

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/21/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical status for one (Resident #1) of seven residents reviewed for resident rights. The facility failed to ensure LVN A notified the resident's responsible party/medical power of attorney within a reasonable time when Resident # 1's x-ray's result revealed she had bronchitis (an inflammation of the tubes that carry air to the lungs).This failure could place residents at risk of not having their responsible party/medical power of attorney notified of changes, which could result in a delay in timely intervention and a decline in condition. Findings included:Record review of Resident #1's face sheet dated 07/17/2026 revealed she was an [AGE] year-old female who was originally admitted into the facility on [DATE] with the following diagnoses: Dementia (loss of thinking, remembering, and reasoning skills), pulmonary edema (fluid build-up in the lungs), heart failure (the heart muscle is unable to pump enough blood and oxygen), kidney disease (when the kidneys cannot filter waste and excess fluids from the blood), urinary tract infection (bacteria in the urinary system), high blood pressure, diabetes (high levels of sugar in the blood), anemia (not enough oxygen in the blood) and urinary incontinence.Record review of Resident #1's MDS dated [DATE] revealed her BIMS score was not graded-indicating she was unable to complete the interview. Section Q-Participating in assessment and goal setting indicated family. Section Q0500-Information source indicated family.Record review of Resident #1's care plan dated 08/02/2024 revised on 07/03/2026 revealed: Respiratory illness. Goal: Will have no adverse effects from developing or being at risk for respiratory viral illnesses. Intervention: Monitor resident for signs/symptoms of respiratory illnesses (fever, chills, fatigue, cough, runny nose and headaches). Notify the Physician for new symptoms (of respiratory illnesses and recommend testing for viral respiratory illnesses where appropriate.In an interview with the Nurse practitioner on 07/21/2026 at 12:20 p.m., she said prior to Resident # 1 being hospitalized for bronchitis, she had discussed the option of hospice with the family. The NP said after she and the Doctor assessed Resident #1, and they ordered chest x-ray. When they received the report from the nurse, she ordered antibiotics, breathing treatment, steroid and cough medication. She said when the nurse called and said that Resident #1 was further declining, she gave orders for the resident to be transferred to the hospital for a higher level of care. She was diagnosed with aspiration pneumonia (when you breath food, liquid, vomit, or saliva into your airways instead of swallowing it down your stomach)which could have resulted from her own secretions, food or fluids.In an interview with RN A on 07/21/2026 at 1:16 p.m., she said it is the responsibility of the nurse who received the X-ray result to have notified the family with the result. She said she expected the nurse who provided care to Resident #1 on the day the (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	x-ray was ordered to have notified the responsible party before and after the x-ray was completed of the result. She said the fact that important information was not communicated to the responsible party who knows their loved one best, could have resulted in delayed care. In an interview with LVN A on 07/21/2026 at 1:30 p.m., she said she notified Resident #1's responsible party number one before the x-ray was completed. She said the x-ray result revealed Resident #1 had bronchitis. LVN A said she did not remember if she had notified the responsible parties of the x-ray result. She said she did not document in the resident's chart that she notified the responsible parties. She said as nurses if there was no documentation, it meant she did not notify the responsible parties. Interview with Resident # 1's two responsible parties on 07/21/2026 at 1:56 p.m., they both said they were not notified of the x-ray result. The primary party responsible said she was called by LVN A prior to the x-ray, but no one called her with the result. She said she complained to the ADM whose response was we did not have to tell you. Both responsible parties said, if they were notified in a timely manner of the x-ray result, they would have requested Resident #1 to be transferred to the hospital immediately. In an interview with the ADON on 07/21/2026 at 2:31 p.m., she said after an x-ray the Doctor and the family should have been notified because it was part of the resident's care. The family should have been notified of any changes. She said nurses were expected to document every communication. She said the fact that LVN A did not document her communication with the responsible parties after the x-ray was completed with the result meant she did not notify them. She said that was a break in communication. The ADON said the consequence of delayed communication could be delay in care. She said if care was delayed, the situation might not improve. In an interview with the DON on 07/21/2026 at 2:31 p.m., she said it was the responsibility of the nurse to report the x-ray result to the Doctor and the family. She said the x-ray report was not communicated to the family in a timely manner, it could have resulted in hospitalization. She said she would in-service the staff to prevent this from happening in the future. In an interview with the ADM on 07/21/2026 at 3:50 p.m., she said if she had to follow best practice, if the staff had notified the family of the x-ray orders, she should have notified the Responsibility party of the result and documented her communication with the family. She said if the nurse did not notify the family, they would be annoyed. Record review of the facility's Job description: Licensed Vocational Nurse, revealed: Utilize established methods for coordination and communication of nursing services with other resident services to ensure the continuity of the residents' total regime of care.		