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	09/08/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide evidence that all alleged violations of abuse were thoroughly investigated, and that the results of the investigations were reported to the State Survey Agency within five working days of the incident for 6 of 8 residents (CR #1, CR#2, CR#3, CR#6, Resident #4, Resident#5) reviewed for Abuse, Neglect, and Exploitation.The facility failed to submit via State Survey Agency database, TULIP the five-day thoroughly investigated evidence that the allegations made on 12/26/2024, by CR #1 and CR#2, stating that CNA A provided rough care during activities of daily living (ADL) assistance. The facility failed to submit via State Survey Agency database, TULIP the five-day thoroughly investigated evidence that the family complaint made on 12/26/2024, regarding rough care provided by MA L during medication pass to CR#3.The facility failed to submit via State Survey Agency database, TULIP the five-day thoroughly investigated evidence that the family complaint made on 02/25/2025, regarding CNA R's failure to provide essential care to CR#3. The facility failed to submit via State Survey Agency database, TULIP the five-day thoroughly investigated evidence that the allegations made on 02/10/2025, of Resident #4 hitting Resident #5 across the head.The facility failed to submit via State Survey Agency database, TULIP the five-day thoroughly investigated evidence that the allegations made on 09/16/2024, reported by insurance provider regarding CR#6, including a new-onset rectal bleeding noted on 9/17/24 (reported to be absent on 9/16/24) with concern of possible sexual assault, absence of a dressing on the dialysis catheter, and unsanitary conditions in the room with mold and mildew.These failures could place residents at risk for abuse and/or neglect by not having their concerns and allegations of abuse thoroughly investigated and reported. 1.Record review of facility reported intake created on 01/18/2025 via TULIP, with allegations of Resident Abuse, indicated CR# 1 and CR #2 alleged that CNA was rough when providing ADL care. Further review revealed no five-day investigation submission was found. No additional information related to the incident was submitted via the TULIP intake database. Record review of CR#1's Face Sheet dated 09/07/2025 revealed a [AGE] year-old who was originally admitted on [DATE] due to end Stage 4 chronic kidney disease (kidneys are moderately or severely damaged and are not properly filtering waste from your blood) and discharged from the facility on 02/04/2025. Record review of CR#1's care plan last reviewed on 02/10/2025 revealed CR#1's had a self-care deficit related to below knee amputation, with interventions including provide prompt assistance, aid of for toileting/incontinent care, provide total assistance for bed mobility, bathing, and showering. Record review of CR#1's Comprehensive MDS (resident assessment tool) dated 04/29/2024 revealed a BIMS score of 15, indicating intact cognition. Further review revealed that CR#1 was totally dependent on helper(s) for toileting hygiene. Record review of CR#2's Face Sheet dated 09/07/2025 revealed a [AGE] year-old who was originally admitted on [DATE] due to Type 2 diabetes mellitus with other specified complication (a lifelong disease that keeps your body from using insulin the way it should) and discharged from the facility on 04/18/2025. Record review of CR#2's care plan last reviewed on 04/23/2025 revealed CR#2's had a self-care deficit, with interventions including provide prompt assistance, provide encouragement and cueing as needed to performed ADL cares, aid of for toileting care, aid with bathing, and showering. Record review of CR#2's Comprehensive MDS (resident assessment tool) dated 02/07/2025 revealed a BIMS score of 15, indicating intact cognition. Further review revealed that CR#2' was dependent on helper(s) for toileting hygiene. Record review of CR#1's and CR#2's progress notes revealed: On 01/16/2025 at 5:00pm, reflected Nurse V wrote that she was notified by CR#1 and CR#2 that CNA was rough when ADL care was provided. The progress note did not identify the CNA and included additional details. Grievance dated 01/15/2025, reflected CR#2 reported that she would like CNAs to take more time and care when doing patient care. Documentation did not identify a particular CNA. The surveyor was unable to interview CR#1's and CR#2 as residents no longer resided at the facility. The interview on 09/08/2025 @ 11:00am with the Regional Nurse, she stated CNA A was identity during the facility investigation as the CNA assigned to CR#1's and CR#2 on 01/16/2025. Regional Nurse stated CNA A was suspended to ensure CR#1's and CR#2 safety during the facility investigation. Regional Nurse stated that the allegations of abuse and neglect related to CNA A providing rough care during med pass were unfound due to lack of information provided evidence, CNA A's denial of allegations. She stated the facility is required to report allegations of abuse and conduct a thorough internal investigation within 5 days timeframe. If an incident (such as an injury, abuse, or neglect) is not reported in a timely manner, it could delay any