

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675971	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Paradigm at the Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and failed to protect and promote the rights of the residents for three (Resident #4, Resident #5, and Resident #6) of eight residents reviewed for resident rights.</p> <p>The facility failed to purchase cigarettes for approximately five days for Residents #4, #5, and #6.</p> <p>This failure placed residents at risk for a decreased quality of life, loss of enjoyment, and loss of freedom.</p> <p>Findings included:</p> <p>Resident #4</p> <p>Review of Resident #4's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including legal blindness, history of stroke, and type II diabetes.</p> <p>Review of Resident #4's quarterly MDS assessment, dated 08/10/24, reflected a BIMS score of 6, indicating he had a severe cognitive impairment.</p> <p>Review of Resident #4's quarterly care plan, dated 08/27/24, reflected he had a potential for injury related to him being a smoker with an intervention of informing him of the facility's smoking policy and potential consequences of noncompliance.</p> <p>Resident #5</p> <p>Review of Resident #5's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including depression, generalized anxiety disorder, bipolar disorder, and history of stroke.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 675971	If continuation sheet Page 1 of 38

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review f Resident #5's quarterly MDS assessment, dated 09/14/24, reflected a BIMS score of 10, indicating he had a moderate cognitive impairment.</p> <p>Review of Resident #5's quarterly care plan, dated 09/10/24, reflected he had a potential for injury related to him being a smoker with an intervention of his smoking material to be maintained by staff if indicated.</p> <p>Resident #6</p> <p>Review of Resident #6's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental disorder characterized variously by hallucinations, delusions, disorganized thinking and behavior, and flat or inappropriate affect), unspecified psychosis, and muscle wasting and atrophy (wasting away).</p> <p>Review of Resident #6's quarterly MDS assessment, dated 09/06/24, reflected a BIMS of 15, indicating she was cognitively intact.</p> <p>Review of Resident #6's quarterly care plan, dated 03/06/24, reflected she had a potential for injury related to her being a smoker with an intervention of informing her of the facility's smoking policy and potential consequences of noncompliance.</p> <p>During an observation and interview on 11/06/24 at 9:14 AM revealed Residents #4, #5, and #6 in the smoking area but were not smoking. All three residents were verbally upset. Resident #5 stated the staff use their (residents') money to buy the cigarettes but they always run out before they go and buy more. Resident #6 stated they were not having a smoke break that day because something happened to the check. Resident #4 stated they had not been able to smoke for days, and it was not fair.</p> <p>During an observation and interview on 11/06/24 at 9:50 AM revealed Residents #4, #5, and #6 in the smoking area and visibly agitated. Resident #4 stated it was ridiculous and it was his right to be able to smoke. Resident #5 stated he felt terrible and sick and it made him extremely mad that they were treated like that.</p> <p>During an interview on 11/06/24 at 10:23 AM, the MDSC stated the ADM or DON had to sign a check and get it cashed so the BOM could go and buy the residents cigarettes. She stated the smoking times were at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. She stated she knew the residents had been without cigarettes since the Friday prior, 11/01/24. She stated smoking was one of the only things the residents who smoke found pleasure in. She stated not being able to smoke could cause behaviors. She stated she believed it was a resident rights issue and this was not the first time it had happened where the residents went several days without being able to smoke.</p> <p>During an interview on 11/06/24 at 1:10PM, the BOM stated the ADM (who was no longer there) would have to sign and cash a check to give her the funds to purchase cigarettes for the residents. She stated she did not know why the ADM had not done that, but their Regional Nurse had just given her cash to go purchase some. She stated she was in the process of logging the packs of cigarettes in and writing the residents' name on them and they would be able to smoke soon. She stated she was not sure if they did have any cigarettes over the weekend but did know they had not had any that week (11/04/24 - 11/06/24).</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/07/24 at 2:29 PM, the DO stated she was not sure what the smoking times were, but her expectation was that the staff followed the designated times. She stated the BOM was responsible for purchasing the cigarettes. She stated the ADM was the one responsible for giving her the money, but she was not there yesterday (11/06/24). She stated she was not aware the residents had gone without cigarettes since last week and that did not meet her expectations. She stated it could have a negative effect on the residents, especially those that had been smoking since they were teenagers. She stated cigarettes were important due to the resident population and the behaviors they exhibited when they were not able to smoke.</p> <p>Review of in-services, dated 08/15/24, reflected staff were in-serviced on the Smoking Policy and Resident Rights.</p> <p>Review of the facility's Safe Smoking Policy, revised 03/2024, reflected the following:</p> <p>We are committed to providing a safe, healthy, and comfortable environment for all residents, staff, and visitors. Our policy is designed to ensure residents are aware of their privilege when it comes to smoking, but also following guidelines in which smoking may occur in our setting.</p> <p>1.The facility may permit smoking for certain individuals at designated times in designated areas .</p>		

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<p>F 0584</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for one (Resident #3) of five residents reviewed for a homelike environment.</p> <p>The facility failed to fix a plumbing issue in Resident #3's closet for approximately six months which caused his closet to secrete a musty/moldy odor causing him to be embarrassed and humiliated to wear his clothes which embodied the odor.</p> <p>This failure could affect residents by placing them at risk for diminished quality of life and being in an unsafe environment.</p> <p>Findings included:</p> <p>Review of Resident #3's undated care plan reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a disabling disease of the brain and spinal cord), depression, and muscle wasting and atrophy (wasting away).</p> <p>Review of Resident #3's quarterly MDS assessment, dated [DATE], reflected a BIMS score of 15, indicating he had no cognitive impairment.</p> <p>Review of Resident #3's quarterly care plan, revised [DATE], reflected he had a mood problem with an intervention of assisting the resident, family, caregivers to identify strengths, positive coping skills, and reinforcing these.</p> <p>Review of a Maintenance Request form, dated [DATE] and requested by the nursing department, reflected the following:</p> <p>Work Location - Closet in (room)</p> <p>Description of work/repair - Closet is flooded with water.</p> <p>Requested Priority - Low - When you get a chance.</p> <p>Date Work Completed: [DATE] and [DATE]</p> <p>During an observation and interview on [DATE] at 9:54 AM revealed Resident #3 requesting to speak and show something to the Surveyor. He asked the Surveyor to look at his closet. His room had a musty/moldy odor that intensified at the location of his closet. His closet floor was warped from moisture and there were dirty soaked towels lining the floor of the closet. He stated he felt like it had been that way since he moved in, but it had only progressively gotten worse. He stated the odor made his clothes smell bad and it made him feel humiliated to wear them. He stated, I am not a dirty person, but I bet that is what people think of me. He stated he had been asking for it to be fixed forever as it embarrassed him to live like that.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on [DATE] at 10:01 AM revealed the MAINTD walking into Resident #3's room with a mop bucket and dry towels. He stated Resident #3's closet had been like that since he started working at the facility six months ago. He stated he had been told it had to do with an AC unit located above/behind the closet that was leaking condensation. He stated he had been told it was going to be fixed by an outside party. He stated he only worked at the facility three days a week but on those days, he removed the wet dirty towels, mopped up the excess water, and put new towels down.</p> <p>During an interview on [DATE] at 10:23 AM, the MDSC stated Resident #3's closet had been that way for awhile, but at least six months. She stated she had not really noticed an odor due to her persistent allergies. She stated from a nursing perspective, being in that environment could cause Resident #3 to be exposed to mold or fungus which could lead to breathing issues.</p> <p>During an interview on [DATE] at 2:29 PM, the DO stated she was covering as the IADM. She observed Resident #3's closet and stated there had been a dry wall problem and thought it had been fixed. She acknowledged the floor was all wet and stated they would have to get a plumber. She stated it should not be leaking like that and once any of the staff found out, they should have moved the resident to another room until it had been repaired. She stated the state of his closet was not good and would contact a company that day. She stated it was important for the residents to have a safe, clean, and homelike environment because this was their home, and it promoted their overall well-being. She stated the residents could get an infection or have an accident with the floor being wet.</p> <p>Review of the facility's Resident Rights/Dignity Policy, revised ,d+[DATE], reflected the following:</p> <p>.</p> <p>7.) Create a home-like environment for the resident that includes:</p> <p>.</p> <p>c. Clean, orderly, comfortable, safe environment .</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on interview and record review, the facility failed to protect Resident #1's right to be free of sexual abuse by Resident #2.</p> <p>The facility failed to keep Resident #1 from being sexual assaulted by Resident #2 on 11/02/24.</p> <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 11/05/24 at 3:47 PM and an IJ template was given. While the IJ was removed on 11/07/24 at 3:21 PM, the facility remained out of compliance at a level 2 of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This deficient practice could place residents at risk of abuse, injury, and psychosocial harm.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Review of Resident #1's undated care plan reflected a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, depressive episodes, anxiety disorder, and muscle weakness and atrophy (wasting away).</p> <p>Review of Resident #1's quarterly care plan assessment, dated 09/03/24, reflected a BIMS score of 0, indicating she had a severe cognitive impairment. Section E (Behaviors) reflected she had not exhibited any physical or verbal behaviors.</p> <p>Review of Resident #1's quarterly care plan, revised 09/04/24, reflected she had impaired cognitive cognition and was at risk for further decline and injury with an intervention of explaining all procedures using terms and gestures the resident can understand. It further reflected she had a diagnosis of dementia and was at risk for increased confusion and decline in ADLs as the disease progresses with an intervention of re-assuring her when confusion has increased.</p> <p>Resident #2</p> <p>Review of Resident #2's undated care plan reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including history of stroke and muscle wasting and atrophy.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 09/12/24, reflected a BIMS score of 13, indicating he had no cognitive impairment. Section E (Behaviors) reflected he had not exhibited any physical or verbal behaviors.</p> <p>Review of Resident #2's quarterly care plan, revised 06/28/24, reflected he was a registered sex offender with an intervention of staff redirecting as needed.</p> <p>Review of a witness statement, dated 11/04/24 and hand-written by CNA B, reflected the following:</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>We laid [Resident #1] down after lunch (fully clothed). After I finished up on my hall I assisted a coworker with a hooyer lift.</p> <p>After we finished, I went back to my hall. A resident stated, He had her clothes off. [Resident #1] was in [Resident #2]'s room. Clothes off. Chair locked, hands in her private area, her clothes in a pile where she couldn't reach. (The nurse was notified.) We removed [Resident #1] from his room. She stated, she was afraid for her life. She cried. We removed him from the hall.</p> <p>During a telephone interview on 11/05/24 at 1:33 PM, CNA B was read the statement the ADM provided the Surveyor. She stated that was not the statement she wrote, and she would send her hand-written statement. She stated she saw Resident #2's hand penetrating Resident #1's private area. She stated she believed all the woman residents were in danger of him.</p> <p>During a telephone interview on 11/05/24 at 10:14 AM, MA C stated she was working on 11/02/24. She stated sometime after lunch she observed Resident #1 in her wheelchair sitting in front of the door to her room. She saw Resident #2 cross the hall and got in front of Resident #1 and she told him to back up because he was too close to her face. She stated she then went and tended to another resident and when she went back into the hall, she didn't see either Resident #1 or #2 and she just thought they had gone to their rooms. She stated a few minutes passed when she saw CR D trying to flag her down, using his hand in a come here motion like something was wrong. She stated as she approached CR D, CNA B, CNA E and LVN A showed up due to the commotion. She stated she then noticed there was another resident in Resident #2's room where CR D was pointing. She stated as they approached the room, they saw Resident #2 with his hand between Resident #1's legs penetrating her private area. She stated she was completely naked including her brief which had BM in it. She stated Resident #2 had BM on one of his hands. She stated Resident #1 was shaking as if she was scared. She stated she and CNA E were in shock and removed Resident #1 from the area. She stated she had never known Resident #2 to do anything of that nature but did know he watched porn on his cell phone a lot which made her uncomfortable. She stated LVN A did contact the ADM right away and was told not to do or say anything about the incident. She stated when she worked the next day (11/03/24), Resident #1 was not herself - she was agitated, could not sit still, and kept trying to leave the building. She stated she still could not believe the ADM did not acknowledge something so serious. She stated she and other staff members were outraged. She stated in her opinion, every resident in the facility was at risk of being harmed by Resident #2. She began crying and stated she knew Resident #1 was psychologically harmed as that was a very traumatic event.</p> <p>During an interview on 11/05/24 at 10:32 AM, CR D stated he remembered calling for the CNAs when he saw Resident #1 in Resident #2's room (on 11/02/24). He stated he did not see much but he did see Resident #2 touching her inappropriately.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/05/24 at 10:38 AM, the SW stated she was notified of an incident between Residents #1 and #2 on Monday, 11/04/24. She stated she was told Resident #1 was in Resident #2's room and disrobed somehow and that Resident #2 had some of her BM on his hand somehow. She stated she had spoken to Resident #2 directly and he had told her he was helping her get dressed and must have gotten BM on his hand. She stated two staff members (MA C and CNA E) reported to her that they saw Resident #2's hands between Resident #1's legs. She stated when she spoke to the ADM the on 11/04/24, they decided to keep other residents safe, they would move him to the locked unit. She stated she knew Resident #1 had a history of disrobing and a history of wandering into other resident's rooms, but since they did not have all of the facts yet, that was probably why the ADM had not made a report to HHSC. She stated if it had been her, she would have wanted Resident #1 to have been sent to the hospital for evaluation as she could have suffered trauma. She stated that to her knowledge, the nurse (LVN A) was 'blocked' from sending her out to the hospital but was not sure by who.</p> <p>During a telephone interview on 11/05/24 at 11:11 AM, the ST stated she worked all day on 11/02/24. She stated LVN A sought her out after the incident between Residents #1 and #2. She was told Resident #1 was found in her wheelchair, wheelchair locked (which is was not able to do), she was shaking, all of her clothes were off and Resident #2's hands were between her legs. She stated when they took his hands, he had BM on his fingers. LVN A stated she contacted the ADM and told her not to do anything. She stated in the morning meeting on 11/04/24, the ADM stated it was Resident #1's fault because she should not have been in his room in the first place. She stated everyone was disgusted and it brought her to tears. She stated the police should have been called and Resident #1 should have been sent to the hospital. She stated the ADM was the Abuse and Neglect Coordinator and should have done something. She stated she had turned in her resignation due to this situation.</p> <p>During a telephone interview on 11/05/24 at 11:22 AM, LVN A stated she was the charge nurse on Saturday, 11/02/24. She stated she heard a loud commotion sometime after lunch. She stated she went down the hall towards the commotion and got to Resident #2's room at the same time as CNA B, MA C, and CNA E. She stated CR D was in the hall screaming that Resident #2 was messing with Resident #1 and was pointing in the room. When she got there, she saw Resident #1 in her wheelchair which was locked. She stated her wheelchair was never locked because she did not have the mental capacity to know to lock it. She stated she was completely nude, and her clothes and brief were beside her wheelchair and Resident #2's hands were between her legs. She stated when she raised her voice Resident #2 raised his hands and stated, I'm not doing anything! She stated Resident #1 rarely talked but when she went into the room, she put her arms around her chest, was shaking, and kept stating, I'm scared. She stated she did conduct an assessment on her but put it on paper because the ADM told her not to document anything in her chart. She stated while on the phone with her, she kept cutting her off and telling her to do nothing. She then told her to not call her anymore after threatening her license. She stated she wanted to send Resident #1 to the hospital, but the ADM told her not to. She stated one of Resident #2's hands had feces on it. She stated she worked the following day, 11/03/24, and Resident #1 was not the same person. She stated she was more withdrawn and anxious. She stated she contacted the ADON on 11/02/24 after she spoke with the ADM, and she told her to follow the ADM's instructions. She stated she also contacted the SW who did not do anything. She stated if it had been up to her, she would have called 911 and sent Resident #1 to the hospital. She stated in the morning meeting on 11/04/24, the ADM stated that they were not going to do anything because it was absolutely Resident #1's fault and everyone was outraged by the comment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 11:38 AM, Resident #1's NP stated she had no knowledge of an incident between Residents #1 and #2. She stated Resident #1 did not have the ability to consent to any kind of sexual interactions. She stated it would have been a wise thing to do when asked if her expectation would be for Resident #1 to have been sent to the hospital after the incident.</p> <p>During a telephone interview on 11/05/24 at 1:15 PM, Resident #1's RP stated he had not been notified by the facility of anything regarding an incident from 11/02/24. He stated as far as he was aware, she did not have a history of wandering into other resident rooms or disrobing herself. He stated she would not have the ability to consent to a sexual relationship and would have loved to have been notified. He stated she would have a hard time taking off her own clothes due to her dexterity and she would not even think to lock her wheelchair.</p> <p>During a telephone interview on 11/05/24 at 1:55 PM, the ADON stated she did receive a call from LVN A on 11/02/24. She stated she was informed that Resident #1 was naked in Resident #2's room and his room was on her leg or something of that nature. She stated she never mentioned any kind of fondling. She stated the ADM told her she was going to do the investigation and get written statements.</p> <p>During an interview on 11/05/24 at 2:00 PM, the ADM stated she received a call sometime Saturday (11/02/24) night and was informed that Resident #1 was in Resident #2's room and she did not have any clothes on. She stated she asked LVN A where the CNAs were because if they had been around, she would not have been able to get in his room. She stated she contacted CNA B the following day (11/03/24) and she told her that Resident #1 had been found naked in Resident #2's room. She stated she asked her to write a statement. She stated nobody was in the room, nobody could have witnessed him touching her. She stated on 11/04/24, she interviewed Resident #2 who told her that Resident #1 had come into his room, and she had tried to hold his hand. She stated he told her he was looking at the TV and when he turned around, she had no clothes on. She stated he then told her he tried to help her put her clothes back on and did not have any sexual contact with her. She stated she did move Resident #2 into the locked unit to keep him safe from Resident #1 wandering in/out of his room because he was a sex offender and did not want him to be put in a situation like he was in today. She stated she only interviewed CNA B and no other staff because that was her hall she was working on, not MA C or CNA E. She stated she did not interview CR D because he was not competent enough to tell her what happened. She stated no staff members told her there had been any kind of penetration. She stated if they would have, she would have reported it at that time. When asked what the time frame was to report abuse, she stated it would have to be considered abuse. She stated there were no witnesses and Resident #2 told her he did not touch Resident #1, and he would not lie to her. She stated a possibility/suspicion of abuse did not mean it needed to be reported. When asked if she was always contacted when a resident was found naked and for no other purpose (such as abuse), she stated not always but sometimes.</p> <p>During a telephone interview on 11/05/24 at 2:28 PM, LVN A stated the ADM was not telling the truth. She stated she contacted her on 11/02/24 around 2:30 - 3:00 PM right after the incident between Residents #1 and #2 happened. She stated if she had just found Resident #1 naked without the witnessed abuse, she would not have had a reason to contact the ADM. She stated she did tell her about the explicit abuse, and she told her to do absolutely nothing and to not call her back.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/05/24 at 2:53 PM, Resident #2 stated the lady (Resident #1) went to his room, took off her clothes, and now they brought him down (to the locked unit). He stated she had a dirty diaper and when he was trying to help her, he may have stuck his hands in that. He stated he did not touch her, that he did [AGE] years (in prison) for that and I know better.</p> <p>During an interview on 11/06/24 at 10:23 AM, the MDSC stated Resident #1 having a history of disrobing had not been care planned was because that was the first time she had heard of her doing that - she did not have a history of it. She stated her care plan does mention her wandering, but she had never heard of her wandering into other residents' rooms. She stated she could not care plan what the nurses did not document. She stated, as a nurse, if she walked in and saw the incident between Residents #1 and #2, she would have definitely called the ADM who was was the Abuse and Neglect Coordinator, and that was why LVN A called the ADM. She said Resident #1 was forgetful and never locked her wheelchair. She stated obviously Resident #2 was doing something inappropriate for her to make that phone call. The MDSC then stated to the Surveyors that she wanted to be honest about something. She stated that on 11/04/24, she, the ADM, the DON, and the SW interviewed Resident #2 and he admitted that he touched her. She stated he was then asked about the BM on his hand was told you had to have touched her butt and he replied with, well . her diaper was off . She stated he kept trying to back-track after that, but he definitely admitted to touching her. She stated the ADM was aware of what he had done.</p> <p>Review of in-services, dated 08/16/24 and 10/28/24, reflected staff were in-serviced on Abuse and Neglect.</p> <p>Review of the facility's Abuse and Neglect Policy, revised 06/2019, reflected the following:</p> <p>.</p> <p>Types of Abuse and Examples:</p> <p>Sexual: Sexual abuse includes but is not limited to harassment, coercion, disparaging remarks or sexual assault.</p> <p>If an allegation of sexual abuse towards a resident is reported by any of the following persons, a family member, employee, volunteer and/or visitor, the facility will send the resident to the emergency room to be evaluated . A report will be made to the local police department the same day the allegation is made.</p> <p>Review of an in-service, dated 09/07/24, reflected staff were in-serviced on Sexual Allegations.</p> <p>Review of the facility's Abuse - Sexual Allegations Policy, revised 03/2019, reflected the following:</p> <p>Resident (victim) will remain with a same gender staff person until transferred to the hospital.</p> <p>The person accused will remain 1:1 with a staff person until police arrive for questioning.</p> <p>.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Notify the appropriate State Agencies within two (2) hours.</p> <p>.</p> <p>If the person accused of the sexual abuse is a resident, they will be sent to the hospital for a further psych evaluation.</p> <p>The ADM was notified on 11/05/24 at 3:47 PM that an IJ had been identified and an IJ template was provided.</p> <p>The following POR was approved on 11/07/24 at 11:44 AM and indicated:</p> <p>F 600 According to the IJ template, the facility failed to keep the residents free from abuse. According to the IJ template, the facility failed to ensure Resident #1 was not sexually assaulted by Resident #2. According to the IJ template, the facility failed to appropriately assess Resident #1 after the incident, nor did they send her to the hospital or call Law Enforcement.</p> <p>Resident # 1 was assessed by the Interim DON on 11/5/24 with no adverse findings. The Interim DON was hired on 11/18/2022 before the incident occurred and promoted effective 11/01/2024. The Interim DON received training on 10/28/2024 and 11/05/2024, prior to and after the IJ, by the administrator.</p> <p>Resident # 1's POA was notified by the Administrator and Regional Director of Operations on 11/5/24 and refused transfer to the emergency room for Evaluation.</p> <p>Resident # 2 was placed on 1:1 observation by the social worker until the resident was transferred out. The social worker was instructed by the administrator on 11/05/2024 to not leave the resident unattended. On 11/5/24, the sheriff's Department was notified by the administrator and regional director of operations, and they came to the facility to investigate the incident and left without police intervention. Resident # 2 was admitted to inpatient psych on 11/5/24. Resident #2 Parole Officer was contacted by the social worker on 11/05/2024 & 11/06/2024 to issue a warrant for his arrest, awaiting a return call. The Regional Director of Operations contacted the admission department on 11/06/2024 to inform them that the resident would not return to this facility.</p> <p>On 11/5/24 the Regional Director of Operations suspended the Administrator pending investigation of failure to report and investigate the incident from 11/2/24.</p> <p>The Regional Director of Operations reported the allegation of sexual abuse to HHSC and initiated an investigation on 11/5/24. On 11/06/2024, safe surveys were conducted by the social worker with no adverse findings of sexual abuse.</p> <p>The Regional Director of Operations reviewed the Abuse, Neglect, and Exploitation Prohibition Policies and Procedures on 11/05/2024 with no changes required.</p> <p>The Regional Administrator educated the Interim DON on 11/05/2024, and the Interim DON initiated education on Abuse, Neglect, and Exploitation Prohibition with current, new and PRN staff on 11/5/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Regional Nurse Consultant educated the Interim DON on 11/05/2024 and the Interim DON began training Charge Nurses on completing SBARs and Incident Reports for any resident-to-resident incidents, including those involving sexual allegations, and emphasized the importance of notifying the Administrator as of 11/5/2024.</p> <p>The Regional Director of Operations initiated education with current, new and PRN staff on the Compliance Hotline and how to utilize the Compliance Hotline for any incidents that may require further investigation by the Corporate Team: including incidents where Abuse, Neglect, or Exploitation may not be reported or investigated properly on 11/05/24. Education will be completed by 11/6/24. The Regional Administrator/Designee will ensure staff members receive the education before starting their next shift. QAPI meeting was conducted on 11/05/2024 with the Medical Director, Administrator and Interim DON over Abuse, Neglect, and Exploitation Prohibition Policies and Procedures.</p> <p>The Surveyor monitored the POR on 11/07/24 as followed:</p> <p>During an interview on 11/07/24 at 2:29 PM, the DO stated she was the direct Supervisor for the Administrator. She stated the ADM was suspended on 11/05/24 pending their investigation. She stated she would be the Abuse and Neglect Coordinator for the time being. She stated she if she had known about the incident between Residents #1 and #2, she would have told the ADM to report it and to send Resident #2, not allow him to stay in the facility. She stated he had since been sent out and would not be coming back. She stated she spoke to the RP of Resident #1, and he did not want to send her out to the hospital, stating it would be more traumatic. She stated all staff had been trained on abuse and neglect - went through the entire provider letter and policy, compliance training, reporting, incident reports, and SBAR.</p> <p>During interviews on 11/07/24 from 12:42 PM - 2:40 PM, staff (four CNAs, one LVN, one RN, and the SW) from multiple shifts stated they were in-serviced before working their shift. They stated they were in-serviced on abuse and neglect and to notify the IADM (the DO) immediately if there was every any abuse or neglect suspected. They all gave examples of abuse such as mental, physical, sexual, and emotional. They all stated if they did not like the way it was being handled, they were to call the compliance hotline which was posted in the hallways. The RN and LVN stated that an SBAR was to be completed whenever a resident had a change in condition. They stated this was to ensure all nursing staff were aware of any changes or issues that needed monitoring.</p> <p>Review of the facility's QAPI attendance sheet, dated 11/05/24, reflected the MD, the ADM , the DON, the ADON, the MAINTD, and the DOR were in attendance.</p> <p>Review of Resident #2's progress note, dated 11/05/24 and documented by the SW, reflected the following:</p> <p>On Saturday, November 5 [sic], 2024, a naked female resident (Resident #1) was found in [Resident #2]'s room. [Resident #1] had an incontinent episode and [Resident #2] was observed with BM on his hand . it was determined that [Resident #2] should be admitted to (psychiatric hospital).</p> <p>Review of Resident #1's SBAR, dated 11/05/24, reflected a Change of Condition assessment had been completed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's SBAR, dated 11/05/24, reflected a Change of Condition assessment had been completed.</p> <p>Review of an Incident Intake, dated 11/05/24, reflected the incident between Residents #1 and #2 on 11/02/24 was reported to HHSC by the DO.</p> <p>Review of an in-service, dated 11/05/24 and conducted by the RLNFA, reflected the DON and LVN A were in-serviced on their abuse and neglect policies and procedures.</p> <p>Review of an in-service, dated from 11/05/24 -11/07/24 and conducted by the DON, reflected staff from all shifts were in-serviced on their abuse and neglect policies and procedures.</p> <p>Review of an in-service entitled Compliance Hotline, dated 11/05/24 and conducted by the DO, reflected the DON was in-serviced on utilizing the compliance hotline for any incidents that may require further investigation by the corporate team: including incidents where abuse, neglect, or exploitation may not be reported or investigated properly.</p> <p>Review of an in-service entitled Compliance and Ethics, dated from 11/05/24 - 11/07/24 and conducted by the DON, reflected staff from all shifts on the Compliance Hotline.</p> <p>Review of an in-service entitled SBAR/Notification of Abuse to Coordinator/Administrator, dated 11/05/24 and conducted by the RNC, reflected the DON was in-serviced on the following:</p> <p>Charge Nurses/Licensed Nurses are required to complete an SBAR and incident report for any type of resident-to-resident incident, including those including sexual allegations and are required to notify the Administrator.</p> <p>Review of an in-service entitled SBAR/Notification of Abuse to Coordinator/Administrator, dated 11/05/24 - 11/07/24 and conducted by the DON, reflected staff from all shifts were in-serviced on the following:</p> <p>Charge Nurses/Licensed Nurses are required to complete an SBAR and incident report for any type of resident-to-resident incident, including those including sexual allegations and are required to notify the Administrator.</p> <p>Review of resident safe surveys, dated 11/06/24 and conducted by the SW, reflected no concerns from the residents.</p> <p>The DO was notified on 11/07/24 at 3:21 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on interview and record review, the facility failed to implement their written policies and procedures regarding prohibiting and preventing abuse for two (Resident #1 and Resident #2) of eight residents reviewed for developing and implementing abuse and neglect policies.</p> <p>The facility failed to implement the facility abuse and neglect policy when they failed to protect Resident #1 from being sexually assaulted by Resident #2. The ADM was notified, and she failed to action to keep Resident #1 from further abuse or psychosocial harm. She did not thoroughly investigate the incident or report it to HHSC.</p> <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 11/05/24 at 3:47 PM and an IJ template was given. While the IJ was removed on 11/07/24 at 3:21 PM, the facility remained out of compliance at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This deficient practice could place residents at risk of continued abuse, injury, trauma, and psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #1's undated care plan reflected a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, depressive episodes, anxiety disorder, and muscle weakness and atrophy (wasting away).</p> <p>Review of Resident #1's quarterly care plan assessment, dated 09/03/24, reflected a BIMS score of 0, indicating she had a severe cognitive impairment.</p> <p>Review of Resident #1's quarterly care plan, revised 09/04/24, reflected she had impaired cognitive cognition and was at risk for further decline and injury with an intervention of explaining all procedures using terms and gestures the resident can understand. It further reflected she had a diagnosis of dementia and was at risk for increased confusion and decline in ADLs as the disease progresses with an intervention of re-assuring her when confusion has increased.</p> <p>Review of Resident #2's undated care plan reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including history of stroke and muscle wasting and atrophy.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 09/12/24, reflected a BIMS score of 13, indicating he had no cognitive impairment.</p> <p>Review of Resident #2's quarterly care plan, revised 06/28/24, reflected he was a registered sex offender with an intervention of staff redirecting as needed.</p> <p>Review of a witness statement, dated 11/04/24 and hand-written by CNA B, reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>We laid [Resident #1] down after lunch (fully clothed). After I finished up on my hall I assisted a coworker with a hooyer lift.</p> <p>After we finished, I went back to my hall. A resident stated, He had her clothes off. [Resident #1] was in [Resident #2]'s room. Clothes off. Chair locked, hands in her private area, her clothes in a pile where she couldn't reach. (The nurse was notified.) We removed [Resident #1] from his room. She stated, she was afraid for her life. She cried. We removed him from the hall.</p> <p>During a telephone interview on 11/05/24 at 10:14 AM, MA C stated she was working on 11/02/24. She stated sometime after lunch she observed Resident #1 in her wheelchair sitting in front of the door to her room. She saw Resident #2 cross the hall and got in front of Resident #1 and she told him to back up because he was too close to her face. She stated she then went and tended to another resident and when she went back into the hall, she didn't see either Resident #1 or #2 and she just thought they had gone to their rooms. She stated a few minutes passed when she saw CR D trying to flag her down, using his hand in a come here motion like something was wrong. She stated as she approached CR D, CNA B, CNA E and LVN A showed up due to the commotion. She stated she then noticed there was another resident in Resident #2's room where CR D was pointing. She stated as they approached the room, they saw Resident #2 with his hand between Resident #1's legs penetrating her private area. She stated she was completely naked including her brief which had BM in it. She stated Resident #2 had BM on one of his hands. She stated Resident #1 was shaking as if she was scared. She stated she and CNA E were in shock and removed Resident #1 from the area. She stated she had never known Resident #2 to do anything of that nature but did know he watched porn on his cell phone a lot which made her uncomfortable. She stated LVN A did contact the ADM right away and was told not to do or say anything about the incident. She stated when she worked the next day (11/03/24), Resident #1 was not herself - she was agitated, could not sit still, and kept trying to leave the building. She stated she still could not believe the ADM did not acknowledge something so serious. She stated she and other staff members were outraged. She stated in her opinion, every resident in the facility was at risk of being harmed by Resident #2. She began crying and stated she knew Resident #1 was psychologically harmed as that was a very traumatic event.</p> <p>During an interview on 11/05/24 at 10:32 AM, CR D stated he remembered calling for the CNAs when he saw Resident #1 in Resident #2's room (on 11/02/24). He stated he did not see much but he did see Resident #2 touching her inappropriately.</p> <p>During an interview on 11/05/24 at 10:38 AM, the SW stated she was notified of an incident between Residents #1 and #2 on Monday, 11/04/24. She stated she was told Resident #1 was in Resident #2's room and disrobed somehow and that Resident #2 had some of her BM on his hand somehow. She stated she had spoken to Resident #2 directly and he had told her he was helping her get dressed and must have gotten BM on his hand. She stated two staff members (MA C and CNA E) reported to her that they saw Resident #2's hands between Resident #1's legs. She stated when she spoke to the ADM the on 11/04/24, they decided to keep other residents safe, they would move him to the locked unit. She stated she knew Resident #1 had a history of disrobing and a history of wandering into other resident's rooms, but since they did not have all of the facts yet, that was probably why the ADM had not made a report to HHSC. She stated if it had been her, she would have wanted Resident #1 to have been sent to the hospital for evaluation as she could have suffered trauma. She stated that to her knowledge, the nurse (LVN A) was 'blocked' from sending her out to the hospital but was not sure by who.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 11:11 AM, the ST stated she worked all day on 11/02/24. She stated LVN A sought her out after the incident between Residents #1 and #2. She was told Resident #1 was found in her wheelchair, wheelchair locked (which is was not able to do), she was shaking, all of her clothes were off and Resident #2's hands were between her legs. She stated when they took his hands, he had BM on his fingers. LVN A stated she contacted the ADM and told her not to do anything. She stated in the morning meeting on 11/04/24, the ADM stated it was Resident #1's fault because she should not have been in his room in the first place. She stated everyone was disgusted and it brought her to tears. She stated the police should have been called and Resident #1 should have been sent to the hospital. She stated the ADM was the Abuse and Neglect Coordinator and should have done something. She stated she had turned in her resignation due to this situation.</p> <p>During a telephone interview on 11/05/24 at 11:22 AM, LVN A stated she was the charge nurse on Saturday, 11/02/24. She stated she heard a loud commotion sometime after lunch. She stated she went down the hall towards the commotion and got to Resident #2's room at the same time as CNA B, MA C, and CNA E. She stated CR D was in the hall screaming that Resident #2 was messing with Resident #1 and was pointing in the room. When she got there, she saw Resident #1 in her wheelchair which was locked. She stated her wheelchair was never locked because she did not have the mental capacity to know to lock it. She stated she was completely nude, and her clothes and brief were beside her wheelchair and Resident #2's hands were between her legs. She stated when she raised her voice Resident #2 raised his hands and stated, I'm not doing anything! She stated Resident #1 rarely talked but when she went into the room, she put her arms around her chest, was shaking, and kept stating, I'm scared. She stated she did conduct an assessment on her but put it on paper because the ADM told her not to document anything in her chart. She stated while on the phone with her, she kept cutting her off and telling her to do nothing. She then told her to not call her anymore after threatening her license. She stated she wanted to send Resident #1 to the hospital, but the ADM told her not to. She stated one of Resident #2's hands had feces on it. She stated she worked the following day, 11/03/24, and Resident #1 was not the same person. She stated she was more withdrawn and anxious. She stated she contacted the ADON on 11/02/24 after she spoke with the ADM, and she told her to follow the ADM's instructions. She stated she also contacted the SW who did not do anything. She stated if it had been up to her, she would have called 911 and sent Resident #1 to the hospital. She stated in the morning meeting on 11/04/24, the ADM stated that they were not going to do anything because it was absolutely Resident #1's fault and everyone was outraged by the comment.</p> <p>During a telephone interview on 11/05/24 at 11:38 AM, Resident #1's NP stated she had no knowledge of an incident between Residents #1 and #2. She stated Resident #1 did not have the ability to consent to any kind of sexual interactions. She stated it would have been a wise thing to do when asked if her expectation would be for Resident #1 to have been sent to the hospital after the incident.</p> <p>During a telephone interview on 11/05/24 at 1:15 PM, Resident #1's RP stated he had not been notified by the facility of anything regarding an incident from 11/02/24. He stated as far as he was aware, she did not have a history of wandering into other resident rooms or disrobing herself. He stated she would not have the ability to consent to a sexual relationship and would have loved to have been notified. He stated she would have a hard time taking off her own clothes due to her dexterity and she would not even think to lock her wheelchair.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Paradigm at the Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 507 West Ave Schulenburg, TX 78956	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 1:33 PM, CNA B was read the statement the ADM provided the Surveyor. She stated that was not the statement she wrote, and she would send her hand-written statement. She stated she saw Resident #2's hand penetrating Resident #1's private area. She stated she believed all of the woman residents were in danger of him.</p> <p>During a telephone interview on 11/05/24 at 1:55 PM, the ADON stated she did receive a call from LVN A on 11/02/24. She stated she was informed that Resident #1 was naked in Resident #2's room and his room was on her leg or something of that nature. She stated she never mentioned any kind of fondling. She stated the ADM told her she was going to do the investigation and get written statements.</p> <p>During an interview on 11/05/24 at 2:00 PM, the ADM stated she received a call sometime Saturday (11/02/24) night and was informed that Resident #1 was in Resident #2's room and she did not have any clothes on. She stated she asked LVN A where the CNAs were because if they had been around, she would not have been able to get in his room. She stated she contacted CNA B the following day (11/03/24) and she told her that Resident #1 had been found naked in Resident #2's room. She stated she asked her to write a statement. She stated nobody was in the room, nobody could have witnessed him touching her. She stated on 11/04/24, she interviewed Resident #2 who told her that Resident #1 had come into his room, and she had tried to hold his hand. She stated he told her he was looking at the TV and when he turned around, she had no clothes on. She stated he then told her he tried to help her put her clothes back on and did not have any sexual contact with her. She stated she did move Resident #2 into the locked unit to keep him safe from Resident #1 wandering in/out of his room because he is a sex offender and did not want him to be put in a situation like he was in today. She stated she only interviewed CNA B and no other staff because that was her hall she was working on, not MA C or CNA E. She stated she did not interview CR D because he was not competent enough to tell her what happened. She stated no staff members told her there had been any kind of penetration. She stated if they would have, she would have reported it at that time. When asked what the time frame was to report abuse, she stated it would have to be considered abuse. She stated there were no witnesses and Resident #2 told her he did not touch Resident #1, and he would not lie to her. She stated a possibility/suspicion of abuse did not mean it needed to be reported. When asked if she was always contacted when a resident was found naked and for no other purpose (such as abuse), she stated not always but sometimes.</p> <p>During a telephone interview on 11/05/24 at 2:28 PM, LVN A stated the ADM was not telling the truth. She stated she contacted her on 11/02/24 around 2:30 - 3:00 PM right after the incident between Residents #1 and #2 happened. She stated if she had just found Resident #1 naked without the witnessed abuse, she would not have had a reason to contact the ADM. She stated she did tell her about the explicit abuse, and she told her to do absolutely nothing and to not call her back.</p> <p>During an interview on 11/05/24 at 2:53 PM, Resident #2 stated the lady (Resident #1) went to his room, took off her clothes, and now they brought him down (to the locked unit). He stated she had a dirty diaper and when he was trying to help her, he may have stuck his hands in that. He stated he did not touch her, that he did [AGE] years (in prison) for that and I know better.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 10:23 AM, the MDSC stated Resident #1 having a history of disrobing had not been care planned was because that was the first time she had heard of her doing that - she did not have a history of it. She stated her care plan does mention her wandering, but she had never heard of her wandering into other residents' rooms. She stated she could not care plan what the nurses did not document. She stated, as a nurse, if she walked in and saw the incident between Residents #1 and #2, she would have definitely called the ADM who is the Abuse and Neglect Coordinator, and that was why LVN A called the ADM. She said Resident #1 was forgetful and never locked her wheelchair. She stated obviously Resident #2 was doing something inappropriate for her to make that phone call. The MDSC then stated to the Surveyors that she wanted to be honest about something. She stated that on 11/04/24, she, the ADM, the DON, and the SW interviewed Resident #2 and he admitted that he touched her. She stated he was then asked about the BM on his hand was told you had to have touched her butt and he replied with, well . her diaper was off . She stated he kept trying to back-track after that, but he definitely admitted to touching her. She stated the ADM was aware of what he had done.</p> <p>Review of in-services, dated 08/16/24 and 10/28/24, reflected staff were in-serviced on Abuse and Neglect.</p> <p>Review of an in-service, dated 09/07/24, reflected staff were in-serviced on Sexual Allegations.</p> <p>Review of the facility's Abuse and Neglect Policy, revised 06/2019, reflected the following:</p> <p>.</p> <p>Types of Abuse and Examples:</p> <p>Sexual: Sexual abuse includes but is not limited to harassment, coercion, disparaging remarks or sexual assault.</p> <p>If an allegation of sexual abuse towards a resident is reported by any of the following persons, a family member, employee, volunteer and/or visitor, the facility will send the resident to the emergency room to be evaluated . A report will be made to the local police department the same day the allegation is made .</p> <p>.</p> <p>If abuse/neglect is suspected, the facility will:</p> <ol style="list-style-type: none"> 1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the abuser and/or provision of medical care. 2. The facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. The facility's Leadership will conduct a careful and deliberate investigation, centering on facts, observations and statements from the alleged victim and witnesses, of any allegation received of suspected abuse, neglect, or exploitation or mistreatment and will implement immediate action to safeguard resident.</p> <p>4. The facility's Leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law.</p> <p>5. Report the investigation findings to the appropriate State Agencies, as required by law.</p> <p>Review of the facility's Abuse - Sexual Allegations Policy, revised 03/2019, reflected the following:</p> <p>Resident (victim) will remain with a same gender staff person until transferred to the hospital.</p> <p>The person accused will remain 1:1 with a staff person until police arrive for questioning.</p> <p>.</p> <p>Notify the appropriate State Agencies within two (2) hours.</p> <p>.</p> <p>If the person accused of the sexual abuse is a resident, they will be sent to the hospital for a further psych evaluation.</p> <p>The ADM was notified on 11/05/24 at 3:47 PM that an IJ had been identified and an IJ template was provided.</p> <p>The following POR was approved on 11/07/24 at 11:44 AM indicated:</p> <p>F 607 According to the IJ template, the facility must develop and implement written policies and procedures that prohibit and prevent abuse and neglect. According to the IJ template, the facility failed to follow their abuse and neglect policy after Resident #1 was sexually assaulted by Resident #2. According to the IJ template, the facility failed to investigate or report the abuse allegation per the policy.</p> <p>On 11/5/24 the Regional Director of Operations suspended the Administrator pending investigation of failure to report and investigate the incident from 11/2/24.</p> <p>The Regional Director of Operations reported the allegation of sexual abuse to HHSC on 11/5/24 and initiated an investigation. On 11/5/24, the sheriff's Department was notified by administrator and regional director of operations, and they came to the facility to investigate the incident and left without police intervention. Resident # 2 was admitted to inpatient psych on 11/5/24. Resident #2 Parole Officer was contacted by the social worker on 11/05/2024 & 11/06/2024 to issue a warrant for his arrest, awaiting a return call.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident # 1's POA was notified by the Administrator and Regional Director of Operations on 11/5/24 and refused transfer to the emergency room for Evaluation.</p> <p>The Regional Director of Operations will act as the Abuse, Neglect, and Exploitation Prohibition Coordinator effective 11/5/24 until an Interim Administrator is identified, this information is relayed with the ANE education related to this incident.</p> <p>The Regional Director of Operations reviewed the Abuse, Neglect, and Exploitation Prohibition Policies and Procedures on 11/05/2024 with no changes required.</p> <p>The Surveyor monitored the POR on 11/07/24 as followed:</p> <p>During interviews on 11/07/24 from 12:42 PM - 2:40 PM, staff (four CNAs, one LVN, one RN, and the SW) from multiple shifts stated they were in-serviced before working their shift. They stated they were in-serviced on abuse and neglect and to notify the IADM (the DO) immediately if there was every any abuse or neglect suspected. They all gave examples of abuse such as mental, physical, sexual, and emotional. They all stated if they did not like the way it was being handled, they were to call the compliance hotline which was posted in the hallways.</p> <p>Review of the facility's QAPI attendance sheet, dated 11/05/24, reflected the MD, the ADM , the DON, the ADON, the MAINTD, and the DOR were in attendance.</p> <p>Review of an Incident Intake, dated 11/05/24, reflected the incident between Residents #1 and #2 on 11/02/24 was reported to HHSC by the DO.</p> <p>Review of Resident #1's incident report, dated 11/05/24 and documented by the DON, reflected the following:</p> <p>[Resident #1] was assessed on 11/05/24 with no adverse findings. POA refused any type of hospital transfer, and no new order was received from the physician.</p> <p>Review of Resident #2's progress note, dated 11/05/24 and documented by the SW, reflected the following:</p> <p>On Saturday, November 5 [sic], 2024, a naked female resident (Resident #1) was found in [Resident #2]'s room. [Resident #1] had an incontinent episode and [Resident #2] was observed with BM on his hand . it was determined that [Resident #2] should be admitted to (psychiatric hospital).</p> <p>During an interview on 11/07/24 at 2:29 PM, the DO stated she was the direct Supervisor for the Administrator. She stated the ADM was suspended on 11/05/24 pending their investigation. She stated she would be the Abuse and Neglect Coordinator for the time being. She stated she if she had known about the incident between Residents #1 and #2, she would have told the ADM to report it and to send Resident #2, not allow him to stay in the facility. She stated he had since been sent out and would not be coming back. She stated she spoke to the RP of Resident #1, and he did not want to send her out to the hospital, stating it would be more traumatic. She stated all staff had been trained on abuse and neglect - went through the entire provider letter and policy, compliance training, reporting, incident reports, and SBAR.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The DO was notified on 11/07/24 at 3:21 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect resulted in bodily injury, to other officials (including the State Agency) for one (Resident #1) of five residents reviewed for abuse.</p> <p>The facility failed report an incident of sexual abuse to HHSC after Resident #2 was observed sexually assaulting Resident #1.</p> <p>This deficient practice could place residents at risk of abuse and neglect.</p> <p>Findings included:</p> <p>Review of Resident #1's undated care plan reflected a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, depressive episodes, anxiety disorder, and muscle weakness and atrophy (wasting away).</p> <p>Review of Resident #1's quarterly care plan assessment, dated 09/03/24, reflected a BIMS score of 0, indicating she had a severe cognitive impairment.</p> <p>Review of Resident #1's quarterly care plan, revised 09/04/24, reflected she had impaired cognitive cognition and was at risk for further decline and injury with an intervention of explaining all procedures using terms and gestures the resident can understand. It further reflected she had a diagnosis of dementia and was at risk for increased confusion and decline in ADLs as the disease progresses with an intervention of re-assuring her when confusion has increased.</p> <p>Review of Resident #2's undated care plan reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including history of stroke and muscle wasting and atrophy.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 09/12/24, reflected a BIMS score of 13, indicating he had no cognitive impairment.</p> <p>Review of Resident #2's quarterly care plan, revised 06/28/24, reflected he was a registered sex offender with an intervention of staff redirecting as needed.</p> <p>Review of a witness statement, dated 11/04/24 and hand-written by CNA B, reflected the following:</p> <p>We laid [Resident #1] down after lunch (fully clothed). After I finished up on my hall I assisted a coworker with a hoyer lift.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>After we finished, I went back to my hall. A resident stated, He had her clothes off. [Resident #1] was in [Resident #2]'s room. Clothes off. Chair locked, hands in her private area, her clothes in a pile where she couldn't reach. (The nurse was notified.) We removed [Resident #1] from his room. She stated, she was afraid for her life. She cried. We removed him from the hall.</p> <p>During a telephone interview on 11/05/24 at 10:14 AM, MA C stated she was working on 11/02/24. She stated sometime after lunch she observed Resident #1 in her wheelchair sitting in front of the door to her room. She saw Resident #2 cross the hall and got in front of Resident #1 and she told him to back up because he was too close to her face. She stated she then went and tended to another resident and when she went back into the hall, she didn't see either Resident #1 or #2 and she just thought they had gone to their rooms. She stated a few minutes passed when she saw CR D trying to flag her down, using his hand in a come here motion like something was wrong. She stated as she approached CR D, CNA B, CNA E and LVN A showed up due to the commotion. She stated she then noticed there was another resident in Resident #2's room where CR D was pointing. She stated as they approached the room, they saw Resident #2 with his hand between Resident #1's legs penetrating her private area. She stated she was completely naked including her brief which had BM in it. She stated Resident #2 had BM on one of his hands. She stated Resident #1 was shaking as if she was scared. She stated she and CNA E were in shock and removed Resident #1 from the area. She stated she had never known Resident #2 to do anything of that nature but did know he watched porn on his cell phone a lot which made her uncomfortable. She stated LVN A did contact the ADM right away and was told not to do or say anything about the incident. She stated when she worked the next day (11/03/24), Resident #1 was not herself - she was agitated, could not sit still, and kept trying to leave the building. She stated she still could not believe the ADM did not acknowledge something so serious. She stated she and other staff members were outraged. She stated in her opinion, every resident in the facility was at risk of being harmed by Resident #2. She began crying and stated she knew Resident #1 was psychologically harmed as that was a very traumatic event.</p> <p>During an interview on 11/05/24 at 10:32 AM, CR D stated he remembered calling for the CNAs when he saw Resident #1 in Resident #2's room (on 11/02/24). He stated he did not see much but he did see Resident #2 touching her inappropriately.</p> <p>During an interview on 11/05/24 at 10:38 AM, the SW stated she was notified of an incident between Residents #1 and #2 on Monday, 11/04/24. She stated she was told Resident #1 was in Resident #2's room and disrobed somehow and that Resident #2 had some of her BM on his hand somehow. She stated she had spoken to Resident #2 directly and he had told her he was helping her get dressed and must have gotten BM on his hand. She stated two staff members (MA C and CNA E) reported to her that they saw Resident #2's hands between Resident #1's legs. She stated when she spoke to the ADM the on 11/04/24, they decided to keep other residents safe, they would move him to the locked unit. She stated she knew Resident #1 had a history of disrobing and a history of wandering into other resident's rooms, but since they did not have all of the facts yet, that was probably why the ADM had not made a report to HHSC. She stated if it had been her, she would have wanted Resident #1 to have been sent to the hospital for evaluation as she could have suffered trauma. She stated that to her knowledge, the nurse (LVN A) was 'blocked' from sending her out to the hospital but was not sure by who.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 11:11 AM, the ST stated she worked all day on 11/02/24. She stated LVN A sought her out after the incident between Residents #1 and #2. She was told Resident #1 was found in her wheelchair, wheelchair locked (which is was not able to do), she was shaking, all of her clothes were off and Resident #2's hands were between her legs. She stated when they took his hands, he had BM on his fingers. LVN A stated she contacted the ADM and told her not to do anything. She stated in the morning meeting on 11/04/24, the ADM stated it was Resident #1's fault because she should not have been in his room in the first place. She stated everyone was disgusted and it brought her to tears. She stated the police should have been called and Resident #1 should have been sent to the hospital. She stated the ADM was the Abuse and Neglect Coordinator and should have done something. She stated she had turned in her resignation due to this situation.</p> <p>During a telephone interview on 11/05/24 at 11:22 AM, LVN A stated she was the charge nurse on Saturday, 11/02/24. She stated she heard a loud commotion sometime after lunch. She stated she went down the hall towards the commotion and got to Resident #2's room at the same time as CNA B, MA C, and CNA E. She stated CR D was in the hall screaming that Resident #2 was messing with Resident #1 and was pointing in the room. When she got there, she saw Resident #1 in her wheelchair which was locked. She stated her wheelchair was never locked because she did not have the mental capacity to know to lock it. She stated she was completely nude, and her clothes and brief were beside her wheelchair and Resident #2's hands were between her legs. She stated when she raised her voice Resident #2 raised his hands and stated, I'm not doing anything! She stated Resident #1 rarely talked but when she went into the room, she put her arms around her chest, was shaking, and kept stating, I'm scared. She stated she did conduct an assessment on her but put it on paper because the ADM told her not to document anything in her chart. She stated while on the phone with her, she kept cutting her off and telling her to do nothing. She then told her to not call her anymore after threatening her license. She stated she wanted to send Resident #1 to the hospital, but the ADM told her not to. She stated one of Resident #2's hands had feces on it. She stated she worked the following day, 11/03/24, and Resident #1 was not the same person. She stated she was more withdrawn and anxious. She stated she contacted the ADON on 11/02/24 after she spoke with the ADM, and she told her to follow the ADM's instructions. She stated she also contacted the SW who did not do anything. She stated if it had been up to her, she would have called 911 and sent Resident #1 to the hospital. She stated in the morning meeting on 11/04/24, the ADM stated that they were not going to do anything because it was absolutely Resident #1's fault and everyone was outraged by the comment.</p> <p>During a telephone interview on 11/05/24 at 11:38 AM, Resident #1's NP stated she had no knowledge of an incident between Residents #1 and #2. She stated Resident #1 did not have the ability to consent to any kind of sexual interactions. She stated it would have been a wise thing to do when asked if her expectation would be for Resident #1 to have been sent to the hospital after the incident.</p> <p>During a telephone interview on 11/05/24 at 1:15 PM, Resident #1's RP stated he had not been notified by the facility of anything regarding an incident from 11/02/24. He stated as far as he was aware, she did not have a history of wandering into other resident rooms or disrobing herself. He stated she would not have the ability to consent to a sexual relationship and would have loved to have been notified. He stated she would have a hard time taking off her own clothes due to her dexterity and she would not even think to lock her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 1:33 PM, CNA B was read the statement the ADM provided the Surveyor. She stated that was not the statement she wrote, and she would send her hand-written statement. She stated she saw Resident #2's hand penetrating Resident #1's private area. She stated she believed all of the woman residents were in danger of him.</p> <p>During a telephone interview on 11/05/24 at 1:55 PM, the ADON stated she did receive a call from LVN A on 11/02/24. She stated she was informed that Resident #1 was naked in Resident #2's room and his room was on her leg or something of that nature. She stated she never mentioned any kind of fondling. She stated the ADM told her she was going to do the investigation and get written statements.</p> <p>During an interview on 11/05/24 at 2:00 PM, the ADM stated she received a call sometime Saturday (11/02/24) night and was informed that Resident #1 was in Resident #2's room and she did not have any clothes on. She stated she asked LVN A where the CNAs were because if they had been around, she would not have been able to get in his room. She stated she contacted CNA B the following day (11/03/24) and she told her that Resident #1 had been found naked in Resident #2's room. She stated she asked her to write a statement. She stated nobody was in the room, nobody could have witnessed him touching her. She stated on 11/04/24, she interviewed Resident #2 who told her that Resident #1 had come into his room, and she had tried to hold his hand. She stated he told her he was looking at the TV and when he turned around, she had no clothes on. She stated he then told her he tried to help her put her clothes back on and did not have any sexual contact with her. She stated she did move Resident #2 into the locked unit to keep him safe from Resident #1 wandering in/out of his room because he is a sex offender and did not want him to be put in a situation like he was in today. She stated she only interviewed CNA B and no other staff because that was her hall she was working on, not MA C or CNA E. She stated she did not interview CR D because he was not competent enough to tell her what happened. She stated no staff members told her there had been any kind of penetration. She stated if they would have, she would have reported it at that time. When asked what the time frame was to report abuse, she stated it would have to be considered abuse. She stated there were no witnesses and Resident #2 told her he did not touch Resident #1, and he would not lie to her. She stated a possibility/suspicion of abuse did not mean it needed to be reported. When asked if she was always contacted when a resident was found naked and for no other purpose (such as abuse), she stated not always but sometimes.</p> <p>During a telephone interview on 11/05/24 at 2:28 PM, LVN A stated the ADM was not telling the truth. She stated she contacted her on 11/02/24 around 2:30 - 3:00 PM right after the incident between Residents #1 and #2 happened. She stated if she had just found Resident #1 naked without the witnessed abuse, she would not have had a reason to contact the ADM. She stated she did tell her about the explicit abuse, and she told her to do absolutely nothing and to not call her back.</p> <p>During an interview on 11/05/24 at 2:53 PM, Resident #2 stated the lady (Resident #1) went to his room, took off her clothes, and now they brought him down (to the locked unit). He stated she had a dirty diaper and when he was trying to help her, he may have stuck his hands in that. He stated he did not touch her, that he did [AGE] years (in prison) for that and I know better.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 10:23 AM, the MDSC stated Resident #1 having a history of disrobing had not been care planned was because that was the first time she had heard of her doing that - she did not have a history of it. She stated her care plan does mention her wandering, but she had never heard of her wandering into other residents' rooms. She stated she could not care plan what the nurses did not document. She stated, as a nurse, if she walked in and saw the incident between Residents #1 and #2, she would have definitely called the ADM who is the Abuse and Neglect Coordinator, and that was why LVN A called the ADM. She said Resident #1 was forgetful and never locked her wheelchair. She stated obviously Resident #2 was doing something inappropriate for her to make that phone call. The MDSC then stated to the Surveyors that she wanted to be honest about something. She stated that on 11/04/24, she, the ADM, the DON, and the SW interviewed Resident #2 and he admitted that he touched her. She stated he was then asked about the BM on his hand was told you had to have touched her butt and he replied with, well . her diaper was off . She stated he kept trying to back-track after that, but he definitely admitted to touching her. She stated the ADM was aware of what he had done.</p> <p>Review of in-services, dated 08/16/24 and 10/28/24, reflected staff were in-serviced on Abuse and Neglect.</p> <p>Review of an in-service, dated 09/07/24, reflected staff were in-serviced on Sexual Allegations.</p> <p>Review of the facility's Abuse and Neglect Policy, revised 06/2019, reflected the following:</p> <p>.</p> <p>Types of Abuse and Examples:</p> <p>Sexual: Sexual abuse includes but is not limited to harassment, coercion, disparaging remarks or sexual assault.</p> <p>If an allegation of sexual abuse towards a resident is reported by any of the following persons, a family member, employee, volunteer and/or visitor, the facility will send the resident to the emergency room to be evaluated . A report will be made to the local police department the same day the allegation is made .</p> <p>.</p> <p>If abuse/neglect is suspected, the facility will:</p> <ol style="list-style-type: none"> 1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the abuser and/or provision of medical care. 2. The facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. The facility's Leadership will conduct a careful and deliberate investigation, centering on facts, observations and statements from the alleged victim and witnesses, of any allegation received of suspected abuse, neglect, or exploitation or mistreatment and will implement immediate action to safeguard resident.</p> <p>4. The facility's Leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law.</p> <p>5. Report the investigation findings to the appropriate State Agencies, as required by law.</p> <p>Review of the facility's Abuse - Sexual Allegations Policy, revised 03/2019, reflected the following:</p> <p>Resident (victim) will remain with a same gender staff person until transferred to the hospital.</p> <p>The person accused will remain 1:1 with a staff person until police arrive for questioning.</p> <p>.</p> <p>Notify the appropriate State Agencies within two (2) hours.</p> <p>.</p> <p>If the person accused of the sexual abuse is a resident, they will be sent to the hospital for a further psych evaluation.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observation, interview, and record review, the facility failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance for three (Resident #5, Resident #7, and CR #8) of eight residents reviewed for meal palatability.</p> <p>The facility failed to serve food that was palatable and aesthetically appetizing for Resident #5, Resident #7, and CR #8 .</p> <p>This failure could place residents at risk for altered nutritional status, weight loss, and a decline in quality of life.</p> <p>Findings included:</p> <p>Resident #5</p> <p>Review of Resident #5's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including depression, generalized anxiety disorder, bipolar disorder, and history of stroke.</p> <p>Review of Resident #5's quarterly MDS assessment, dated 09/14/24, reflected a BIMS score of 10, indicating he had a moderate cognitive impairment.</p> <p>Review of Resident #5's quarterly care plan, dated 09/10/24, reflected he had a nutritional problem or potential nutritional problem with an intervention of assisting him with developing a support system to aid in weight loss efforts.</p> <p>During an interview on 11/06/24 at 9:21 AM, Resident #5 stated the food was terrible, it was not cooked right, had no flavor, and it was always the same old crap.</p> <p>Resident #7</p> <p>Review of Resident #7's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including depression, hypertension (high blood pressure), and pain.</p> <p>Review of Resident #7's quarterly MDS assessment, dated 08/07/24, reflected a BIMS score of 5, indicating he had a severe cognitive impairment.</p> <p>Review of Resident #7's quarterly care plan, dated 08/12/24, reflected he had a nutritional problem or potential nutritional problem with an intervention of assisting him with developing a support system to aid in weight loss efforts.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/06/24 at 9:14 AM, Resident #7 stated the food was terrible and the staff do not care because they do not have to eat the same stuff we do. He stated the staff get to go buy food, but the residents could not. He stated it was not right the way they were treated when it was supposed to be their home.</p> <p>During a confidential interview, CR #8 stated the food was terrible, non-appetizing, bland, and no had no flavor. He stated for lunch yesterday (11/05/24), it was some kind of pasta and meat dish, and he could not even tell what it was supposed to be. He stated it had no flavor but he ate it so he would not go hungry.</p> <p>Observation on 11/05/24 at 12:59 PM revealed a test tray that was delivered the Surveyor. The lunch items were beef stroganoff and steamed broccoli. The beef stroganoff was a scoop of a mush-like substance. The broccoli was mushy and over-cooked. Neither the main dish or the broccoli had any taste or flavor.</p> <p>On 11/07/24 at 2:00 PM, an interview with the Dietary Manager was attempted but he was not available.</p> <p>During an interview on 11/07/24 at 2:29 PM, the DO stated it was extremely important for the food served to the residents to be palatable and to look appetizing because if it did not look good, they would not eat it. She stated negative outcomes could be weight loss, lack of nutrition, lack of wound healing, and depression.</p> <p>Review of the facility's Food Palatability, dated 12/31/19, reflected the following:</p> <ol style="list-style-type: none"> 1. Facility menus should be prepared by a food vendor or other source using a menu-planning system that provides a nutrient-dense, flavorful, colorful, aromatic, and culturally appropriate foods that meets the standards of care and nutrient analysis requirements. 2. Food is prepared by methods that conserve nutritive value, flavor, and appearance. 		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on interview and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable well-being of each resident for two (Resident #1 and Resident #2) of eight residents reviewed for administration.</p> <p>The facility Administrator failed to:</p> <ul style="list-style-type: none"> - Investigate or report to HHSC an incident where Resident #2 was observed sexually assaulting Resident #1. - Allow LVN A to document the incident between Residents #1 and #2, notify law enforcement, or send Resident #1 to the hospital for evaluation. - Accurately document CNA B's witness statement without altering what she wrote regarding the incident between Residents #1 and #2. <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 11/05/24 at 3:47 PM and an IJ template was given. While the IJ was removed on 11/07/24 at 3:21 PM, the facility remained out of compliance at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These deficient practices could place residents at risk for abuse, serious injury, serious harm, serious impairment, and death.</p> <p>Findings included:</p> <p>Review of Resident #1's undated care plan reflected a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, depressive episodes, anxiety disorder, and muscle weakness and atrophy (wasting away).</p> <p>Review of Resident #1's quarterly care plan assessment, dated 09/03/24, reflected a BIMS score of 0, indicating she had a severe cognitive impairment.</p> <p>Review of Resident #1's quarterly care plan, revised 09/04/24, reflected she had impaired cognitive cognition and was at risk for further decline and injury with an intervention of explaining all procedures using terms and gestures the resident can understand. It further reflected she had a diagnosis of dementia and was at risk for increased confusion and decline in ADLs as the disease progresses with an intervention of re-assuring her when confusion has increased.</p> <p>Review of Resident #2's undated care plan reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including history of stroke and muscle wasting and atrophy.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's quarterly MDS assessment, dated 09/12/24, reflected a BIMS score of 13, indicating he had no cognitive impairment.</p> <p>Review of Resident #2's quarterly care plan, revised 06/28/24, reflected he was a registered sex offender with an intervention of staff redirecting as needed.</p> <p>Review of a witness statement, dated 11/04/24 and typed by the ADM, reflected a statement made by CNA B:</p> <p>We laid [Resident #1] down after lunch, fully clothed. After I finished up on my hall I assisted another CNA with a hoyer lift.</p> <p>After we finished, I went back to my hall and [CR C] stated [Resident #1] had her clothes off. [Resident #1] was in [Resident #2]'s room. Clothes off, chair looked dirty and hands were shitty as if he had his hands in her private area. Her clothes were in a pile where she could reach. The nurse was notified. We removed [Resident #1] from the room and she stated she was afraid of him and we removed him from that hall.</p> <p>Review of a witness statement, dated 11/04/24 and hand-written by CNA B, reflected the following:</p> <p>We laid [Resident #1] down after lunch (fully clothed). After I finished up on my hall I assisted a coworker with a hoyer lift.</p> <p>After we finished, I went back to my hall. A resident stated, He had her clothes off. [Resident #1] was in [Resident #2]'s room. Clothes off. Chair locked, hands in her private area, her clothes in a pile where she couldn't reach. (The nurse was notified.) We removed [Resident #1] from his room. She stated, she was afraid for her life. She cried. We removed him from the hall.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 10:14 AM, MA C stated she was working on 11/02/24. She stated sometime after lunch she observed Resident #1 in her wheelchair sitting in front of the door to her room. She saw Resident #2 cross the hall and got in front of Resident #1 and she told him to back up because he was too close to her face. She stated she then went and tended to another resident and when she went back into the hall, she didn't see either Resident #1 or #2 and she just thought they had gone to their rooms. She stated a few minutes passed when she saw CR D trying to flag her down, using his hand in a come here motion like something was wrong. She stated as she approached CR D, CNA B, CNA E and LVN A showed up due to the commotion. She stated she then noticed there was another resident in Resident #2's room where CR D was pointing. She stated as they approached the room, they saw Resident #2 with his hand between Resident #1's legs penetrating her private area. She stated she was completely naked including her brief which had BM in it. She stated Resident #2 had BM on one of his hands. She stated Resident #1 was shaking as if she was scared. She stated she and CNA E were in shock and removed Resident #1 from the area. She stated she had never known Resident #2 to do anything of that nature but did know he watched porn on his cell phone a lot which made her uncomfortable. She stated LVN A did contact the ADM right away and was told not to do or say anything about the incident. She stated when she worked the next day (11/03/24), Resident #1 was not herself - she was agitated, could not sit still, and kept trying to leave the building. She stated she still could not believe the ADM did not acknowledge something so serious. She stated she and other staff members were outraged. She stated in her opinion, every resident in the facility was at risk of being harmed by Resident #2. She began crying and stated she knew Resident #1 was psychologically harmed as that was a very traumatic event.</p> <p>During an interview on 11/05/24 at 10:32 AM, CR D stated he remembered calling for the CNAs when he saw Resident #1 in Resident #2's room (on 11/02/24). He stated he did not see much but he did see Resident #2 touching her inappropriately.</p> <p>During an interview on 11/05/24 at 10:38 AM, the SW stated she was notified of an incident between Residents #1 and #2 on Monday, 11/04/24. She stated she was told Resident #1 was in Resident #2's room and disrobed somehow and that Resident #2 had some of her BM on his hand somehow. She stated she had spoken to Resident #2 directly and he had told her he was helping her get dressed and must have gotten BM on his hand. She stated two staff members (MA C and CNA E) reported to her that they saw Resident #2's hands between Resident #1's legs. She stated when she spoke to the ADM the on 11/04/24, they decided to keep other residents safe, they would move him to the locked unit. She stated she knew Resident #1 had a history of disrobing and a history of wandering into other resident's rooms, but since they did not have all of the facts yet, that was probably why the ADM had not made a report to HHSC. She stated if it had been her, she would have wanted Resident #1 to have been sent to the hospital for evaluation as she could have suffered trauma. She stated that to her knowledge, the nurse (LVN A) was 'blocked' from sending her out to the hospital but was not sure by who.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 11:11 AM, the ST stated she worked all day on 11/02/24. She stated LVN A sought her out after the incident between Residents #1 and #2. She was told Resident #1 was found in her wheelchair, wheelchair locked (which is was not able to do), she was shaking, all of her clothes were off and Resident #2's hands were between her legs. She stated when they took his hands, he had BM on his fingers. LVN A stated she contacted the ADM and told her not to do anything. She stated in the morning meeting on 11/04/24, the ADM stated it was Resident #1's fault because she should not have been in his room in the first place. She stated everyone was disgusted and it brought her to tears. She stated the police should have been called and Resident #1 should have been sent to the hospital. She stated the ADM was the Abuse and Neglect Coordinator and should have done something. She stated she had turned in her resignation due to this situation.</p> <p>During a telephone interview on 11/05/24 at 11:22 AM, LVN A stated she was the charge nurse on Saturday, 11/02/24. She stated she heard a loud commotion sometime after lunch. She stated she went down the hall towards the commotion and got to Resident #2's room at the same time as CNA B, MA C, and CNA E. She stated CR D was in the hall screaming that Resident #2 was messing with Resident #1 and was pointing in the room. When she got there, she saw Resident #1 in her wheelchair which was locked. She stated her wheelchair was never locked because she did not have the mental capacity to know to lock it. She stated she was completely nude, and her clothes and brief were beside her wheelchair and Resident #2's hands were between her legs. She stated when she raised her voice Resident #2 raised his hands and stated, I'm not doing anything! She stated Resident #1 rarely talked but when she went into the room, she put her arms around her chest, was shaking, and kept stating, I'm scared. She stated she did conduct an assessment on her but put it on paper because the ADM told her not to document anything in her chart. She stated while on the phone with her, she kept cutting her off and telling her to do nothing. She then told her to not call her anymore after threatening her license. She stated she wanted to send Resident #1 to the hospital, but the ADM told her not to. She stated one of Resident #2's hands had feces on it. She stated she worked the following day, 11/03/24, and Resident #1 was not the same person. She stated she was more withdrawn and anxious. She stated she contacted the ADON on 11/02/24 after she spoke with the ADM, and she told her to follow the ADM's instructions. She stated she also contacted the SW who did not do anything. She stated if it had been up to her, she would have called 911 and sent Resident #1 to the hospital. She stated in the morning meeting on 11/04/24, the ADM stated that they were not going to do anything because it was absolutely Resident #1's fault and everyone was outraged by the comment.</p> <p>During a telephone interview on 11/05/24 at 11:38 AM, Resident #1's NP stated she had no knowledge of an incident between Residents #1 and #2. She stated Resident #1 did not have the ability to consent to any kind of sexual interactions. She stated it would have been a wise thing to do when asked if her expectation would be for Resident #1 to have been sent to the hospital after the incident.</p> <p>During a telephone interview on 11/05/24 at 1:15 PM, Resident #1's RP stated he had not been notified by the facility of anything regarding an incident from 11/02/24. He stated as far as he was aware, she did not have a history of wandering into other resident rooms or disrobing herself. He stated she would not have the ability to consent to a sexual relationship and would have loved to have been notified. He stated she would have a hard time taking off her own clothes due to her dexterity and she would not even think to lock her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/05/24 at 1:33 PM, CNA B was read the statement the ADM provided the Surveyor. She stated that was not the statement she wrote, and she would send her hand-written statement. She stated she saw Resident #2's hand penetrating Resident #1's private area. She stated she believed all of the woman residents were in danger of him.</p> <p>During a telephone interview on 11/05/24 at 1:55 PM, the ADON stated she did receive a call from LVN A on 11/02/24. She stated she was informed that Resident #1 was naked in Resident #2's room and his room was on her leg or something of that nature. She stated she never mentioned any kind of fondling. She stated the ADM told her she was going to do the investigation and get written statements.</p> <p>During an interview on 11/05/24 at 2:00 PM, the ADM stated she received a call sometime Saturday (11/02/24) night and was informed that Resident #1 was in Resident #2's room and she did not have any clothes on. She stated she asked LVN A where the CNAs were because if they had been around, she would not have been able to get in his room. She stated she contacted CNA B the following day (11/03/24) and she told her that Resident #1 had been found naked in Resident #2's room. She stated she asked her to write a statement. She stated nobody was in the room, nobody could have witnessed him touching her. She stated on 11/04/24, she interviewed Resident #2 who told her that Resident #1 had come into his room, and she had tried to hold his hand. She stated he told her he was looking at the TV and when he turned around, she had no clothes on. She stated he then told her he tried to help her put her clothes back on and did not have any sexual contact with her. She stated she did move Resident #2 into the locked unit to keep him safe from Resident #1 wandering in/out of his room because he is a sex offender and did not want him to be put in a situation like he was in today. She stated she only interviewed CNA B and no other staff because that was her hall she was working on, not MA C or CNA E. She stated she did not interview CR D because he was not competent enough to tell her what happened. She stated no staff members told her there had been any kind of penetration. She stated if they would have, she would have reported it at that time. When asked what the time frame was to report abuse, she stated it would have to be considered abuse. She stated there were no witnesses and Resident #2 told her he did not touch Resident #1, and he would not lie to her. She stated a possibility/suspicion of abuse did not mean it needed to be reported. When asked if she was always contacted when a resident was found naked and for no other purpose (such as abuse), she stated not always but sometimes.</p> <p>During a telephone interview on 11/05/24 at 2:28 PM, LVN A stated the ADM was not telling the truth. She stated she contacted her on 11/02/24 around 2:30 - 3:00 PM right after the incident between Residents #1 and #2 happened. She stated if she had just found Resident #1 naked without the witnessed abuse, she would not have had a reason to contact the ADM. She stated she did tell her about the explicit abuse, and she told her to do absolutely nothing and to not call her back.</p> <p>During an interview on 11/05/24 at 2:53 PM, Resident #2 stated the lady (Resident #1) went to his room, took off her clothes, and now they brought him down (to the locked unit). He stated she had a dirty diaper and when he was trying to help her, he may have stuck his hands in that. He stated he did not touch her, that he did [AGE] years (in prison) for that and I know better.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 10:23 AM, the MDSC stated Resident #1 having a history of disrobing had not been care planned was because that was the first time she had heard of her doing that - she did not have a history of it. She stated her care plan does mention her wandering, but she had never heard of her wandering into other residents' rooms. She stated she could not care plan what the nurses did not document. She stated, as a nurse, if she walked in and saw the incident between Residents #1 and #2, she would have definitely called the ADM who is the Abuse and Neglect Coordinator, and that was why LVN A called the ADM. She said Resident #1 was forgetful and never locked her wheelchair. She stated obviously Resident #2 was doing something inappropriate for her to make that phone call. The MDSC then stated to the Surveyors that she wanted to be honest about something. She stated that on 11/04/24, she, the ADM, the DON, and the SW interviewed Resident #2 and he admitted that he touched her. She stated he was then asked about the BM on his hand was told you had to have touched her butt and he replied with, well . her diaper was off . She stated he kept trying to back-track after that, but he definitely admitted to touching her. She stated the ADM was aware of what he had done.</p> <p>Review of the facility's undated Governing Body Policy reflected the following:</p> <p>The Governing Body is ultimately responsible for the operation of the Facility. The Governing Body must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a data gathering, risk analysis and reporting systems exists and (2) the reporting system is adequate to assure the Governing Body that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.</p> <p>Review of the facility's Abuse and Neglect Policy, revised 06/2019, reflected the following:</p> <p>.</p> <p>If abuse/neglect is suspected, the facility will:</p> <ol style="list-style-type: none"> 1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the abuser and/or provision of medical care. 2. The facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures. 3. The facility's Leadership will conduct a careful and deliberate investigation, centering on facts, observations and statements from the alleged victim and witnesses, of any allegation received of suspected abuse, neglect, or exploitation or mistreatment and will implement immediate action to safeguard resident. 4. The facility's Leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law. 5. Report the investigation findings to the appropriate State Agencies, as required by law. <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The ADM was notified on 11/05/24 at 3:47 PM that an IJ had been identified and an IJ template was provided.</p> <p>The following POR was approved on 11/07/24 at 11:44 AM:</p> <p>F 835 According to the IJ template, the facility failed to ensure the Administrator acted in a professional manner. According to the IJ template, the administrator failed to allow a nurse to document an incident of sexual abuse between Residents #1 and #2.</p> <p>On 11/5/24 the Regional Director of Operations suspended the Administrator pending investigation of failure to report and investigate the incident from 11/2/24.</p> <p>The Regional Director of Operations reported the allegation of sexual abuse to HHSC on 11/5/24 and initiated an investigation.</p> <p>The Regional Director of Operations will act as the Abuse, Neglect, and Exploitation Prohibition Coordinator effective 11/5/24 until an Interim Administrator is identified.</p> <p>On 11/5/24 the Regional Director of Operations reviewed the Abuse, Neglect, and Exploitation Prohibition Policies and Procedures with no changes required.</p> <p>The Interim DON educated the Charge Nurse, and she completed an SBAR and Incident Report on Resident # 1 and Resident # 2 on 11/5/24 detailing the events of the incident from 11/2/24. The Charge Nurse notified the Physician and</p> <p>Responsible Party of Resident # 1 and # 2 on 11/5/24 of the event from 11/2/24.</p> <p>The Regional Nurse Consultant educated the Interim DON on 11/05/2024, and the Interim DON began training Charge Nurses on completing SBARs and Incident Reports for any resident-to-resident incidents, including those involving sexual allegations, and emphasized the importance of notifying the Administrator as of 11/5/24. QAPI meeting was conducted on 11/05/2024 with the Medical Director, Administrator and Interim DON over Abuse, Neglect, and Exploitation Prohibition Policies and Procedures.</p> <p>The Surveyor monitored the POR on 11/07/24 as followed:</p> <p>During an interview on 11/07/24 at 2:29 PM, the DO stated she was the direct Supervisor for the Administrator. She stated the ADM was suspended on 11/05/24 pending their investigation. She stated she would be the Abuse and Neglect Coordinator for the time being. She stated she if she had known about the incident between Residents #1 and #2, she would have told the ADM to report it and to send Resident #2, not allow him to stay in the facility. She stated he had since been sent out and would not be coming back. She stated she spoke to the RP of Resident #1, and he did not want to send her out to the hospital, stating it would be more traumatic. She stated all staff had been trained on abuse and neglect - went through the entire provider letter and policy, compliance training, reporting, incident reports, and SBAR.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interviews on 11/07/24 from 12:42 PM - 2:40 PM, staff (four CNAs, one LVN, one RN, and the SW) from multiple shifts stated they were in-serviced before working their shift. They stated they were in-serviced on abuse and neglect and to notify the IADM (the DO) immediately if there was every any abuse or neglect suspected. They all gave examples of abuse such as mental, physical, sexual, and emotional. They all stated if they did not like the way it was being handled, they were to call the compliance hotline which was posted in the hallways. The RN and LVN stated that an SBAR was to be completed whenever a resident had a change in condition. They stated this was to ensure all nursing staff were aware of any changes or issues that needed monitoring.</p> <p>Review of the facility's QAPI attendance sheet, dated 11/05/24, reflected the MD, the ADM, the DON, the ADON, the MAINTD, and the DOR were in attendance.</p> <p>Review of Resident #1's SBAR, dated 11/05/24, reflected a Change of Condition assessment had been completed.</p> <p>Review of Resident #2's SBAR, dated 11/05/24, reflected a Change of Condition assessment had been completed.</p> <p>Review of an Incident Intake, dated 11/05/24, reflected the incident between Residents #1 and #2 on 11/02/24 was reported to HHSC by the DO.</p> <p>Review of an in-service, dated 11/05/24 and conducted by the RLNFA, reflected the DON and LVN A were in-serviced on their abuse and neglect policies and procedures.</p> <p>Review of an in-service, dated from 11/05/24 -11/07/24 and conducted by the DON, reflected staff from all shifts were in-serviced on their abuse and neglect policies and procedures.</p> <p>Review of an in-service entitled Compliance Hotline, dated 11/05/24 and conducted by the DO, reflected the DON was in-serviced on utilizing the compliance hotline for any incidents that may require further investigation by the corporate team: including incidents where abuse, neglect, or exploitation may not be reported or investigated properly.</p> <p>Review of an in-service entitled Compliance and Ethics, dated from 11/05/24 - 11/07/24 and conducted by the DON, reflected staff from all shifts on the Compliance Hotline.</p> <p>Review of an in-service entitled SBAR/Notification of Abuse to Coordinator/Administrator, dated 11/05/24 and conducted by the RNC, reflected the DON was in-serviced on the following:</p> <p>Charge Nurses/Licensed Nurses are required to complete an SBAR and incident report for any type of resident-to-resident incident, including those including sexual allegations and are required to notify the Administrator.</p> <p>Review of an in-service entitled SBAR/Notification of Abuse to Coordinator/Administrator, dated 11/05/24 - 11/07/24 and conducted by the DON, reflected staff from all shifts were in-serviced on the following:</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Charge Nurses/Licensed Nurses are required to complete an SBAR and incident report for any type of resident-to-resident incident, including those including sexual allegations and are required to notify the Administrator.</p> <p>The DO was notified on 11/07/24 at 3:21 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		