STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675971	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Oak	507 West Ave Schulenburg, TX 78956

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of four residents reviewed for medications. The facility failed to ensure LVN A did not administer Resident #1 an injection of diphenhydramine HCl solution (an antihistamine) used for agitation without a physician's order. This deficient practice could place residents at risk of consuming unprescribed medications, harm, and hospitalization . Findings include: Record review of Resident #1's, undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included epilepsy (seizures), bipolar disorder, major depressive disorder, and anxiety disorder. Record review of Resident #1's quarterly MDS assessment, dated 02/08/24, reflected he had a BIMS of 15, which indicated he had no cognitive impairment. Section E (Behavior) reflected he had not exhibited any physical or verbal behavioral symptoms directed at others. Record review of Resident #1's quarterly care plan, revised 02/08/24, reflected he had the potential to be physically aggressive related to anger with an intervention of administering medications as ordered. Record review of Resident #1's progress note, dated 03/29/24 and documented by LVN A, reflected the following: [Resident #1] was outside caught with cigarettes and light outside of smoking time. Nurse educated [Resident #1] regarding smoking policy. [Resident #1] became angry and was trying to physically come at nurse and CNA. [Resident #1] was yelling 'I am fixing to tear this place up' . Nurse administered Benadryl Infection to calm [Resident #1] down (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician order, dated 03/30/24, reflected diphenhydramine HCl injection solution 50 MG/ML - Inject 1 ml intramuscularly every 6 hours as needed for outbursts or increased aggression related to anxiety disorder. During an interview on 06/12/24 at 12:09 PM, the DON stated she was notified LVN A had to administer a Benadryl shot to Resident #1 on 03/29/24. She stated the staff were able to get verbal orders for Benadryl and LVN A stated she got it out of their emergency kit. She stated LVN A may have failed to document her contacting the NP in her progress note but did believe she contacted the NP before administering the Benadryl . During a telephone interview on 06/12/24 at 12:28 PM, Resident #1's NP stated she did remember the incident with Resident #1 on 03/29/24. She stated, I would say yes, LVN A probably did call me because the staff called me for orders nine out of ten times. Multiple telephone attempts were made on 06/12/24 to interview LVN A. A returned call was not received prior to exit. Record review of the facility's, undated, Medication Administration Policy, reflected the following: .2. Review and confirm medication orders for each individual resident on the Medication Administration Record prior to administering medications to each resident.