

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 11/14/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</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 11/14/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents had the right to reside and received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and or safety of the resident or other residents for 2 of 12 residents (Resident #1 and #2) reviewed for resident rights. The facility failed to ensure Resident's #1's and Resident #2's call lights were within reach on 11/12/2025. This failure could place residents at risk of their needs not being met. Findings include: 1. Record review of Resident #1's quarterly MDS assessment, dated 08/25/25, reflected a [AGE] year-old female with an original admission date of 02/07/24. Her diagnoses included non-Alzheimer's dementia (confusion, memory impairments, difficulty with attention), cerebrovascular accident, transient ischemic attack, or stroke (interrupted blood flow to the brain or temporary blockage to the brain), spinal stenosis (narrowing of one or more spaces within your spinal canal), and muscle weakness. Resident #1 was independent for eating, required substantial/maximal assistance for toileting, required substantial/maximal assistance for bathing, and required partial/moderate assistance for personal hygiene. Resident #1 had a BIMS score of 13, which indicated she had intact cognition. Record review of Resident #1's care plan, dated 11/11/25, reflected: Falls: [Resident #1] is at risk for falls and injuries AEB Goal: Resident #1 would be free from falls and injuries over the next 90 days. Interventions included: 2/9/25 Ensure call light is within reach and answer promptly-make sure bed controls are in reach at all times. In an interview and observation on 11/12/25 at 2:00 PM, Resident #1 stated sometimes the staff did not return her call light to her reach after they helped her with things. She stated if she needed help, and could not find or reach her call light, she would wave at someone when they walked past her room to get their attention. Observed Resident #1's call light was hanging down behind the right side of the bed below where the resident's right elbow was positioned, and not within the reach of her left arm. Her bed control was hanging on the left side of her bed near her left arm, and she was observed to use her left hand to press the controls to control her bed. 2. Record review of Resident #2's quarterly MDS assessment, dated 09/16/25, reflected an [AGE] year-old male with an original admission date of 02/20/25. His diagnoses included debility, cardiorespiratory conditions (range of medical conditions that affect the heart and lungs), heart failure (heart cannot pump enough blood to meet the body's needs), neurogenic bladder (nerve damage that affects bladder control), respiratory failure (when the body does not get enough oxygen or has too much carbon dioxide in the blood), lack of coordination, and muscle weakness. Resident #2 was independent for eating and required supervision or touching assistance from staff for toileting, bathing, and personal hygiene. Resident #2 had a BIMS score of 02, which indicated he had severely impaired cognition. Record review of Resident #2's care plan, dated 11/06/25, reflected: Falls: [Resident #1] is at risk for falls and injuries Goal: Resident #2 would be free from falls and injuries over the next 90 days Interventions included: 11/2/25-Ensure call light is within reach In an interview and observation on 11/12/25 with Resident #2, his call light was observed to be behind his bed and behind a nightstand, twisted up amongst other cords that were plugged into the wall. He stated he used his voice to yell for help, because oftentimes his call light was not on his bed. He stated he did not get out of bed often, but he used the restroom and looked around when he could. In an interview on 11/12/25 at 2:50 PM with RN A, she stated Resident #2 often called for help with his voice. She stated it would be easier on the resident if he were to use his call light. She stated she was unsure why the call light was behind the bed and it was the nurses' responsibility to ensure call lights were within reach. She stated it was important for a resident's call light to be within reach because sometimes it was hard to understand residents and ultimately the call light was to alert someone to go provide assistance to the resident(s). In an interview on 11/14/25 at 8:50 AM, the DON stated her expectation for call lights was that they were to always be within the residents' reach. She stated staff were trained on call light placement. She stated Resident #2 had a lot of behaviors, but she had not heard any about call lights. She stated Resident #1 did her own thing and would sometimes throw her call light down. In an interview on 11/14/25 at 9:45 AM, the ADM stated it was her expectation that all residents' call lights were within reach, and it was all staff's responsibility for ensuring call light placement and any staff could answer call lights to see what residents needed and to ensure safety. She stated if a resident was non-compliant or lacked the mental capacity for use of a call light, staff should still ensure the call light was in place. She stated they should care plan systemic issues they saw so staff would be aware Record review of the facility's policy titled Call Lights, dated 12/23, reflected The facility will</p>		