

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  06/04/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for 4 of 8 residents reviewed for abuse.</p> <p>Resident #1 and Resident # 2 had an altercation on 5/2/25 due to Resident # 1 was moving too slowly per Resident # 5.</p> <p>Resident #3 and Resident #4 had an altercation on 5/1/25 regarding possession of sunglasses.</p> <p>These failures could place residents at risk of physical harm, mental anguish, and/or emotional distress.</p> <p>Findings included:</p> <p>Resident #1 and Resident #2:</p> <p>Record review of Resident #1's chart revealed Resident #1 was admitted to the facility on [DATE] and was a [AGE] year-old male with diagnoses which include: Atherosclerotic Heart Disease (Atherosclerosis is the buildup of plaque in the arteries, which can reduce blood flow and cause heart disease, stroke, or other conditions), Type 2 Diabetes Mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), Vascular Dementia without behavioral disturbance ( Vascular dementia is a common type of dementia that happens when there's decreased blood flow to areas of your brain).</p> <p>Record review of Resident #1's MDS assessment dated [DATE] revealed his BIMS scored is 1 (indicating severe cognitive impairment). Resident # 1 used a wheelchair for mobility, and he required substantial/ maximal assistance score 2 regarding Functional Abilities. There are no documented behaviors on the MDS.</p> <p>Record review of Resident #1's care plan Date 3/13/25 revealed Resident #1 reflected: Resident is sexually inappropriate with staff physically and verbally. Resident #1 has verbal altercations monthly, bimonthly with other residents. revisions on 03/31/2025 revealed, Resident #1 will have less of these episodes monthly. Interventions included: Staff will redirect resident as needed.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's chart revealed Resident #1 admitted to the facility on [DATE] and was a [AGE] year-old male with diagnoses of Unspecified Cirrhosis of Liver( Liver Scarring that is triggered by chronic inflammation), Generalized Anxiety Disorder (is a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things), and Depression, unspecified (is used when someone displays depressive symptoms, but there isn't enough information for a specific diagnosis.).</p> <p>Record review of Resident #2's MDS dated [DATE] revealed Resident #2 Resident's BIMS score was 9 which suggested he had moderate cognitive impairment. MDS did not indicate the resident had behaviors toward others.</p> <p>Record review of Resident #2's care plan dated 4/3/25 revealed Resident #2 had episodes of behaviors and was at risk for further increased episodes and injury. The resident often cursed and made false allegations against staff.</p> <p>An interview on 06/04/2025 at 10:24 AM with Resident # 1 revealed Resident # 1 was seated in his wheelchair facing the wall. Resident #1 was asked if he had been injured in the altercation with Resident # 2. He smiled, turned his head away and he was not able to respond verbally to any questions.</p> <p>Interview on 06/04/2025 at 10:29 with the AD C revealed Resident # 5 reported the incident on 05/02/2025 to DON stating Resident #5 reported to AD C that on 5/1/25 at 4pm he saw Resident #2 pushing Resident #1's wheelchair and Resident #2 hit Resident #1 on his back because he moved too slowly. AD C immediately contacted DON and ADMIN. AD C stated DON did X-Rays on Resident #1's upper body, and they did not see any injuries to Resident #1. AD C stated, she thought the resident would feel not good at all if they were abused. AD C said not much could be done to prevent this type of incident from occurring because it happened so quickly all staff could do was respond. AD C was not aware of Resident # 2 having a history of aggressive behaviors.</p> <p>Interview on 6/4/20205 at 10:31 AM with Resident # 5 revealed that Resident # 2 pushed and hit Resident # 1 on the back because Resident # 2 was frustrated that Resident # 1 was moving so slowly. denied ever seeing abuse in the facility before this incident.</p> <p>Interview 06/04/2025 at 10:10 AM the DON stated he did not find any injuries to Resident #1. The DON stated he called resident # 2's Parole Officer to report the incident. The DON was asked how he thought it made a resident feel if they were abused and he stated they may become fearful. The DON stated the facility could keep monitoring the residents who were prone to outbursts.</p> <p>Interview on 06/04/2025at 10:15 AM the ADMIN was asked what they did after the incident occurred and they stated they provided in- service training after the incident on 5/3/2025. ADMIN stated Resident #2 was no longer a concern because he was discharged from the facility.</p> <p>In an interview on 6/4/25 at 12:10pm with Family of Resident #2 revealed he had been discharged from the facility and moved to a halfway house in Fort Worth.</p> <p>Resident #3 and Resident #4:</p> <p>Record review of Resident #3's chart revealed Resident #1 admitted on [DATE] was a [AGE] year-old male with diagnoses of: Cerebral Infarction, Aphasia, Generalized Anxiety Disorder.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's care plan dated 04/18/2025 revealed Resident #3 revealed he gets agitated with staff; Resident #3 is verbally aggressive; he called another resident nigger and became loud and unruly. Intervention tasks included: Resident #3 to increase of meds. Care Plan stated to arrange for psych consult, follow up as indicated.</p> <p>Record review of Resident #3's MDS revealed Resident #3 Resident's BIMS score was 2 which suggests he has a severe cognitive impairment.</p> <p>Record review of Resident #4's chart revealed Resident #4 admitted to the facility on [DATE] and was a [AGE] year-old male with diagnoses of Dementia (Dementia is the loss of cognitive functioning that interferes with daily life and activities) and Alzheimer's Disease with late onset ( is the most common form of dementia, a brain disorder that destroys memory and thinking skills), Cognitive Communication Deficit (is a consequence of brain injuries that affects communication skills. and Heart Failure (condition where the heart muscle doesn't pump blood as well as it should, causing fluid buildup and shortness of breath).</p> <p>Record review of Resident #4's MDS dated [DATE] revealed Resident #4 has a BIMSs score of 11 which suggested moderate cognitive impairment The MDS did not report that the resident had any behaviors.</p> <p>Record review of Resident #4's care plan dated 4/30/25 revealed Resident #4 solicited another resident for sexual favors. Interventions included for staff to redirect and intervene as needed. Resident #4 was caught standing over another resident very angry. Psychiatrist to review medications.</p> <p>Interview/Observation of Resident # 4 on 06/04/2025 at 2PM revealed Resident #4 stated Resident # 3 came into the dining room wearing his (Resident # 4) glasses on top of his head. Resident #4 stated he confronted Resident # 3 about having his glasses. Resident #4 said, Resident # 3 then took his glasses off his head and did like this (the resident demonstrated glasses being hit on a table). Resident #4 stated he hit Resident #3, because Resident #3 wouldn't give him (Resident #4) the glasses back and Resident #3 broke the glasses. Resident #4 indicated it was ok for him to hit Resident #3 because Resident #4 took his glasses and broke them. Resident #4 said if someone took his possessions in the future, he should tell someone.</p> <p>Interview on 06/04/2025 at 1:30 PM with MA A revealed MA A was a witness to the altercation between Resident # 3 and Resident # 4. The MA A described her observation of the events leading up to the altercation. MA A stated Resident # 3 entered the dining room from the patio using his wheelchair to mobilize. MA A observed Resident # 3 was wearing a pair of sunglasses. Resident # 3 approached a dining table where Resident # 4 was seated in his wheelchair. MA A stated she heard raised voices and observed Resident # 3 smash the sunglasses on the dining table. MA A stated she saw Resident # 4 rise from his wheelchair and take 3 paces toward Resident #3. MA A left the medication cart, and she entered the dining room and went over to Resident # 3 to move his wheelchair out of range of Resident #4. At that time, another staff member, LVN B, arrived and she assisted Resident # 4 in getting back to his wheelchair. MA A stated that Resident #3 got very angry, aggressive and he acted out a lot. MA A did not know whose sunglasses they were. MA A said she did not know what could have been done differently to avoid this altercation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/04/2025 at 2:35PM with LVN B revealed she was called by another staff member (unknown) to come into the dining room to assist the fighting residents. LVN B stated she witnessed Resident # 4 swinging his hands toward Resident # 3 and Resident #3 raising his hands in defense. LVN B stated, she was told that Resident # 3 had smashed Resident # 4's sunglasses on the dining table. LVN B stated the staff should keep a better eye on the residents to prevent altercations in the future.</p> <p>Interview by phone with Resident #4's Parole Officer 06/04/2025 at 2:18 PM revealed Parole Officer indicated he received a call from the facility staff regarding Resident # 4's altercation with another resident. The Parole Officer stated no charges were filed against Resident # 4 regarding this incident. The Parole Office stated it was reported to him that Resident # 4 was not aggressive.</p> <p>An interview on 06/04/2025 at 3:45pm CNA D stated, she had been working here 5 years stated she was trained on abuse and neglect if they see any abuse such as physical, verbal abuse to report it to the abuse coordinator ADMIN. CNA D stated, she had not seen any abuse. CNA D stated, she had the abuse training last week.</p> <p>An interview on 06/04/2025 at 3:56pm MA F stated she had been here 3 years she was trained on abuse and neglect and the training covered recognizing abuse who to report it and what to do if you suspect abuse, she said it is reported to the ADMIN.</p> <p>Interview on 06/04/2025at 3:59 PM the DON stated he was called by MA A, and he was told about the incident. The DON stated he spoke with the LVN B, and he told her to call the doctor, inform the Psychiatrist of the escalation of the behaviors for possible adjustment of medications, to call the responsible party, and do an assessment. The DON stated to prevent altercation escalations Resident # 3 was a target behavior and nursing staff monitor him for behaviors then report to psychiatrist if any behaviors occurred. DON stated the Medical Practitioner was made aware of the situation, and the responsible party for Resident # 3 was contacted.</p> <p>Record review of in-service Abuse, Neglect &amp; Exploitation Prohibition dated 4/28/25 and 05/29/2025, revealed facility had provided this training to staff.</p> <p>Record review of abuse policy dated 05/29/2025, revealed, 7 key components: screening, Training, Prevention, Identification, Investigation, Protection and Reporting / Response.</p>		