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	06/11/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who needed respiratory care were provided with such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 (CR #1) residents reviewed for respiratory care.The facility administered oxygen to CR #1 without an order from the physician from [DATE] through [DATE].This failure could have placed residents who received respiratory care at an increased risk of developing respiratory complications and receiving a decreased quality of care.Findings includedRecord review of CR #1's face sheet dated [DATE] revealed she was admitted to the facility on [DATE] from the hospital and expired on [DATE]. CR #1 had diagnoses which included presence of aortocoronary bypass graft (surgery that created a new path for blood to flow around a blocked or narrowed artery in the heart), atherosclerotic heart disease (plaque buildup inside the arteries that supplied blood to the heart), atrial fibrillation (irregular and chaotic heartbeat), and heart failure (heart could not pump enough blood to meet the body's needs).Record review of CR's MDS assessment revealed CR #1 did not have any completed MDS assessments because she was a new admission.Record review of CR #1's BIMS dated [DATE] revealed CR #1 had a BIMS score of 13, indicating intact cognition.Record review of CR #1's baseline care plan, initiated on [DATE], revealed CR #1 had oxygen via nasal cannula to maintain adequate oxygen saturation and respiratory comfort; Intervention: follow physician orders for oxygen therapy delivery.Record review of CR #1's orders dated [DATE] did not reveal that the resident had an order for oxygen administration.Record review of CR #1's MOT(Memorandum of Transfer) with EXP [DATE] revealed, in part, .oxygen flow rate 1.5 -4L[PM] NC.During a telephone interview on [DATE] at 9:32 a.m., LVN A said CR #1 received oxygen through a nasal cannula when she made her initial round, and that it was her first day working with CR #1. LVN A said she did not check if CR #1 had an order for oxygen because CR #1 already had oxygen on, and she assumed CR #1 had an order, but she could not recall how many liters of oxygen CR #1 was receiving. She said oxygen was considered a medication and CR #1 should have had an order before oxygen was administered to her.During an interview on [DATE] at 3:37 p.m., LVN B said she verified CR #1's orders with the NP, and the NP said to continue with all orders from the hospital discharge list. She said she was not the person who transcribed CR #1's orders into the computer and that it was the DON who transcribed the orders. She said the paper (MOT) that was given to her by the admission staff, had an oxygen order, and that was why she administered oxygen to CR #1. She was not aware the DON did not transcribe the oxygen order. LVN B said the nurse should have had an order for oxygen before oxygen was administered to CR #1 because it was considered a medication. LVN B said she documented that she administered 3 liters (per minute) of oxygen to CR #1 for anxiety because of the oxygen order on the MOT, and the NP said to continue all medications. She assumed the oxygen was part of the order even though there was no oxygen order on the hospital discharge summary. During a telephone interview on [DATE] at 1:36 p.m., the NP said she reviewed CR #1 medication orders with LVN B and she did not mention that CR #1 needed oxygen or had oxygen on her discharge orders from the hospital. The NP said if a resident had an emergency respiratory condition that required oxygen, then the nurse could use the facility's (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
	455812	A. Building B. Wing	06/11/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protocol, start oxygen administration, and then call the physician or NP to obtain an oxygen order. During an interview on [DATE] at 1:00 p.m., the DON said oxygen was considered an intervention during respiratory distress, which meant the nurse could put oxygen on a resident, and after the resident had stabilized, the nurse would call the Physician to obtain an order for oxygen. The DON said the facility did not have a policy to administer oxygen for anxiety and did not know where LVN B got the order to administer oxygen; maybe she came up with the intervention. The DON said he reviewed the hospital discharge orders and there was no oxygen order. He said the ADON was supposed to verify the orders for a new admit within 24 hours and ensure CR #1's orders were transcribed correctly. He did not respond when he was asked if he checked whether CR #1 had an order for oxygen because he transcribed CR #1's orders on admission. He said he did not know if there were any negative side effects for CR #1 when oxygen was administered without an order.During an interview on [DATE] at 4:41 p.m., the ADON said LVN B documented that CR #1 was on continuous oxygen at 1.5-4 L(PM). She said she reviewed the orders from the night of admission, and they revealed the DON transcribed the orders and did not transcribe any order for oxygen. She said CR #1 came from the hospital with a discharge order summary, and there was no order for oxygen. The ADON said the facility did not have any policy regarding oxygen when a resident was demonstrating anxiety. She said if the resident was having a respiratory emergency, the nurse could apply oxygen to the resident and, after the resident was stabilized, the nurse would notify the doctor, and the doctor would provide an order for oxygen administration. She said if there was no emergency, the resident would have had an order for oxygen before the nurse applied oxygen to the resident. She said the ADON would follow up and review the new admit' s medications and make sure they were verified and transcribed correctly. The ADON said she did not check the MOT to determine whether it had an order for oxygen for CR #1. The ADON did not respond when she was asked if she checked CR #1's orders since she was aware LVN B documented administering oxygen to CR #1. The ADON said if a resident did not need oxygen and it was given, then it would do the exact opposite of what the administration of oxygen was intended to do.Record review of the undated facility Policy on Oxygen Therapy revealed, in part, .it is the policy of this facility that the facility will provide oxygen therapy. procedures. 1. Review physician's order on the chart for completeness. a. modality (method used to administer oxygen), liters, frequency.