in skilled nursing, representing the average cost, hours, or supply usage allocated to one patient over 24 hours) and if residents had higher acuity they would staff more. She said if there was an increase in falls or skin issues then they would look at increasing the staffing ratio. In an observation on 4/19/26 at 10:16pm, LVN O was sitting at the nurse's station on Station 3. CNA N was walking down the hallway toward Station 2 with another staff member. No staff were observed on the memory care unit. In an observation on 4/19/26 at 10:18pm, CNA N entered the memory care unit with the state surveyor. There were no other staff members observed on the unit. In an interview on 4/19/26 at 10:20pm, CNA N said she thought the facility was staffed well. She said some residents wanted care right away and they could not provide that. She said she made rounds to all residents on station 3 and memory care with no problems. CNA N said she was the only aide assigned to the memory care unit tonight. She said she primarily worked during the night shift. In an and interview on 4/19/26 at 11:32pm, LVN P said she primarily worked the night shift. She said there were only two nurses after 10:00pm at the facility. She said when the nurse left at 10:00pm, she covered both station 2 and station 3, caring for about 50 residents. She said if there was a change of condition or a resident admission, it could get busy. She further said she had to pass medications. She said there should always be someone in the memory care unit. She said the CNA assigned to memory care also cared for the residents on Station 3. She worried about the residents in the memory care unit because they were at risk of falls, behaviors and needed supervision. She thought that they needed 2 CNAs on the hall. In an interview on 4/19/26 at 11:45pm, the DON said LVN O worked from 6pm-10pm on station 3, then moved over to station 1 at midnight. She said the nurse who worked on station 1 worked from 6pm to midnight. When asked if there were only 2 nurses at night, the DON said she was a little unfamiliar with the schedule because she had been off for medical leave. In a telephone interview on 4/20/26 at 8:44am, LVN O said she did not think the facility was staffed appropriately. She said they had two nurses who worked the night shift, with four CNAs. She said the CNAs were running around answering call lights, doing rounds, then had to do rounds all over again. She said the CNAs were not taking a lunch break. She said she had took her concerns to the DON. She said someone should always be in the memory care unit. She said the residents in the memory care unit did not sleep at times and some residents had behaviors. She said the aide had to leave the memory care unit to check on the other residents on Station 3. She said they tried their best to keep someone on the unit. In a telephone interview on 4/20/26 at 11:30am, CNA T said the facility was not sufficiently staffed in the memory care unit. She said there should be two people in the unit at all times. She said there were residents in the common area, and some were in the room, and they could not monitor and supervise all of them. She said she would be on the memory care unit by herself at times. She said some residents had behaviors like going in other residents' rooms and taking other residents' belongs. In an interview on 4/20/26 at 2:25pm, the DON said the memory care unit should always have a staff member. When the state surveyor informed the DON that there were no staff members in the memory care unit on the night of 4/19/26, she said it was surprising. She said it was the charge nurses' responsibility to direct their CNAs and tell them who to care for. She said staff needed to ensure that someone was there all the time, and if they stepped out of the memory care unit then they needed to call someone for help. The DON said the nurses would always ask for more staff, regardless of how many people were working. She said 2 nurses and 5 CNAs was appropriate for their census. Record review of the facility policy and procedure for Contingency Staffing dated 1/2025 read, The facility is committed to maintaining adequate staffing levels to ensure the safety and well-being of residents.