STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455812	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at First Colony	4710 Lexington Blvd Missouri City, TX 77459

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 residents (Resident#1) reviewed for accuracy of medical records in that: The facility failed to ensure that Resident #1's pain level was documented in the resident's clinical record. This deficient practice could affect residents whose records were maintained by the facility and could place the residents at risk for errors in their care and treatment. Findings included: Record review of Resident #1's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included atherosclerotic heart disease of disease of native coronary artery without angina pectoris (a buildup of fat, cholesterol, and other substances in and on the artery walls), type 2 diabetes (high blood sugar), hyperlipidemia (high levels of fat in the blood), essential hypertension (high blood pressure), peripheral vascular disease (circulatory condition in which narrow blood vessels reduce blood flow to the limbs) and lower extremity amputation (loss or removal of body parts) Record review of Resident #1's baseline care plan dated 8/19/24 revealed the resident was alert, had no memory issues and was incontinent of bowel and bladder. Record review of Resident#1's care plan dated 8/20/2024 revealed the following: SKIN CONDITION: (Resident's Name) has non pressure/surgical skin conditions: o (resident name)'s skin condition will be free from signs and symptoms of infection through the review date. o (Resident's Name)'s pain related to the skin condition will be managed through the review date. o (Resident's Name)'s skin condition will improvement through the review date. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455812	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at First Colony	4710 Lexington Blvd Missouri City, TX 77459

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Assess the wound bed and surrounding skin for signs of infection or other complications. Record review of the pain assessment log revealed the following: 8/21/2024 11:25 am 0 Numerical (Manual) 8/21/2024 08:30 am 0 Numerical (Manual) 8/21/2024 05:30 am 6 Numerical (Manual) 8/21/2024 04:56 am 0 Numerical (Manual) 8/20/2024 10:00 pm 0 Numerical (Manual) 8/20/2024 6:58 pm 0 Numerical (Manual) 8/20/2024 10:48 am 8 Numerical (Manual) 8/19/2024 10:11 pm 0 Numerical (Manual) An interview was attempted on 8/21/2024 at 2:33 pm with LVN G but she did not answer. A call back number was left, but the staff did not return the call. In an interview on 8/21/2024 at 4:15pm with the Director of Nursing she said that if the doctor was called and orders for the medication was sent to the pharmacy, then the resident must have expressed some pain to the nurse. She said she was sure the nurse must have forgotten to document in the progress notes. She said in nursing if was not documented it was not done. She said nurses were expected to document in the nurse's notes. She said that she was going to call the nurse. Further interview with the DON revealed LVN G had an emergency, but she was available by text. Observation of Resident #1 on 8/21/2024 at 4:35pm revealed he was up in his wheelchair, clean and groomed with no odor. He was alert and oriented and could make his needs known. In an interview on 8/21/2024 at 4:35pm with Resident #1 he said he was not in pain. Resident #1 said he got his medication on 8/20/2024 when he was in pain. He said he could not remember what time on 8/20/2024 he got his medication. In an interview on 8/21/2024 at 4:50pm with Doctor J he said he was in the facility on 8/20/2024 around 1:00pm and he assessed Resident #1 and he said he was not in pain, and he did not express any signs and symptoms of pain. He said around 5:30pm LVN G called to say that Resident #1 was in pain, and he called the pharmacy and placed an order for Norco for pain. He said he was comfortable giving the order for the Norco because Resident #1 had an amputation, and it was very likely he would be in pain. Record review of the nurse's progress notes dated 8/20/2024 revealed no documentation what Resident #'s 1 pain level was when the Norco was ordered. There was no evidence if when the doctor was notified at 5:30pm on 8/20/2024 of Resident #1's pain level nor was it documented on the pain assessment log. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455812	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at First Colony	4710 Lexington Blvd Missouri City, TX 77459

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/21/2024 at 5:15pm via text with LVN G she said that Resident #1 complained of pain on 8/20/2024, and she called the doctor. She said the doctor called in the pain medication Norco to the pharmacy. She said she should have documented it in the nurse's notes, but she got busy and forgot to document. Record review of the facility's nursing policies and procedures dated 06/2019 reflected in part . Subject: Documentation: Licensed Nurse Policy: It is the policy off the facility that documentation pertaining to the resident will be recorded will be recorded in accordance with the regulatory requirements. Procedures: The nursing staff will be responsible for recording care and treatment observation, and assessment and other appropriate entries in the resident's clinical records. Post Admission Documentation Nursing documentation will occur every shift for 72 hours after admission and will address vital signs and reasons for admission.