STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675971	A. Building B. Wing	01/17/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and supervision, in that: The facility failed to ensure Resident #1 received adequate supervision to prevent him from exiting the facility undetected on 12/09/24 and 12/31/24. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 12/09/24 and ended on 01/01/25. The facility corrected the non-compliance before the investigation began on 01/08/25. The Past Non-Compliance form (a document used to report a past violation that has been rectified, at the time of the current investigation) sent to Administrator on 01/17/25 at 3:20pm. This failure could place the residents with exit seeking behaviors at risk for injury or death. The findings included: Record review of Resident #1's admission record dated 01/08/25 reflected a [AGE] year-old male initially admitted to the facility on [DATE] and re admitted on [DATE]. His diagnoses including Parkinson, Dementia, Abnormalities of gait and mobility, Lack of coordination, Muscle wasting and atrophy, Cognitive communication deficit, Pain, Tremor and Schizophrenia. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 11, indicating Resident #1' s cognition was moderately impaired. The MDS stated he had hallucinations and delusions however there was no wandering behavior exhibited. Record review of Resident #1's care plan dated 01/01/25 reflected: Resident #1 was deemed at risk for wandering. On 12/09/24 and 12/31/24 he eloped from the facility. The relevant interventions were: 1. Reeducated staff on elopement. 2. Q 15 min monitoring, (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Look for alternative placement. 4. Maintain resident safety during increased episodes of wandering. 5. Observe and document resident's location frequently throughout shift. Record review of Resident #1's quarterly Elopement risk evaluation dated 11/15/22 reflected Resident #1 had a score of 17 indicating he was at moderate risk for elopement. Record review of Resident #1's Elopement risk evaluation dated 01/01/25 reflected Resident #1 had a score of 33 indicating he was at high risk for elopement. Record review of FRI dated 12/09/24 and Inservice records reflected , on 12/09/24 at 2:30 pm, Resident #1 eloped through a malfunctioning gate and the facility completed the following interventions : In serviced the staff on elopement risks on 12/09/24. 1. Q 15 min monitoring commenced immediately after the elopement episode on 12/09/24 and continued till the resident discharged from the facility on 01/09/25. 2. Psychiatric Subsequent Assessment conducted on Resident #1 on 12/09/24. 3. Maintain resident safety during increased episodes of wandering. 4. Observed and documented resident's location frequently throughout shift 5. All the interventions were monitored and audited by DON on daily basis. Record review of FRI dated 01/01/25 and Inservice records reflected, on 12/31/24, Resident #1 was up during the night and entered into the kitchen through a door to the kitchen from memory care unit and then eloped down the street through the door at the back of the kitchen. The facility completed the following interventions : 1. Completed Inservice on 'kitchen Door Check on 01/01/25. 2. Looked for alternative placement. Resident #1 was discharged to another facility on 01/09/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/08/25 at 11:30 am , RN A stated she was the charge nurse on 01/08/25. She stated she was not on duty on 12/09/24 as well as on 12/31/24 when Resident #1 eloped. She stated she was informed by the DON that on 12/09/24 at about 2:00 pm, memory care residents were smoking in the yard. After the smoking session over, all the residents were returned to the memory care unit, however, the door to the yard from the memory care was not closed properly by the staff . She stated it was reported that one of the residents from the memory care reported to the staff that he saw Resident #1 getting out of the facility in his wheelchair by kicking the fence gate. RN A stated she also was informed, on 12/31/24 at night, Resident #1 entered the kitchen through the unlocked kitchen door that opened to the memory care, and from there, went to the street through the exit door at the back of the kitchen. She stated as the staff was not giving proper attention to ensure the doors were closed properly , Resident #1 had the opportunity to elope. RN A said the resident was on 15 minutes checks since the first incident that happened on 12/09/24 and that helped the staff who worked in the night on 12/31/24 to notice Resident #1's absence in the facility sooner than later at that time . During an interview on 01/08/24 at 2:00pm, CNA C stated she was working at the facility on 12/09/24. She stated on 12/09/24 at about 2:30 pm, one of the residents who resided in memory care reported to the staff that he saw Resident #1 leaving the facility in his wheelchair by opening the fence gate. CNA C stated she immediately went out with CNA D in search of Resident #1 and found him two blocks away on the street. She stated Resident #1 was not very happy to come back, however, he was compliant with nursing directions and returned to the facility with her and CNA D. She stated every staff who worked at the facility should ensure residents' safety by making sure all the exit doors remained locked properly. CNA C stated she received an in-service on elepement process on 12/09/24 and learnt the importance of securing the safety of the residents by ensuring the external doors and gates were closed and locked properly. CNA C stated she also learnt the process that to be followed step by step, after an incident of elopement occurred. During an interview on 01/08/25 at 2:30 pm, CNA D stated on 12/09/24, he worked at the memory care unit in the day shift. He said, on that day at about 2:00 pm, the residents were having q smoking session in the courtyard. He stated at about 2:30 pm, one resident from memory care reported to him that he noticed Resident #1 exiting the facility through the gate that opens from the yard to the street. CNA D said he and CNA C went out immediately in search of Resident #1 and found him in a church compound about 50 yards away from facility. CNA D stated Resident #1 was humorous and playful at that time and made numerous jokes about his elopement attempt. CNA C stated he received an in-service on elopement process on 12/09/24 and learnt the importance of securing the safety of the residents by ensuring the external doors and gates were closed and locked properly. CNA C stated she also learnt the process that to be followed step by step, after an incident of elopement occurred. During a telephone interview on 01/08/25 at 3:13 pm, LVN G stated she was the nurse who assessed Resident #1 after the incident of elopement on 12/09/24. She said the head-to-toe assessment revealed Resident #1 had no issues with skin integrity or any discoloration or inflammation. There were no deformities noticed. His vitals were within normal parameters. She said Resident #1 presented as jovial and funny, and did not show any signs of any injury, trauma, or pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/08/25 at 12.35 pm, MM B stated he started working at the facility as MM on 11/24/24 . He stated he was informed that on 12/09/24, in the afternoon, Resident #1 escaped from the memory care unit to the street through the door that opened to the yard, and from the yard through the gate on the fence. He said the incident of elopement occurred as the staff had not ensured that the door and gate were closed properly. He stated the staff should have pushed the door and gate after closing, to ensure they were locked properly. He stated the facility replaced the gate's digital lock with a more powerful magnet by a professional company. He said prior to 12/09/24, he used to check the gate twice a week. However, after the incident, it was increased to daily to make sure it was working properly. He said the second incident of elopement also occurred as the staff had not locked the kitchen door properly. During a telephone interview on 01/08/25 at 3:40 pm, RN H stated on 12/31/24, she worked in the night shift . RN H stated she was checking on Resident #1 every 15 minutes and noticed he was in his room until 11:00 pm . She said, at 11:00 pm, he approached her at the nursing station for snacks. She said he was at the nursing station area eating the snack until about 11:15pm. RN H stated, when she went to check on him at 11:30pm, he was not in his room, and she started searching other areas in the unit. She said since he was not seen anywhere, she requested the help from the staff who worked at the other side of the facility (non-secured area). She said , as the search was not fruitful, she called 911 and police arrived to help. In the meantime, one of the staff members noticed the kitchen door was to remain opened , made to assume he might have eloped through that door. RN H stated the police located Resident #1 four blocks away and brought him back to the facility. RN H stated she made a head-to-toe assessment and there were no injuries or issues noticed. RN H stated , when she asked Resident #1 how he managed to escape , Resident #1 replied that he went into the kitchen and from there to the street through the exit door at the back of the kitchen. She stated she asked him why he attempted to go away and in response he giggled and stated he was naughty to make that decision. She stated the facility amended the care plan to include the elopement risk and interventions. During an interview on 01/08/25 at 2:45 pm, DA E stated she worked at the facility as the DA for about 6 years. She said she started her shift every day at 11:00am and finished at 6:00pm, after the dinner being served. She stated after her shift finished, she made sure the exit door at the back of the kitchen and the passage door to the dining area of the memory care unit were locked properly . She added, she exited the facility through the secured door between the memory care unit and the non-secured area and left the facility through the main entrance. She said on 12/31/24, she worked the evening shift with DA F. She stated DA F was the last person who left the kitchen on 12/31/24 and she was sure that he secured all the kitchen doors before he left the facility. She stated she received an Inservice on Kitchen Door Check on 01/01/25 and learnt the importance of securing the safety of the residents by ensuring the kitchen doors were closed and locked properly. During an interview on 01/08/25 at 2:50 pm, DA F stated he started to work at the facility 4 days ago, on 12/27/24. He stated on 12/31/24, he worked with DA E and left the kitchen with her in the evening at approximately 6:30pm . DA F stated he was the one who exited the kitchen last, and clearly remembered that he closed the door. However, he was not sure if he made a point to check if it was locked . DA F stated he heard one resident escaped through the kitchen door on 12/31/24 , indicating he might not have locked the door properly . He said the incident was a lesson and thereafter made it sure that the kitchen doors were locked properly any time before leaving the kitchen . He said he received an Inservice on Kitchen Door Check on 01/01/25 and learnt the importance of securing the safety of the residents by ensuring the kitchen doors were closed and locked properly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 01/08/25 at 11:30 am of the memory care unit, it was revealed the facility's kitchen was situated in the memory care unit. There were two doors that opened from the kitchen to the memory care, and they had keypad on it. There was an exit door at the back of the kitchen that opened to an open yard and a street. The street was not busy with traffic. The exit door at the back of the kitchen was locked from the inside with a latch. The entrance to the secured unit (memory care unit) from the general area of the facility was through a door ,controlled with keypad and required passcode. There was another door with a number lock and passcode and that opens to a fenced yard. The smoking area was in this yard. There was a gate on the fence that opened to a main street. It was a busy street with traffic. This gate also was protected with a digital pad and required passcode to open it. All the doors and gate were closed and locked during the observation. During an observation and interview on 01/08/25 at 1:45 pm, Resident #1 was in the hallway in his wheelchair interacting with staff and other residents. There was a carry-on bag beside his wheelchair and he stated he was ready to go to the new facility. He was pleasant, jovial, and humorous on interaction. When asked about the elopement attempts that he made on 12/09/24 and 12/31/24, he changed the subject and made some jokes on other issues. When re-directed to the subject of elopement, after some time, he stated he was being stupid . He again changed the subject and showed his disinterest in discussing it anymore. He stated he was moving out of the facility on that day and waiting for someone from the new facility to pick him up. He stated he had no issue or concern about going to another facility. During an interview on 01/08/25 at 4:10 pm, the DON stated he started working at the facility about 6 weeks ago; he transferred from a sister facility. He said when the resident was admitted initially about a year ago, he was at low risk of elopement . However after the elopement incident happened on 12/09/24, on further investigation, it was revealed that he had long history of elopement at the previous facility, and they had not communicated about it during his discharge from the old facility. He stated after the incident on 12/09/24, he was under 15-minute observations . He added, the facility did an in-service with all staff members regarding the importance of ensuring all the exit doors and the gate on the fence remained closed. He said the next day, the lock on the gate had been changed by a professional company. The DON stated the new kitchen staff, who started 4 days prior to the incident, did not follow through the practice of ensuring the doors were locked, and that led to another elopement. DON stated on further assessment, it was revealed the layout of the facility and the location of the memory care unit was not suitable for Resident #1. He stated , for that reason the facility was looking out for an appropriate placement and managed to find a safer facility for Resident #1. DON said Resident #1 would be discharged to that facility on 01/08/25. DON said Resident #1 did not have any family and his legal guardian agreed with this arrangement. During an interview on 01/17/25 at 12:20pm ADM stated she joined the facility about 6 weeks ago. She stated the elopement on 12/09/24 happened before she joined however was aware of the incident and the interventions that were in place for monitoring Resident #1 from elopement. She stated the second incident of elopement that happened on 12/31/24 was due to a lapse that was totally unexpected. She stated the new dietary staff had not ensured if the kitchen door was locked. ADM stated the kitchen staff were in serviced immediately about the importance of keeping the kitchen door locked all the time. She stated Resident #1 was transferred on 01/09/24 to a facility that was more appropriate to his needs and safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review on 01/08/25 of the 15-minute checks on the MAR revealed the checks were completed starting from 12/09/24 and record review of the Inservice revealed all the staff worked in the memory care unit were in serviced on elopement process and all kitchen staff were in serviced on the expectation of before checking all the doors to ensure its closed before leaving the kitchen specially on last Shift for the day. Record review of the facility's policy Elopement revised in 08/2019 reflected: It is the policy of this facility to safely and timely redirect residents to a safe environment. A prompt investigation and search will be conducted if a resident is considered missing. It is the policy of this facility to safely and timely redirect residents to a safe environment. A prompt investigation and search will be conducted if a resident is considered missing. 3)The DON or designee organizes and institutes an immediate and thorough search of the facility and surrounding grounds. including but not limited to a search of the area outside the nearest exit to the resident's room or the exit where he/she was last seen, and the entire unit where the resident resides or was last seen, the remainder of the facility (all rooms, closets - including storage facilities - and bathrooms) and grounds, extending beyond the fence line. 4)The entire search process of the facility and grounds, from the time the resident is missing, will be completed within (30) thirty minutes. .7) When the resident is located, the Charge Nurse completes a head-to-toe assessment. The Social Service Designee assesses the resident for emotional distress. The Charge Nurse reports any findings to the Director of Nursing or designee. The Director of Nursing or designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician and resident's legal representative. Record review and verification of the corrective action implemented by the facility beginning on 12/09/24. 1. In serviced the staff on elopement risks on 12/09/24. 2. Q 15 min monitoring commenced immediately after the elopement episode on 12/09/24 and continued till the resident discharged from the facility on 01/09/25. 3. Psychiatric Subsequent Assessment conducted on 12/09/24. 4. Maintained resident safety during increased episodes of wandering. 5. Observed and documented resident's location frequently throughout shift. 6. All the interventions were monitored and audited by DON on daily basis. 7. The gate lock was fixed on 12/11/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. Completed Inservice on 'kitchen Door check on 01/01/25. 9. Looked for alternative placement. Resident #1 was discharged to new facility on 01/09/25. 10. Elopement risk assessment conducted on 12/10/24 on all the 26 residents in the secured unit revealed there were no residents with high risk of elopement except Resident #1. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 12/09/24 and ended on 01/01/25. The facility corrected the non-compliance before the investigation began on 01/08/25. Past Non-Compliance form sent to Administrator on 01/17/25 at 3:20pm.