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	03/18/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (Resident #1) reviewed for rights. -The facility failed to ensure CR #1 was not left in a soiled bed after his colostomy bag leaked on the evening of 1/8/26.-The facility failed to ensure CR #1 was not left in a soaked bed of urine and tube-feeding formula after his g-tube leaked on 1/28/26. This failure could place residents at risk for decreased quality of life, decreased self-esteem and diminished dignity.Findings included:Record review of CR #1's face sheet dated 3/17/26, revealed a [AGE] year-old male with an original admission date of 12/6/23 and readmitted to the facility on [DATE]. CR #1's diagnoses included: atherosclerotic heart disease of native coronary artery, dementia (loss of memory, language, problem-solving and other thinking abilities), dysphagia (difficulty swallowing), esophageal obstruction (a blockage or severe narrowing of the food pipe that prevents food or liquid from entering the stomach) colostomy status, unspecified ileus (a condition in which the bowel does not work correctly), and unspecified intestinal obstruction.Record review of CR #1's most recent Quarterly MDS dated [DATE], revealed a BIMS score of 6 indicating severe cognition. CR #1 was dependent (helper does all of the effort) on toileting hygiene. CR #1 had an indwelling catheter and ostomy; urinary and bowel continence was not rated. Further review of the Quarterly MDS indicated CR #1 did not have a swallowing disorder. CR #1 while a resident had parenteral/IV feeding and a feeding tube.Record review of CR #1's care plan dated 1/4/26 indicated CR #1 had the following care areas:*required the use of an ostomy and was at risk for complications AEB ostomy type-colostomy. 5/8/24-Staff report he plays with his colostomy. Interventions included: document colostomy care in the clinical record, monitor site for swelling, pain, redness-report to MD, teach/educate resident to leave colostomy in place, staff will empty bag as needed, make sure bag is properly placed.*feeding tube- at risk for aspiration, unplanned weight loss, dehydration, and nutritional complications d/t dysphagia. Feeding-Jevity 1.2. Interventions included: assess abdomen prior to initiating feeding/water flush- assess bowel sounds, check for residual, report abnormalities to MD. Check placement of tube prior to initiating feeding/water flush, report abnormalities to MD. Give all feedings/water flushes via feeding tube as ordered, check for tolerance. Continue feedings as ordered. Monitor for s/sx of aspiration such as coughing, runny nose, increased secretions, report any noted to MD/RP. Staff will serve Grafition diet-regular pureed diet. He will continue with current tube feeding as ordered.*an ADL self-care deficit and was at risk for further decline in ADL functioning and injury. Intervention was to provide (extensive) assistance x1 for toileting/incontinent care.*at risk for alteration in skin integrity and pressure ulcer formation AEB dependence on assistance with mobility and w/c status. Interventions included assist resident with incontinent care as indicated, assist with turning/repositioning during rounds and PRN. Record review of CR #1's orders indicated the following:*colostomy observation- SN to assess stoma site daily for any s/s of infection to site. Every shift for colostomy observation monitor resident's colostomy. Ensure colostomy is intact, free from s/s of infection and functioning properly. Notify MD for any changes. Order date (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	3/10/25.*Colostomy- Empty every shift for e empty colostomy bag each shift, Licensed nurse will monitor colostomy and ensure it emptied every shift and as needed. Order date 1/5/24.*enteral order-monitor resident for signs/symptoms of misplacement of enteral tube: difficulty with medication/feeding/water administration, abnormal findings with residual checks, severe abdominal distention, or changes in the length of the tube. Notify MD PRN. Order date 3/10/25.Review of photo submitted by CR #1's family member dated 1/8/26 at 8:00 p.m. revealed CR #1 was lying in a light brown liquid substance that was on his colostomy bag, stomach, adult brief, bedsheets, and clothing.Review of photo submitted by CR #1's family member dated 1/28/26 at 6:49 p.m. revealed CR #1 had an adult brief underneath him, opened, with light tan stains inside the adult brief. The bed sheets were soaked behind the resident with a light tan substance on the sheets.During an interview with CR #1's family member on 3/18/26 at 12:08 p.m., she said on 1/8/26 she visited CR #1. She said she cleaned CR #1, changed his bed sheets and cleaned his floor. The Family Member said she left at approximately 6:40 p.m. The Family Member said when she returned to the facility an hour later, CR #1 was covered in feces. The Family Member said she got the Unit Manager and RN A to come to the room and requested for CR #1 to be showered. The Family Member said on 1/28/26 she visited CR #1 and when she removed the sheet off him, his adult brief was left opened and his bed was soaked with urine and milk. The Family Member said she called LVN B into CR #1's and showed him the mess.On 3/18/26 at 2:14 p.m., surveyor attempted to contact CNA C via phone and left a message with request to call surveyor, but no call back received prior to exit.During an interview with the Unit Manager on 3/18/26 at 2:16 pm., She said she remembered CR #1's Family Member was upset back in January and grabbed her and RN A to put CR #1 in the shower. The Unit Manager said it looked like CR #1's colostomy bag was leaking. The Unit Manager said the Family Member did not say how long he was like that. The Unit Manager said CNA C came and assisted with the shower. She said residents were checked frequently, every 2 to 4 hours. The Unit Manager said the risk to the residents when they are lying in a mess could lead to skin breakdown.During an interview with RN A on 3/18 at 2:28 p.m., she said she remembered when the Family Member was upset back in January because she found CR #1 with feces on him. RN A said CR #1's stoma was leaking. She said the CNAs do their rounds every 2 hours. RN A said she and the Unit Manager took CR #1 to the shower, cleaned up him, and put clean clothes on him. RN A said she did not know how long CR #1 was there in that state. She said the Family Member told her she had just left the facility and when she came back, she found CR #1 in a mess. RN A said the risk to the residents when they are left soiled could result in skin breakdown.During an interview with the DON on 3/18 at 3:19 p.m., he said residents should be checked every 2 hours. The DON said both photos showed the substance glistening and looked wet and fresh. He said brown rings would have formed on the sheets if it had been sitting on the sheets for a long time. The DON said if a resident was left soiled for a short amount of time there was no risk, for a longer period there could be a risk for infection. The DON said it was very common for colotomy bags to fail or bust, or a resident could have a new colostomy, and the skin can reject that. The DON said the colostomy bag can leak through the seal or pop if the resident rolled over hard to one side. He said residents are changed as needed.During an interview with the Administrator on 3/18 at 3:39 p.m., she said CR #1 always had his colostomy bag leaking. The Administrator said CR #1 had come to the facility with this issue. The Administrator said the Family Member did not talk to them. She said the Family Member would send pictures to her, the social worker, the state and the Ombudsman by email. She said nursing staff were supposed to provide care when they need it. She said anytime a resident had an episode, we want it cleaned up, people have diarrhea all the time. The Administrator said in the picture of CR #1, the substance looked fresh and wet. The Administrator said the risk to the resident could cause infection and wounds. The Administrator said she did not think the Family Member complained to her about that issue in January. She said the last complaint she got from the Family Members was CR #1's towels were missing.During an interview with LVN B on 3/18 at 3:56 p.m., he said he recalled CR #1's colostomy bag and his peg tube would leak. LVN B (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455812	A. Building B. Wing	03/18/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	said the colostomy bag would not stick to his skin and had to put extra tape on the bag and skin. LVN B said the colostomy would constantly leak and CR #1 would have to get checked more frequently. LVN B said the risk to the resident when left in a mess could be an infection control issue and a dignity issue.Record review of the facility's policy titled Activities of Daily Living (ADLs)-Highest Level of Functioning dated 01/2026 read in part . the facility promotes resident independence to the greatest extent possible while providing necessary assistance, supervision, and interventions when residents are unable to safely perform ADLs independently . Activities of daily living (ADLs) include personal care task such as bathing, dressing, grooming, oral hygiene, eating, transferring, bed mobility, toileting, and communication .