

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices based on the comprehensive assessment of resident for 1 (CR#1) of 18 residents reviewed for anticoagulants.</p> <p>-The facility delayed sending CR #1 to a higher level of care on 11/21/2024 when CR #1 experienced an unwitnessed fall with a head injury (swelling to right cheek). CR #1 was receiving the medication Eliquis (blood thinner).</p> <p>-CR #1 was diagnosed with an Acute Subdural Hematoma with mass effect</p> <p>An Immediate Jeopardy (IJ) was identified on 11/23/2024 at 4:24PM. While the IJ was removed on 11/25/2024, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility need to evaluate the effectiveness of the corrected system.</p> <p>This failure has the potential to place residents at risk for hospitalization and death.</p> <p>Findings:</p> <p>Record review of CR #1's face sheet dated 11/22/24 revealed a [AGE] year-old female admitted to the NF originally on 05/11/2024 and readmitted on [DATE]. CR #1's diagnoses included the following: muscle weakness, unsteadiness on feet, vascular dementia (memory loss), end stage renal disease (kidney disease), and osteoporosis (bones become weak and brittle).</p> <p>Record review of CR#1's MDS assessment dated [DATE] revealed a BIMS score of 7 indicating the resident's cognition was severely impaired.</p> <p>Record review of CR #1's Comprehensive Care Plan dated 11/04/2024 reflected that the resident was being care planned for anticoagulants that reflected the following:</p> <p>-Give meds per order</p> <p>-Monitor for increase bruising, bleeding, etc.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-Notify MD if bleeding is not stopped with pressure</p> <p>Record review of CR #1's Physician Orders for the month of November 2024 reflected the following orders:</p> <p>-Dated 05/16/24 Eliquis 5mg give one capsule by mouth q 12 hours related to atherosclerosis (build-up of fats, cholesterol, and other substances in and around the artery {a vessel that carry blood away from the heart to the entire body}) walls.</p> <p>-Dated 05/14/24 Acetaminophen Tablet 325mg give 2 tablets by mouth every 6 hours for general discomfort.</p> <p>Record review of CR #1's MAR for the month of November 2024 reflected that RN A medication administered on 11/21/24 to CR #1 included:</p> <p>-Tylenol (325 mg 2 tablets administered by mouth) with a pain level documented as 0.</p> <p>Further review of CR #1's MAR dated November 2024 reflected that Medication Aide RR administered the medication Eliquis 5mg po prior to resident being transported to the hospital on 11/21/24. Further review revealed that CR #1 was receiving the medication Eliquis twice a day as ordered by the physician.</p> <p>Record review of CR #1's Nursing Progress Notes dated 11/21/24 at 5:50 AM revealed CR #1 was found in her room sitting on the floor by RN A. RN A assessed resident and documented that resident had swelling to her right cheek. Further record review revealed that CR #1 was transferred to the hospital on 11/21/24 at 7:40 AM.</p> <p>Record review of CR #1's Progress Notes documented by RN A dated 11/21/24 reflected the following:</p> <p>.CR #1 was assessed, V/S were evaluated to be stable and WNL. Swelling / hematoma was noted to the Right cheek. No distress is noted at this time. CR #1 denies any pain or discomfort at this time. Fall precaution is in place. Neuro assessment is initiated and ongoing. CR #1 educated to call for assistance whenever she needed help, CR #1 verbalized understanding. Bed is put in the lowest position with call bell and personal belonging within her reach. MD was notified. DON and RP were also notified. This nurse called report to hospital. CR #1 is awaiting transfer to the hospital .</p> <p>Record review of CR#1's SBAR dated 11/21/2024 documented by RN A reflected the following:</p> <p>-Form Summary: SBAR (Change of Condition) - Fall Event</p> <p>Date/Time of Fall: 11/21/2024 5:50 AM</p> <p>Location of the Fall: Resident's room</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Classification of the Fall:</p> <p>Unwitnessed</p> <p>What was the resident doing prior to the fall:</p> <p>Resident states I was trying to turn and I rolled over.</p> <p>Initial Vital Signs Post Fall Event:</p> <p>Blood Pressure-124/71</p> <p>Pulse-78</p> <p>Temperature-97.6</p> <p>Respirations-17</p> <p>O2 Saturation-99%</p> <p>Medication Reviewed with the Physician:</p> <p>Yes</p> <p>Notifications</p> <p>Physician/Physician Extender: PCP; 11/21/2024 5:54 AM</p> <p>Resident/Responsible Party: 11/21/2024 5:55 AM</p> <p>Observation on 11/23/2024 at 11:30AM revealed CR# 1in the ICU unresponsive, resting in the hospital bed connected to a ventilator, and a neck collar. The top and left side of CR #1's head was bald with dressing on top of her head. There was a small plastic bulb that appeared to be connected to CR #1's head with red fluids draining inside of bulb. CR #1 was receiving the medication Cardene (used to treat high blood pressure and control chest pain) IV 40 mg in 200 ml of fluid at 75 ml/hr. Resident was receiving gastrostomy feedings Nova Source that read on pump 20 ml/hr.</p> <p>Record review of CR #1's hospital records revealed that CR #1 admitting diagnoses was Acute Subdural Hematoma (a pool of blood between the brainand its outermost coverin) with mass and a left craniotomy ( surgical procedure that involves removing a section of the skull to access the brain) evacuation.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/22/24 at 10:12 AM with the NF Administrator, and the DON present, the Administrator said CR #1 was residing on the Memory Care Unit and on 11/21/24 around 5:30 AM, the staff (RN A and CN B) had gotten CR #1 up for dialysis. The Administrator said from her understanding, the staff placed CR #1 near the nurse station in her wheelchair. The Administrator said the staff began to round on other residents in the MCU at 5:40 AM. The Administrator said CNA B said shortly after, she saw CR #1 laying on her bed. The Administrator said, at 5:50 AM, the Charge Nurse heard a noise coming from CR #1's room and went to see what was going on. The Administrator said when RN A arrived to CR #1's room, she found CR #1 sitting on the floor in between the 2 beds. The Administrator said CR #1 could walk. The DON interjected and said that CR #1 could walk, but had an unsteady gait. The surveyor requested copies from the Administrator of everything that the NF had done (investigation/in-services, etc.) regarding CR #1's fall on 11/21/2024. The Administrator said she had not completed her investigation, but would email so far what the facility had completed.</p> <p>Interview on 11/22/24 at 1:58 PM with a family member of CR #1 said CR #1 was still at the hospital in a coma and her condition was not looking good because CR #1 had a lot of bleeding on the brain. The family member said the NF called her on 11/21/24 around 6:40 AM telling her that CR #1 had a fall, and they were preparing to send CR #1 to the hospital for further evaluation. The family member said she spoke with CR #1 prior to leaving the NF and CR #1's speech was slurred. The family member said the nurse, who name she did not recall, told her it was probably CR #1's medications causing the slurring of speech. The family member said when the nurse called her to report that CR #1 had a fall, the nurse told her that she had called transportation instead of 911.</p> <p>Interview on 11/22/24 at 2:34 PM, RN A said she worked the 6:00 PM- 6:00 AM shift, and worked on 11/20/24. RN A said herself and CNA B had gotten CR #1 out of bed at 5:30 AM to dress CR #1 and placed in her wheelchair for dialysis. RN A said CR #1 was taken to the common area across from the nurse station. RN A said the CNA that was assigned to CR #1 was CNA C, but CNA B assisted with getting CR #1 out of bed for dialysis. RN A said CNA B was in the common area as well but later began to make rounds with CNA C getting the other residents out of bed and taking some to the common area as well, but still checking on CR #1. RN A said she began to pass medications on the other residents while keeping an eye on CR #1. RN A said she could see CR #1 because of the way her cart was positioned on the hallway. RN A said when she came out of a resident room, she did not see CR #1. RN A said she rushed to CR #1's room where she found CR #1 sitting on the floor. RN A said she never heard a noise coming from CR #1's room. RN A said she called CNA C to come and assist her with CR #1. RN A said after she finished assessing CR #1, herself and CNA C placed CR #1 back in bed. RN A said CR #1 had some swelling to the right side of face but was not complaining of pain. RN A said CR #1 vital signs were stable and she initiated neurological checks on CR #1 which were within normal limits. RN A said she called the doctor, resident family member as well as the Administrator. RN A said CR #1's family member wanted to speak to CR #1. Therefore, she took the phone to CR #1's room so she could speak to the family member. RN A said when she initially called the doctor, he did not answer. RN A said CR #1's PCP came to the facility later. RN A said because CR #1 appeared stable, she used her own judgment to send CR #1 to the hospital via regular EMS and not 911. RN A said she was aware that CR #1 was receiving the medication Eliquis and reiterated that she used her own judgement. RN A said the facility policy on unwitnessed falls with head injuries receiving anticoagulants was to send to hospital via 911. RN A said if a resident experienced an unwitnessed fall with a head injury and on blood thinners, they should be sent to the hospital via 911. RN A said if this was not done, the resident could die.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview via phone on 11/22/24 at 3:05 PM, CNA B said she worked the night shift from 10 PM - 6 AM and worked on 11/20/24 on the MCU. CNA B said she was not the CNA assigned to CR #1. CNA B said she never provided any type of care for CR #1 including assisting with placing CR #1 in the wheelchair on 11/21/2024 at 5:30AM.</p> <p>Interview on 11/22/24 at 3:13 PM, the Administrator said RN A initially called regular transportation to transport CR #1 to the hospital. The Administrator said she asked RN A why she called regular transportation instead of 911. The Administrator said RN A said because CR #1 appeared to be stable. The Administrator said according to CR #1's Nursing Progress Notes, RN A sent CR #1 to the hospital via regular EMS at 7:40AM.</p> <p>Interview on 11/22/24 at 3:26 PM, the DON, with the Administrator present, said the NF did not have a policy on unwitnessed falls with head injury receiving anticoagulants. The DON said prior to reviewing CR #1's chart on 11/21/24, she was not aware that CR #1 was on the medication Eliquis. The DON said she was not aware what time CR #1 left the NF to go to the hospital until she reviewed the Nursing Progress Notes. The DON said if the nurse felt that it was okay to send CR #1 to the hospital via regular EMS, she would have to trust RN A's judgement because she was not present at the time of the incident. The DON said if she was present when CR #1 experienced the unwitnessed fall with head injury, she could not say what she would have done. The DON said she in-serviced the staff on falls on 11/21/24.</p> <p>Interview on 11/22/24 at 3:40 PM with the Administrator and the DON being present, the Administrator said she informed the Medical Director about CR #1's fall on 11/21/24. The Administrator said the Medical Director told her she would have to review CR #1's medical records to see if there were concerns about resident's fall with a head injury. The Administrator said she spoke with the Medical Director on 11/22/24 asking the MD about how the resident was transferred to the hospital via regular EMS instead of 911 after an unwitnessed fall with head injury and receiving the medication Eliquis. The Administrator said the MD told her after reviewing CR #1's medical records that the situation regarding CR #1's unwitnessed fall with head injury was tricky. The Administrator did not elaborate further what the MD meant by tricky. The Administrator said after herself and the DON discussed CR #1's incident further, they decided moving forward that any resident that experienced a fall with a head injury witnessed or unwitnessed needed to be transported to the hospital via 911 transport even if the resident was not on blood thinners. The Administrator said this should be done because of the gray areas and one could not see what may be happening to the resident internally. The Administrator said the NF could not perform CT scans (type of x-ray). Therefore, the resident should be sent to the hospital for further evaluation.</p> <p>Interview on 11/22/24 at 4:13 PM the Administrator provided a copy of more in-service, she said, had been conducted by the DON that entailed falls, anticoagulant, and visible head injury. The Administrator said this in-service was in a book with other in-services the DON had done.</p> <p>Attempted an interview via phone on 11/22/24 at 3:52 PM with the Medical Director. There was no answer, and the mailbox was full.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/22/24 at 4:45 PM via phone with the NP revealed the NF notified her of CR #1's fall on 11/21/24 and resident went to the hospital. The NP said the PCP made rounds at the facility on 11/21/24. The surveyor asked the NP if a resident experienced an unwitnessed fall with head injury receiving an anticoagulant medication, should the resident be sent out via regular EMS or 911. The NP said she could not really answer the question and that the surveyor would need to speak with CR #1's PCP.</p> <p>Attempted an interview via phone on 11/22/24 at 4:55 PM with CR #1's PCP. There was no answer; left voicemail.</p> <p>Interview on 11/23/24 at 11:35 AM, the hospital nurse said CR #1 would be taken off the ventilator on 11/23/24, and the family wanted comfort measures (treatments that focus on relieving the pain and distress for a dying person) after taking CR #1 off the ventilator.</p> <p>Interview on 11/24/24/ at 7:26 PM via phone, CNA C said she worked the 10 PM-6 AM shift. CNA C said on 11/20/24, she was CR #1's CNA on the Memory Care Unit. CNA C said the nurse helped her in getting the resident ready for dialysis. CNA C said after her and the nurse got CR #1 ready for dialysis at 5:30 AM, CR #1 was taken to the common area in her wheelchair across from the nurse station. CNA C said she went to check on the other residents. CNA C said the nurse was on another hallway passing medications. CNA C said CNA B was making rounds on the residents. CNA C said the last time she saw CR #1, prior to the fall, was at 5:40 AM in her room laying on her bed. CNA C said shortly after, she heard RN A calling her to come to CR #1's room. CNA C said when she arrived to CR #1's room, she saw CR #1 sitting on the floor. CNA C said RN A assessed CR #1, and afterwards, she assisted RN A in placing CR #1 back in bed. CNA C said CR #1 denied any pain. CNA C said RN A was preparing to send CR #1 to the hospital. CNA C said after assisting RN A, she went to check on the other residents. CNA C said she left the facility at 6 AM.</p> <p>Interview on 11/25/24 at 12:38 PM, the Administrator said the reason she provided the surveyor more in-services via email on 11/22/24 at 4:13 PM, regarding falls and anticoagulants, was due to the surveyor asking about polices. The Administrator said it prompted her to tell the DON to get the rest of the training the NF had done with the staff.</p> <p>Interview on 11/25/24 via phone at 12:50PM with CR #1's PCP said if CR #1's speech was slurred, CR #1 should have been sent to the hospital via 911. The PCP said a good rule of thumb, was if a resident with dementia experienced an unwitnessed fall with head injury, the resident should be sent to the hospital via 911 because the resident might be experiencing bleeding on the brain. The doctor said that he never received a call from the NF because it was not in his call log.</p> <p>Interview on 11/25/24 at 3:25PM via phone, at 3:25PM RN A said on the morning of CR #1's fall, 11/21/24, she administered CR #1 Tylenol because the family asked her to.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A follow up interview via phone on 11/26/24 at 9:31am with CR #1's family member revealed CR #1 was on hospice. The family member said, on 11/21/24, the NF called to tell her that CR #1 fell , but she was okay. The family member said she wanted to talk to CR #1, but when CR #1 was talking back, she was slurring her words. The family member said the only thing the NF told her was that CR #1 had a small hematoma in her cheek. The family member said when she went to see CR #1 , CR #1's left side of the face and nose looked broken and bent to the side. CR #1's face had a lot of swelling and discoloration. The family member said the hospital had to do an emergency surgery on her brain to stop the bleeding. The family member said CR #1 wasn't waking up and she got another CT scan and it showed there was still internal bleeding in the brain and that the second surgery would have been too risky, and the chances of survival were low.</p> <p>Interview on 11/27/24 at 2:15 PM, Medication Aide RR said she worked on the MCU on 11/21/24. The medication aide said when she arrived at the facility on the MCU, the time was between 6:30 AM. Medication Aide RR said CR #1 was sitting up in a wheelchair at the nurse station. Medication Aide RR said CR #1 did not appear to be in any pain. Medication Aide RR said she was told that CR #1 had fallen. Medication Aide RR said CR #1 had some swelling to her face. Medication Aide RR said she asked RN D if it was okay to administer CR #1 her medications before CR #1 went to the hospital, and RN D said that it was okay. RN D said that she administered CR #1's morning medications including the medication Eliquis.</p> <p>Interview on 11/27/24 at 4:02 PM via phone, the Medical Director said she was aware of CR #1's fall on 11/21/24. The Medical Director said if a resident was clinically stable, without doctor's orders, the nurse could not hold a medication. The Medical Director said giving it or not giving Eliquis, it wouldn't have changed any outcome in CR #1's case. The Medical Director said it would not have mattered even with CR #1's face being swollen. The Medical Director said CR #1's vitals were stable before and after the fall. The Medical Director said Medication Aide RR did their job. The Medical Director said she did not have any concerns about the facility administering the medicine Eliquis after the resident had an unwitnessed fall with head injury.</p> <p>Record review of the NF's policy on Change in Condition Communication revised January 2024 reflected in part:</p> <p>. To improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition .If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. The Medical Director will provide medical orders as necessary to treat the patient's/resident's condition .</p> <p>Record review of the NF's policy on Fall Management revised 07/2024 reflected in part:</p> <p>.The facility will provide a safe environment for all residents by implementing a fall management program. This program includes fall risk assessment, individualized care plans, staff education, and post fall evaluations .The charge nurse will notify the Physician/Physician extender of the fall, provide assessment findings and medications review, and receive orders as indicated .If the resident's condition warrants, the charge nurse will arrange for appropriate emergency services or hospital transfer in collaboration with the physician/Physician Extender .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Administrator and DON were notified on 11/23/2024 at 4:24 PM that an Immediate Jeopardy situation (IJ) was identified due to the above failures. The Administrator was provided the IJ template on 11/23/2024 at 4:30 PM and a Plan or Removal (POR) was requested.</p> <p>The facility's POR was accepted on 11/24/2024 at 12:40 PM and indicated:</p> <p><b>PLAN OF REMOVAL</b></p> <p>F684</p> <p>Name of facility: [facility]: 11/24/2024</p> <p>Immediate Action</p> <p>POR F684</p> <p>CR #1 was transferred to hospital on 11/21/24.</p> <p>The Administrator, Director of Nursing, and Medical Director held an ADHOC QAPI meeting on 11/23/24 to review the IJ template and Plan of Removal. RN A was suspended pending investigation on 11/21/24.</p> <p>On 11/22/24 and 11/23/24 the Director of Nursing and Assistant Director of Nursing assessed residents who had unwitnessed fall in the last 10 days for any signs or symptoms of headache, vomiting, or abnormal findings to the scalp/head with no adverse findings.</p> <p>The Director of Nursing initiated an in-service on 11/21/24 with licensed nurses. Topics included: Fall Procedures, specifically on activating the emergency response system (911) for any residents who has a fall with a visible head injury. 911 should be activated upon identification and notification to Physician and the DON would be secondary. Licensed nurses will be educated before starting their next shift. Education will be included in orientation. Education will be completed on 11/23/24.</p> <p>The Director of Nursing provided 1:1 education with RN A on 11/22/24. Education included Fall Procedures and activating the emergency response system (911) for any resident who has a fall with a visible head injury. 911 should be activated upon identification of the abnormal findings and notification to Physician and DON would be secondary; and completing through assessments post-fall with consideration for residents on anticoagulants.</p> <p>The Regional Nurse Consultant provided 1:1 education with the DON on 11/22/24. Education included Fall Procedures and activating the emergency response system (911) for any resident who has a fall with a visible head injury ' 911 should be activated upon identification and notification to Physician and DON secondary; and completing through assessments post-fall with considerations for resident on anticoagulants.</p> <p>Fall documentation will be reviewed each weekday in morning meeting on weekends, holidays, and after hours by DON/designee to ensure completed and appropriate actions are taken and documented.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Administrator and DON reviewed the policy on Fall Management and Changes of Condition no changes noted.</p> <p>The surveyor confirmed the plan of removal had been implemented sufficiently to remove the IJ by the following:</p> <p>Interview on 11/24/24 at 12:50 PM, RN D, on the Memory Care Unit (6AM-6PM), said she had been in-serviced on abuse and neglect as well as falls. RN D said if a resident experienced a fall with head injury witnessed or unwitnessed to prepare to send the resident to the hospital 911, notify the Physician, DON, and the resident's RP. RN D said she was in-serviced to assess the resident for pain, skin assessment, check their vital signs, and began neurological checks per facility protocol. RN D said if the resident was in pain to medicate the resident. RN D said even if the resident was not complaining of pain to give something for pain due to residents in the MCU decrease in cognition, the resident may not be able to express that they were in pain. RN D said she was also in-serviced to document all actions taken in the facility's electronic medical records system.</p> <p>Interview on 11/24/24 at 1:03 PM, RN E said she was the weekend supervisor and worked from 6AM-6PM. RN E said she had been in-serviced on falls witnessed and un-witnessed with head injury and anticoagulants. RN E said a resident that had fallen and developed a head injury, she would have to send to the hospital right away via 911 services. RN E said an assessment had to be done on the resident that included neurological assessment, vital signs, checking for bleeding. RN E said she would also notify the physician, family, DON and document all necessary actions taken in PCC.</p> <p>Interview on 11/24/24 at 1:10 PM, RN F said she was a new grad in orientation. RN F said she had received in-services on fall precautions witnessed or unwitnessed with head injuries receiving blood thinners. RN F said the resident should be sent to the hospital via 911. RN F said, at the time of the fall, neurological checks should be done on the resident and the resident should assessed for pain. RN F said the vital signs were taken and the doctor should be notified as well as the RP and the DON. RN F said documentation had to be done as well.</p> <p>Interview on 11/24/24 at 1:30 PM, LVN G said she worked from 6AM-6PM shift PRN. LVN G said she had been in-serviced on the following: abuse and neglect, resident falls, being sure to round on the residents regularly to see if they needed anything, making sure that personal belongings were in reach to prevent falls, answering their call lights in a timely manner. LVN G said she had been in-serviced on falls with injuries, particularly falls, with head injuries along with resident receiving blood thinners. LVN G said a resident with a head injury had to be sent to the hospital right away via 911 services. LVN G said when a resident had a fall, the resident had to be assessed by the nurse along with initiating neurological checks, vital signs, notifying the physician, DON, and responsible party. LVN G said she was in-serviced to also document all actions taken.</p> <p>Interview on 11/24/24 at 1:40 PM, RN H said she worked the 6AM-6PM shift. RN H said she had been in-serviced on falls witnessed and unwitnessed with head injuries to send to the hospital 911 services. RN H said she had been in-serviced on residents receiving blood thinners, notifying the physician of falls with injuries and the resident receiving blood thinners, how to assess a resident that had a fall being sure to initiate neurological checks per facility protocol, assessing the resident for pain, taking the residents vital signs, documentation and to notify the family and the DON of the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/24/24 at 7:11 PM, LVN I said she worked at the NF PRN on the 6PM-6AM. LVN I said she received in-services on falls, witnessed and unwitnessed with head injuries, to send the resident to the hospital via 911 because the resident's life depended on it. LVN I said the physician needed to be notified right away along with the RP and the DON. LVN I said she was in-serviced on blood thinners and documentation.</p> <p>Interview on 11/24/24 7:40 PM via phone at LVN J said she worked 6PM-6AM shift. LVN J said she was in-serviced on falls with head injuries, blood thinners, notifying the doctor of any changes in a resident condition as well as the DON and RP, documentation, and sending resident out to the hospital 911 if they had fallen and hit their head.</p> <p>Interview on 11/25/24 at 11:58 AM with LVN M 6AM-6PM said she use to work at the facility full time but worked on a PRN basis at that time. LVN M said she had received in-services on the following: witnesses and unwitnessed falls with head injuries to send the resident to hospital 911, call the doctor, family, and the DON. LVN M said she was in-serviced on documentation, assessments, and blood thinners.</p> <p>Interview on 11/25/24 at 12:05 PM, the DON said if a resident experienced a fall with a head injury and speech was slurred, there could be something going on neurologically such as a stroke or bleeding on the brain. The DON said it could only be determined by a test. The DON said she had been in-serviced on falls witnessed and unwitnessed with head injury to notify the physician, sending resident to hospital via 911.</p> <p>Interview on 11/25/24 at 12:19 PM, LVN N said she worked full time 6AM-6PM and had been in-serviced on falls witnessed and unwitnessed. LVN N said a fall with a head injury, 911 services and the doctor should be called right away. LVN N said if they were unable to reach the doctor or NP, they were supposed to call the Medical Director, DON, and document. LVN N said if a resident was on blood thinners need to monitor the resident for bleeding.</p> <p>Interview on 11/25/24 at 3:25 PM via phone, RN A said she had been in-serviced on falls witnessed and unwitnessed with head injuries, blood thinners, sending the resident out via 911, notifying the physician, DON, and family.</p> <p>On 11/25/2024 at 4:56 p.m., the Administrator was informed that the IJ was removed, however, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility need to evaluate the effectiveness of the corrected system.</p> <p>Medication Eliquis Reference <a href="http://www.fda.gov/drugsatfda">www.fda.gov/drugsatfda</a> reference ID: 3237516:</p> <p>.Call your doctor or get medical help right away if expereince unexpected pain .swelling .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35822</p> <p>Based on interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accident for 1 (CR #1) of 18 residents reviewed for accidents in that:</p> <ul style="list-style-type: none"> <li>- The facility failed to provide CR#1, who was on an anticoagulant medication, adequate supervision and interventions to prevent falls on 11/13/24, 11/14/24, 11/17/24, and 11/21/24 causing head injury and hospitalization .</li> <li>-The falls were unwitnessed, CR #1 had dementia and did not remember to use their call light when they needed assistance.</li> </ul> <p>Cr #1 was admitted to the hospital with diagnosis of Acute Subdural Hematoma with mass effect left craniotomy evacuation.</p> <p>An IJ was identified on 11/25/2024. While the IJ was removed on 11/27/2024, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility need to evaluate the effectiveness of the corrected system.</p> <p>This failure could place residents at risk for unwanted hospitalization s and death.</p> <p>Findings included:</p> <p>Record review of CR #1's face sheet dated 11/22/24 revealed a [AGE] year-old female admitted to the NF originally on 05/11/2024 and again on 11/02/2024. CR #1 diagnoses included the following: muscle weakness, unsteadiness on feet, vascular dementia (memory loss), end stage renal disease (kidney disease), and osteoporosis (bones become weak and brittle).</p> <p>Record review of CR#1's MDS dated [DATE] revealed a BIMS score of 7 indicating that resident cognition was severely impaired. Further review section GG-Functional Abilities and Goals reflected that CR #1 required supervision with transfer.</p> <p>Record review of CR #1's Comprehensive Care Plan dated 11/04/2024 reflected that resident was being care planned for risk for falls and injuries due to a hx of falls prior to admission. Further review reflected that CR #1 experienced falls on the following days for the month of November 2024 (11/13/24 unwitnessed fall in room no apparent injuries, 11/14/24 unwitnessed fall in room, 11/17/24 unwitnessed fall in room no injury, and 11/21/24 unwitnessed fall in room). The interventions included the following:</p> <ul style="list-style-type: none"> <li>-Anticipate needs- provide prompt assistance</li> <li>-Assure lighting is adequate and areas are free of clutter</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-Encourage resident to ask for assistance of staff</p> <p>-(Revised on 11/21/24) CR #1 will be reeducated to call for assistance from staff for all transfers, she continued to try to be independent, staff would make frequent rounds for closer monitoring, bed in lowest position, and call light in reach.</p> <p>Record review of CR #1's Physician Orders for the month of November 2024 reflected the following order:</p> <p>-Dated 05/16/24 Eliquis 5mg give one capsule by mouth q 12 hrs related to atherosclerosis (build-up of fats, cholesterol, and other substances in and around the artery {a vessel that carry blood away from the heart to the entire body}) walls.</p> <p>Record review of CR #1's MAR for the month of November 2024 reflected that the NF was administering the medication Eliquis as ordered by the physician.</p> <p>Record review of CR #1's fall incidents:</p> <p>-11/13/24 4:26 pm on the facility's incident report list</p> <p>-11/14/24 4:55 pm on the facility's incident report list</p> <p>-11/17/24 5:50 am on CR #1's change in condition assessment</p> <p>-11/21/24 5:50 am on CR #1's change in condition assessment</p> <p>Record review of CR #1's fall risk assessments, CR #1 had the following fall assessments with scores:</p> <p>-11/14/24 - high risk 25.0</p> <p>-11/17/24 - high risk 19.0</p> <p>-11/21/24 - high risk 19.0</p> <p>Record review of CR #1's fall incident reports:</p> <p>-11/13/24: resident found sitting on bottom beside bed in bedroom. No witness. Resident unable to give description.</p> <p>-11/14/24 incident report- patient found on floor in bedroom, unbothered, patient confused no question answered. No witness. Resident unable to give description.</p> <p>Record review of CR #1's fall incident reports:</p> <p>-11/13/24: resident found sitting on bottom beside bed in bedroom. No witness. Resident unable to give description.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-11/14/24 incident report- patient found on floor in bedroom, unbothered, patient confused no question answered. No witness. Resident unable to give description.</p> <p>Record review of CR #1's Nursing Progress Notes:</p> <p>-11/15/2024 17:02: S/P: Day 1 of 3. Fall occurrence on 1/14/2024. No complaint of pain or distress at this time. resident is moving around in her wheelchair in the common area interacting with other residents. Vitals are WNL. will continue with plan of care.</p> <p>Record review of CR #1's Nursing Progress Notes dated 11/21/24 at 5:50 AM CR #1 was found in room sitting on floor by RN A. RN A assessed resident and documented that resident had swelling to her right cheek. Further record review revealed that resident was transferred to the hospital on 11/21/24 at 7:40AM.</p> <p>Further record review CR #1's Nursing Progress Notes documented by RN A dated 11/21/24 reflected the following:</p> <p>. CR #1 was assessed, V/S were evaluated to be stable and WNL. Swelling / hematoma was noted to the Right cheeks. No distress is noted at this time. CR #1 denies any pain or discomfort at this time. Fall precaution is in place. Neuro assessment is initiated and ongoing. CR #1 educated to call for assistance whenever she needed help, CR #1 verbalized understanding. Bed is put in the lowest position with call bell and personal belonging within her reach. MD was notified. DON and RP were also notified. This nurse called report to hospital. CR #1 is awaiting transfer to the hospital .</p> <p>Further Record review of SBAR documented by RN A reflected the following:</p> <p>-Form Summary: SBAR (Change of Condition) - Fall Event</p> <p>Date/Time of Fall: 11/21/2024 5:50 AM</p> <p>Location of the Fall: Resident's room</p> <p>Classification of the Fall: Unwitnessed</p> <p>What was the resident doing prior to the fall: Resident states I was trying to turn and I rolled over.</p> <p>Initial Vital Signs Post Fall Event: Blood Pressure-124/71</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Pulse-78</p> <p>Temperature-97.6</p> <p>Respirations-17</p> <p>02 Saturation-99%</p> <p>Medication Reviewed with the Physician:</p> <p>Yes</p> <p>Notifications</p> <p>Physician/Physician Extender: PCP; 11/21/2024 5:54 AM</p> <p>Resident/Responsible Party: 11/21/2024 5:55 AM</p> <p>Interview on 11/22/24 at 10:12AM with the NF Administrator and the DON present, the Administrator said CR #1 was residing on the Memory Care Unit and on 11/21/24 around 5:30AM the staff (RN A and CN B) had gotten CR #1 up for dialysis. The Administrator said from her understanding the staff placed CR #1 near the nurse station in wheelchair. The Administrator said the staff began to round on other residents in the MCU at 5:40AM. The Administrator said CNA B said shortly after she saw CR #1 laying on her bed. The Administrator said at 5:50AM the Charge Nurse heard a noise coming from CR #1's room and went to see what was going on. The Administrator said when RN A arrived to CR #1' room, she found CR #1 sitting on the floor in between the 2 beds. The Administrator said CR #1 could walk. The DON interjected and said that CR #1 could walk but had an unsteady gait.</p> <p>Interview on 11/22/24 at 1:58PM with family member of CR #1 said CR #1 was still at the hospital in a coma and her condition was not looking good because CR #1 had a lot of bleeding on the brain. The family member said the NF called her on 11/21/24 around 6:40AM telling her that CR #1 had a fall, and they were preparing to send CR #1 to the hospital for further evaluation. The family member said she spoke with CR #1 prior to leaving the NF and CR #1's speech was slurred.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/22/24 at 2:34PM RN A said she worked the 6:00 PM - 6:00 AM shift and worked on 11/20/24. RN A said herself and CNA B had gotten CR #1 out of bed at 5:30AM to dress CR #1 and placed in wheelchair for dialysis. RN A said CR #1 was taken to the common area across from the nurse station. RN A said the CNA that was assigned to CR #1 CNA C, but CNA B assisted with getting CR #1 out of bed for dialysis. RN A said CNA B was in the common area as well but later began to make rounds with the other CNA C getting the other residents out of bed and taking some to the common area as well but still checking on CR #1. RN A said she began to pass medications on the other residents while keeping an eye on CR #1. RN A said she could see CR #1 because of the way her cart was positioned on the hallway. RN A said when she came out of a resident room, she did not see CR #1. RN A said she rushed to CR #1's room where she found CR #1 sitting on the floor. RN A said she never heard a noise coming from CR #1's room. RN A said she called CNA C to come and assist her with CR #1. RN A said after she finished assessing CR #1, herself and CNA C placed CR #1 back in bed. RN A said CR #1 had some swelling to the right side of face but was not complaining of pain. RN A said CR #1 vital signs were stable and she initiated neurological checks on CR #1 which were within normal limits. RN A said she called the doctor, resident family member as well as the Administrator.</p> <p>Interview on 11/22/24 via phone at 3:05PM CNA B said she worked the night shift from 10PM-6AM. CNA B said she was not the CNA assigned to CR #1. CNA B said she never provided any type of care for CR #1 including assisting with placing resident in wheelchair on 11/21/2024 at 5:30AM.</p> <p>Observation on 11/23/24 at 11:30AM CR #1 in the ICU resting in hospital bed connected to ventilator unresponsive wearing a neck collar. Further observation on the top and left side of CR #1's head was bald with dressing on the top of head. There was a small plastic bulb what appeared to be connected to CR #1's head with red fluids draining inside of bulb. CR #1 was receiving the medication Cardene (used to treat high blood pressure and control chest pain) IV 40mg in 200ml of fluid at 75ml/hr. Resident was receiving gastrostomy feedings Nova Source that read on pump 20ml/hr.</p> <p>Record review of CR #1's Admitting diagnoses revealed that CR #1 was admitted to the hospital for Acute Subdural Hematoma with mass effect left craniotomy evacuation.</p> <p>Interview on 11/23/24 at 11:35AM the hospital nurse said CR #1 would be taken off the ventilator 11/23/24 and the family wanted comfort measures (treatments that focus on relieving pain and distress for a dying person) after taking CR #1 off the ventilator.</p> <p>Interview on 11/24/24/ at 7:26PM via phone CNA C said she worked the 10PM-6AM shift. CNA C said on 11/20/24 she was CR #1's CNA on the Memory Care Unit. CNA C said the nurse helped her in getting resident ready for dialysis. CNA C said after her and the nurse got CR #1 ready for dialysis at 5:30AM CR #1 was taken to the common area in her wheelchair across from the nurse station. CNA C said she went to check on the other residents. CNA C said the nurse was on another hallway passing medications. CNA C said CNA B was making rounds on the residents. CNA C said the last time she saw CR #1 prior to the fall was at 5:40AM in her room laying on her bed. CNA C said shortly after, she heard RN A calling her to come to CR #1's room. CNA C said when she arrived too CR #1's room, she saw CR #1 sitting on the floor. CNA C said RN A assessed CR #1 and afterwards, she assisted RN A in placing CR #1 back in bed. CNA C said CR #1 denied any pain. CNA C said RN A was preparing to send CR #1 to the hospital.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/25/24 at 1:00 PM, the MDS Coordinator said the ways the facility tried to prevent CR #1 from falling was by keeping CR #1 in the common area across from the nurse station as much as possible, but CR #1 moved freely in her wheelchair in the MCU. The MDS Coordinator said the NF also tried to keep CR #1 engaged in activities. The MDS Coordinator said the interventions that were in place for CR #1 were sufficient in preventing continuous falls for CR #1. The MDS Coordinator said due to CR #1 being mobile in her wheelchair, the only other intervention was to place resident maybe on 1 on 1 supervision.</p> <p>Interview on 11/25/24 at 1:25 PM, the DON said, regarding falls. she started working at the NF on 10/21/2024. The DON said she was aware of how often CR #1 was falling because it was discussed in the morning meetings. The DON said the NF tried to put interventions in place to prevent CR #1 from falling. The DON said because of CR #1's resident disease process, regarding her dementia it made it difficult to prevent CR #1 from falling. The DON said the NF did not have the staff to place resident on 1 on 1 supervision. The DON said the interventions that the NF put in place for CR #1 was the best the facility could do to prevent resident from falling. The DON said she could not say if the NF could have done anything different to keep resident from falling.</p> <p>Interview on 11/25/24 at 2:08 PM, the Administrator said CR #1's falls were discussed in the morning meetings. The Administrator said she was aware of CR #1's continuous falls in the month of November, but would have to review her notes to see what was discussed about resident falls. The Administrator never provided any notes about CR #1's falls during the morning meeting.</p> <p>Interview on 11/26/24 at 8:54AM the Rehab Director said she participated in the morning meetings. The Director said she was familiar with CR #1. The Director said CR #1 was pretty much independent prior to hip fracture which took place at the facility about a month and a half ago. The Director said prior to CR #1 hip fracture she was transferring independently but after, she required assistance with transfers. The Director said CR #1's falls on 13, 14, 17, and 21st of November 2024 were discussed in morning meetings and the interventions included all that were in CR #1's care plan. The Director said the problem was due to CR #1's dementia, she would not remember about safety. The Director said she did not meet with the family regarding CR #1's repeated falls. The Director said CR #1 was receiving therapy but cognitively, CR #1 thought she could do what she was doing before. The Director said the NF were trying to keep CR #1 in the common area as much as possible. The Director said she remember coming to pick up another resident and remembered seeing CR #1 trying to walk back to her room. The Director said she had to redirect CR #1 back to the common area. The Director said CR #1 would go to her room and self-transfer. The Director said in some cases during morning meetings they discussed medications and fall. The Director said she could not say if CR #1's medications were discussed, but they should have discussed it. The Director said she was not working at the NF on the 15th and 18th of November. The Director said an intervention would be to ask the psychiatrist to review medications, do labs for UTI maybe, but that was done on an individual basis. The Director said she did not recall if the NF talked about medications and labs regarding CR #1. The Director said the interventions that the facility had in place regarding falls for CR #1 were sufficient. The Director said the NF could not do 1-on-1 supervision. The Director said after reviewing the interventions, the NF implemented their suggestions one being getting CR #1 up earlier so she would not get up on her own.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/26/2024 at 9:31am via phone with CR #1's family member/RP said she never attended a meeting regarding CR #1's falls with the NF. The RP said the NF would sometimes call regarding a fall, and other times would wait until CR #1's family member visited the facility, to tell them CR #1 had a fall. The RP said that on 11/21/2024 the facility called the RP to say that CR #1 fell but that she was okay and that she only had a small hematoma on her cheek. CR #1 speech was slurred on the phone. When the RP went to see CR #1, she saw the entire left side of CR #1's face was swollen and that her nose appeared broken and bent to the side and there was a lot of swelling and discoloration. The RP said that CR #1 had successfully completed emergency brain surgery to stop the bleed, but that CR #1 did not wake up afterward. The hospital informed the RP that another CT scan showed there was still internal bleeding in the brain but that a second surgery would have been too risky, and the chance of survival was low. CR #1 was currently on hospice at that time.</p> <p>Interview on 11/26/2024 at 12:57 PM, the Regional Nurse she said that after a resident fell , the unit manager should conduct a fall risk assessment and that would trigger an incident report. The Regional Nurse said based on that information a skin, pain, or change in condition assessment would be triggered. Those forms could be completed by either the unit manager or charge nurse. The Regional Nurse said from what she was told, a lot of CR #1's falls would be a staff member finding her on the floor, but she was comfortable and unbothered. The Regional Nurse said she was aware of the fall on 11/21/2024 and that the Administrator told her the family called the facility to inform that CR #1 was transferred to another hospital. The Regional Nurse said she was aware that an intervention the NF came up with was placing CR #1 in a common area, but CR #1 would wheel herself around the unit. The Regional Nurse said CR #1 had the right to go into her room or the dining room. The Regional Nurse said the NF notified the family of all CR #1's falls and updated them on lab work, etc. The Regional Nurse said there were no specific meetings regarding the falls.</p> <p>Record review of the NF's policy on Fall Management revised 07/2024 reflected in part:</p> <p>.The facility will provide a safe environment for all residents by implementing a fall management program. This program includes fall risk assessment, individualized care plans, staff education, and post fall evaluations .The charge nurse will notify the Physician/Physician extender of the fall, provide assessment findings and medications review, and receive orders as indicated .If the resident's condition warrants, the charge nurse will arrange for appropriate emergency services or hospital transfer in collaboration with the physician/Physician Extender .</p> <p>The Administrator and Regional Nurse was notified on 11/25/2024 at 3:58 PM an Immediate Jeopardy situation (IJ) was identified due to the above failure. The Administrator was provided the IJ template on 11/25/2024 at 3:58 PM and a Plan or Removal (POR) was requested.</p> <p>The facility POR was accepted on 11/26/2024 4:45PM.</p> <p>PLAN OF REMOVAL</p> <p>F689</p> <p>Name of facility: 11/25/2024</p> <p>Immediate Action</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>According to the IJ template: The facility failed to provide CR#1, who is on an anticoagulant medication, adequate supervision and interventions to prevent falls after multiple falls which lead to an unwitnessed fall on 11/21/24 resulting in a hematoma to the right cheek requiring hospitalization due brain bleed and placed on ventilator.</p> <p>CR #1 was transferred to the hospital on 11/21/24.</p> <p>The Administrator, Director of Nursing, and Medical Director held an ADHOC QAPI meeting on 11/25/24 to review the IJ template and Plan of Removal.</p> <p>CR #1 had a fall on 11/13/24. On 11/13/24 the resident's careplan was reviewed and fall interventions updated by MDS Coordinator to include: Neuro vital signs in place- lab work ordered to rule out infection. Neuros were initiated and completed with no adverse findings.</p> <p>CR #1 had a fall on 11/14/24. On 11/14/24 the resident's careplan was reviewed and fall interventions updated by MDS Coordinator to include: Staff will redirect/offer her to attend activities of choice in the common area.</p> <p>CR #1 had a fall on 11/17/24. On 11/17/24 the resident's careplan was reviewed and fall interventions updated by MDS Coordinator to include: staff will offer to get her up early in the morning is she chooses and she can sit in common area and watch tv/or visit with staff</p> <p>On 11/21/24 the MDS coordinator reviewed residents who had a fall for the last 60 days to ensure adequate interventions are in place, with no adverse findings.</p> <p>The Regional Nurse did 1:1 in-service with MDS on 11/21/24. Topics included: Fall management: to include developing an individualized fall prevention plan for each resident identified at risk and updating the care plan with each fall event to ensure new interventions are implemented according to the resident's risk.</p> <p>Residents who experience a fall event are reviewed during the daily clinical morning meeting, which includes members of the Interdisciplinary Team (IDT). During this meeting, the IDT evaluates the fall event, reviewing documentation in the medical record (progress notes) and the incident report. The MDS Coordinator/Designee updates the resident's care plan to reflect the agreed-upon fall prevention interventions that are individualized and aimed at preventing further falls.</p> <p>The facility will identify residents who are on anticoagulants by Physician Orders, Anticoagulant Care Plans, and side effect monitoring on the EMAR.</p> <p>Residents are assessed for risk for falls by the charge nurse on admission, quarterly, with significant change and fall events. Residents noted at risk for falls careplans are updated to identify the fall risk and appropriate interventions. The ADON conducted an audit on 11/26/24 with no adverse findings.</p> <p>The Director of Nursing initiated an in-service on 11/21/24 with licensed nurses. Topics included: Fall management, change of condition, Kardex; Education was completed on 11/23/24. Licensed nurses will receive education before their next shift, with new hires receiving training during orientation.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Director of Nursing provided education with staff members that provide direct care to residents on 11/21/24. Education included: Reviewing the Kardex for resident-specific fall prevention measures. Staff will receive education before their next shift, with new hires receiving training during orientation. Completion date 11/23/24.</p> <p>The Regional Nurse Consultant provided 1:1 education with the DON on 11/21/24. Education included Fall management to include Developing an individualized fall prevention plan for each resident identified at risk and updating the care plan with each fall event to ensure that any new risks or necessary interventions are addressed.</p> <p>On 11/25/24, the Regional Nurse discussed with CR#1's Nurse Practitioner (NP) the interventions implemented by the facility in response to the falls on 11/13, 11/14, and 11/17. It was determined that the interventions were appropriate for the resident's plan of care and aligned with clinical guidelines. There was no indication or order for 1:1 observation at the time. However, while the interventions were appropriate, the resident remains at high risk for falls.</p> <p>The Administrator and DON reviewed the policy on Fall Management on 11/21/24 with no changes required.</p> <p>Fall trends are brought to QAPI and reviewed monthly with the Medical Director.</p> <p>The Administrator reviewed the facility assessment, staffing on the memory care unit (supervision), and residents who are at risk for falls on 11/21/24 with no adverse findings identified.</p> <p>The surveyor confirmed the plan of removal had been implemented sufficiently to remove the IJ by the following:</p> <p>Interview on 11/26/2024 at 10:07 am via phone, RN A said she received in-services from the DON on 11/22/2024 around 4:00 pm by phone after checking her phone log. RN A said the in-services were on falls regarding residents with physical or head injuries to be sent out by calling 911, notifying the doctor/ NP, RP and DON by phone calls and not through text messaging. RN A also said that she received an in-service on residents taking blood thinners.</p> <p>Interview on 11/26/24 at 10:50 PM via phone, LVN K 6PM-6AM said she had been in-serviced on falls with head injury, anticoagulants, fall prevention (making rounds on the resident anticipating their needs, making sure call light in reach and responding to the resident light in a timely manner, keeping bed locked and in low position, reviewing the resident Kardex on how to care for the resident looking at interventions for resident, make sure resident wearing non-slip socks or shoes) when to call 911 to transport resident to a higher level of care, notifying the doctor, family, DON when there was a change in a resident condition, and documentation.</p> <p>Interview on 11/26/24 at 11:15 PM, CNA B said she worked the 10PM-6AM shift. CNA B said she had received the following in-services: if a resident experienced a fall prevention and falls to report to the nurse immediately so that the nurse could assess the resident, reviewing resident Kardex that was found in POC on how to care for each resident, abuse and neglect, and resident rights.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/26/24 at 11:27 PM, CNA O said she worked the 10PM-6AM shift. CNA O said she received in-service on falls and the prevention of falls, how to access the Kardex in POC to review resident plan of care that included if the resident was a fall risk. CNA O said when a resident experienced a fall, she was in-serviced to send for the nurse immediately, notifying the nurse if notice a change in a resident condition.</p> <p>Interview on 11/26/24 at 11:37 PM, CNA BB on the 10PM-6AM shift said she was in-serviced on resident rights, fall preventions (making sure bed was in the low, locked position, fall mats on the floor, checking the resident frequently every 2 hours or sooner, call light in reach, room free of clutter with call light in reach, answering the call lights in a timely manner, and making sure residents had a on non-slip socks or shoes), reviewing resident Kardex that instructed her on how to care for the resident, notifying the nurse if the resident had a change in condition.</p> <p>Interview on 11/26/24 at 11:39 PM, CNA C 10PM-6AM said she had received in-service on looking at the Kardex to see how to better care for the resident, fall preventions, and abuse/neglect.</p> <p>Interview on 11/26/24 at 11:43 PM, CNA P 10PM-6AM said she received in-service on fall preventions, how to access the Kardex in POC to show how her to care for the resident, and to notify the nurse of any changes in the resident condition.</p> <p>Interview on 11/26/24 at 12:00 AM, CNA Q said she worked the 2PM-10PM and 10PM-6AM shifts. said she had been in-serviced on how to access the resident Kardex in POC to review the resident care, fall preventions, resident rights, and abuse and neglect.</p> <p>Interview on 11/26/24 at 7:35 AM, LVN J said she worked the 6PM-6AM shift and had been in-serviced on fall prevention and supervision of the residents, responding to resident call lights in a timely manner, leaving the resident bed locked and in low position, fall mats in position on the floor for residents on fall risk, keeping the call light in reach along with their personal belongings, keeping the resident room free of clutter and providing adequate lighting, rounding on the residents at least every 2 hours or sooner pending on what was going on with resident, utilizing the Kardex because it provided guidance on how to care for the resident, documenting changes in a resident condition, along with notifying the doctor, family, and DON, falls witnessed and unwitnessed, assessments, blood thinners, and when to send a resident out via 911 services.</p> <p>Interview on 11/27/24 at 7:45AM, LVN R said she worked the 6PM-6AM shift and was in-serviced on fall preventions, falls witnessed and unwitnessed with head injury, blood thinners, sending the resident out 911, calling the doctor, family, and Administration, know what residents that were on blood thinners, utilizing the Kardex to care for the resident, and documentation.</p> <p>Interview on 11/27/24 at 8:00 AM, RN L said she worked the 6PM-6AM shift and was in-serviced on the following: when to send a resident to the hospital via 911 services, falls witnessed and unwitnessed with injuries, blood thinners, the use of the Kardex, abuse and neglect, and resident rights.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/27/24 at 10:30 AM, CNA S said she worked the 6AM-2PM shift and the 2PM-10PM shift. CNA S said she had been in-serviced on where to find the Kardex in POC to review the care for a resident, fall prevention and falls witnessed and unwitnessed not moving the resident but alerting the nurse immediately, making sure residents who were fall risk, had their fall mats on the floor at the bedside, keeping call light in reach, answering the call lights, keeping the resident room organized, making sure the resident was wearing non-slip socks or shoes to prevent any falls, and constantly monitoring the residents because she worked on the Memory Care Unit.</p> <p>Interview on 11/27/24 at 10:35 AM, CNA T 6AM-2PM shift been in-serviced on falls, fall prevention, abuse and neglect, keeping resident room free of clutter, importance of using the Kardex to care for the resident, keeping resident bed in low position and locked, fall mats, and the use of grip socks to prevent residents from slipping and falling.</p> <p>Interview on 11/27/24 at 10:40 AM, LVN G 6AM-6PM in-serviced on falls and fall prevention falls with head injury, sending a resident to the hospital via 911, notifying the doctor, family member, and DON, blood thinners, Kardex, assessments, documentation, and PICC line care.</p> <p>Interview on 11/27/24 at 10:44 AM, CNA U 6AM-2PM on the Memory Care said she had received in-services on abuse and neglect, resident rights, usage of the Kardex regarding resident care, fall prevention, and rounding on the residents frequently.</p> <p>Interview on 11/27/24 at 10:48 AM, the MDS Coordinator said she had been in-serviced on fall prevention, head injuries, how to transport a resident to a higher level of care via 911 services, anticoagulants, being more resident specific to meet each resident needs when discussed in the morning meetings, and the IDT meetings.</p> <p>Interview on 11/27/24 at 10:50AM, the Certified Occupational Therapist Assistant said she had received in-service on fall preventions, making sure a resident on fall precautions mats were on the floor at the bedside, leaving calling light in reach, and making sure the resident wore grip socks to prevent falls.</p> <p>Interview on 11/27/24 at 10:54 AM, the Activity Director said she had received in-services on fall prevention and 1 on 1 supervision when needed, keeping residents engaged, and grip socks.</p> <p>Interview on 11/27/24 at 10:58 AM, the Unit Manager for the weekend said she had received in-services on abuse and neglect, anticoagulants, fall prevention (bed in low position, making sure fall mats on floor at the bedside, resident wearing non-slip shoes or socks, answering call lights in a timely manner, call light in reach, where to find resident Kardex in the computer. The Unit Manager said the Kardex would alert the staff if the resident was a fall risk, etc, and basically how to provide care for the resident). The Unit Manager said she had also been in-service on head injuries and to send the resident to the hospital via 911 and informing the physician, responsible party, and administration.</p> <p>Interview on 11/27/24 at 11:06 AM, CNA V 6AM-2PM shift said she worked at the NF PRN and had received in-services about the Kardex, fall preventions, keeping residents' bed locked and in low position, call light in reach, answering the call lights as quickly as possible, if a resident fell not to move the resident, and to notify the nurse immediately.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 11/27/24 at 11:10 AM, RN H, on the 6AM-6PM shift, said she had received in-service regarding resident Kardex, fall preventions, falls with head injury, anticoagulants, and PICC Lines.</p> <p>Interview on 11/27/24 at 11:11 AM, CNA W 6AM-6PM shift said she received in-services on answering call lights, keeping call light within resident reach, Kardex, rounding on the residents every 2 hours and as needed, keeping the resident room clutter free, bed locked and in low position, fall mats to prevent falls. CNA W said if the resident had a fall, she would not move the resident but call for the nurse to assess the resident.</p> <p>Interview on 11/27/24 at [TRUNCATED]</p>		