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	12/01/2025

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. (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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident representatives had the right to exercise resident's rights to the extent provided by state law for 1 of 1 (Resident #1) residents reviewed for resident rights.The facility failed to ensure clinical records were provided to Resident #1's Power of Attorney (POA) as requested.This failure could place residents at risk of their needs not being met or disrupted continuity of care. Findings Included:Record review of Resident #1's clinical record revealed a [AGE] year-old female admitted on [DATE] with the following diagnosis Altered Mental Status, Unsteadiness on feet, Muscle Weakness, Lack of Coordination, Unspecified Macular Degeneration, Psychotic Disturbance Mood Disturbance and Anxiety. Record review of Residents #1's History and Physical dated 3/15/2025 revealed resident was Alert x3 and AMS was resolved. Record review of Residents #1's admission MDS dated revealed upon admission resident had a BIMS score of 11out of 15, indicating moderately impaired cognition. impaired cognition. Record review of Residents #1's admission Agreement revealed Resident #1's signed all necessary documentation for admission and consent to treatment dated 3/15/2025. Record review of Residents #1's Psychosocial Evaluation by Psychological Services Supportive dated 3/17/2025 Mental Status Exam section Orientation: Fully Oriented, Memory: Intact, Cognitive: Cognition Functionally Intact, Judgement: Adequate, and Thought Process: Adequately Integrated. Record review of Resident #1's Social Services progress note dated 3/31/2025 revealed SW spoke with APS worker and APS worker stated POA was allowed to visit and assist Resident # 1, APS case was still open but no allegations currently against POA. Record review of Residents #1 Texas Durable Power of Attorney dated April 15, 2025, revealed Resident #1's signature as Principal's signature and appointed agent as POA. Texas Durable Power of Attorney revealed the signature of the Notary Public of the State of Texas and official stamped by the Notary Public of the State of Texas along with ID number and expiration date of the Notary Public of State of Texas. Interview with Resident #1's Power of Attorney (POA) on 10/08/2025 at 11:30AM. , POA stated she was told the POA she provided to the facility on Resident #1's behalf was not valid by the facility Administrator and as far as the Administrator was concerned, this was a trash piece of paper and that POA could not move nor did POA have the rights to Resident #1 because POA did not have the right too. The Administrator also told POA that Resident #1 had dementia and could not know what she was signing. POA tried to explain to the Administrator POA was not trying to take Resident #1 home POA just wanted to move Resident #1 closer to her so that POA could visit more and get Resident #1 the things she needed due to POA not driving very far. POA was told there was an open APS case on her and Resident #1 was put into the facility by the APS caseworker and POA was not to have any contact with Resident #1. POA stated she contacted APS and was told Resident #1's case was closed and POA was not accused of anything and POA had all rights to visit and assist Resident #1. Interview with APS worker on 10/08/2025 at 1:30PM. , APS worker stated she was somewhat familiar with the case and the case was closed, no allegations towards POA were established. Interview with facility Social Worker on 10/08/2025 at 1:40PM she stated that she had some concerns with the POA documentation due to the APS case against the POA. The Social Worker stated that she was told by the facility Administrator not to send clinical records because of the POA not being valid. Social Worker stated that Residents #1 was alert x 3 at times but may need some redirection. Social Worker said Resident #1was currently being seen by psychological services for anxiety and psychoactive behaviors. Interview with facility Administrator on 10/08/2025 at 2:00PM she stated that the POA was not valid due to Resident #1 having cognitive impairment and dementia. Administrator stated that Resident #1 could not have known what she was signing because of memory issues and the POA coerced Resident #1 into signing the invalid document. Administrator stated the POA signed Resident #1 out and did not disclose where she was taking her and returned to the facility with Durable Power of Attorney paper stating she was now the POA and would like Resident #1's clinicals to be faxed to another skilled nursing facility. The Administrator stated, I did not have my Social Worker faxed clinicals due to the POA did not appear to be valid. The Administrator stated the Durable Power of Attorney was not valid because it was notarized by someone that did not know Resident #1 and she looked up the notary and she only sold food. The Administrator stated she did not have to send notary to a corporate attorney due to her feeling the notary was not valid even though it had the seal of the State of Texas along with Notary ID # and expiration date. The Administrator stated when she asked Resident #1 if she wanted to go to another facility, Resident #1 told her No. Interview with Resident #1 on