STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675365	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Post Acute	4006 Vista Rd Pasadena, TX 77504

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to adequately allow residents to call for staff assistance from their bedside for four (Resident #1, Resident #5, Resident #9 and Resident #14) out of twenty-five residents for review of resident call systems. The facility failed to ensure call lights were accessible to Resident #1, Resident #5, Resident #9 and Resident #14 while in their beds on 05/12/2026 and 05/13/2026. This failure could place residents at risk of delays in care and emergency assistance. Findings include: A record review of Resident #1's face sheet revealed a [AGE] year-old female with an admission date of 04/21/2026. Resident #1 was diagnosed with Encephalopathy (any disease or disorder that affects brain function), Cerebral Infarction (occurs when blood flow to a part of the brain is obstructed, leading to tissue death due to lack of oxygen), Pneumonitis Due to Inhalation of Food and Vomit (occurs when food particles, vomit, or stomach contents enter the lungs, causing irritation and inflammation of lung tissue), Sepsis Unspecified Organism (occurs when the body's immune system overreacts to an infection, causing widespread inflammation that can damage tissues and organs) and Cognitive Communication Deficit (occurs when a person's ability to communicate effectively is compromised by impairments in cognitive processes such as attention, memory, and executive function, rather than by problems with speech or language mechanics). A record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 00 or 99 and severely impaired. A record review of Resident #1's care plan dated 04/22/2026 revealed resident requiring one person assist with ADL/Mobility, at risk for falls and pain and a diagnosis of seizure disorder. Resident care plan interventions included encourage to use call light for assistance and call light within reach and answered promptly. A record review of Resident #5's face sheet revealed a [AGE] year-old female with an admission date of 01/08/2026. Resident #5 was diagnosed with Encephalopathy (any disease or disorder that affects brain function), Essential Hypertension (persistent high blood pressure) and Dementia. A record review of Resident #5's MDS dated [DATE] revealed a BIMS score of 09. A record review of Resident #5's care plan dated 04/28/2026 identified resident as a one person assist for ADL/Mobility and fall and pain risk. Interventions included keep call light within reach. A record review of Resident #9's face sheet revealed a [AGE] year old female admitted on [DATE] with a diagnosesis of Rheumatoid Arthritis (a chronic autoimmune disease where your immune system mistakenly attacks the lining of your joints), Alzheimer's Disease (a type of dementia that affects memory, thinking and behavior) and Unspecified Psychosis (a temporary diagnostic label used when a person exhibits clear psychotic symptoms but there is insufficient information to assign a specific psychotic disorder). A record review of Resident #9's MDS dated [DATE] did not record a BIMS score. A record review of Resident #9's care plan dated 03/31/2026 identified her as fall risk. Interventions included keep call light within reach. A record review of Resident #14's face sheet revealed a [AGE] year-old male admitted on [DATE] with a diagnosisis of contractures to both knees, stage 3 pressure ulcers to buttocks, communication deficit and paralysis and weakness to right dominant side. A record review of Resident #14's MDS dated [DATE], revealed that resident was rarely/never understood, somewhat understands others, severely impaired and has a BIMS score of 00 or 99. A record review of Resident #14's care plan dated 05/11/2026 revealed (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident had an unwitnessed fall. Interventions included keep call light within reach. During an observation on 05/12/2026 at 10:20 AM revealed:- Resident #1 was asleep in bed and the call button was observed under the bed.- Resident #5 was in bed and the call button was observed behind her bed.- Resident #14 was asleep in bed and the call button was observed on the floor near his bed. During an observation on 05/13/2026 at 10:07 AM revealed:- Resident #1 was asleep in bed. The Call button was observed behind her bed and on the floor.- Resident #5 was in bed. Her call button was observed hanging down over her bedside tray table. - Resident #9 was observed asleep with her call button coiled on the floor near the headboard of her bed.- Resident #14 was observed asleep with his call button on the floor under his IV pole. During an interview on 05/13/2026 at 11:00 AM with CNA A, she said call buttons were important because they ensure if a resident has a need or an emergency, they can get assistance. She said call buttons should be within reach of the resident. She said they were not supposed to be on the floor. She said if a resident was unable to reach their call button, an incident could happen and she wouldn't know. During an interview on 05/13/2025 at 11:06AM with CNA B, she said call buttons were used in case of emergency or if the residents need help with something. She said call buttons should be located next to residents. She said it's more dangerous for a resident if their call button was under bed or out of reach. She said it could put residents at risk of falls. During an interview on 05/13/2026 at 11:10 AM with Resident #5, she said she was able to pull the cord of the call button from over the bedside tray until she was able to reach and push it for assistance. During an interview on 05/13/2026 at 1:52 PM with the Administrator, he said call buttons were used so residents can request assistance or help. He said call buttons should be within a resident's reach. He said not having a call button in reach of a resident could delay responses in assisting them. He said whether a resident was able to use a call button or not, the expectation was that it is within reach. During an interview on 05/15/2026 at 3:37 PM with the DON, he said call buttons should be within reach of residents when they were in bed. He said call buttons not within reach of residents can cause a delay in care. He said it could also put the resident in danger. A record review of the facility's Answering the Call Light policy dated October 2010 stated, when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review, the facility failed to ensure the resident (Resident #14) environment remained as free of accident hazards as is possible over three out of four days to prevent accidents. The facility failed to follow Resident #14's care plan interventions for falls. The failure could place residents at risk of injury, reduced mobility and hospitalization.Findings include: During a record review of Resident #14's face sheet, it was revealed resident was a seventy-two year old male admitted on [DATE] with a diagnoses of contractures to both knees, stage 3 pressure ulcers to buttocks, communication deficit and paralysis and weakness to right dominant side. During a record review of Resident #14's Fall Risk assessment dated [DATE], it was revealed resident was at moderate risk for falls. During a record review of Resident #14's MDS dated [DATE], it was revealed that resident was rarely/never understood, somewhat understands others, severely impaired and had a BIMS of 00 or 99. During a record review of Resident #14's care plan dated 05/11/2026, it was revealed Resident had an unwitnessed fall. Resident goal related to this fall noted he would minimize complications related to the actual fall to the extent possible. Interventions included keep bed in low position with brakes locked.keep call light within reach. During an observation on 05/12/2026 at 10:42 AM Resident #14 was observed lying in bed asleep. Resident's bed was raised approximately two feet above the floor. His call button was on the floor and not within reach. Resident #14 was receiving feeding via gastronomy tube. An oxygen machine was also observed to the left of his bed. Resident #14 did not engage verbally or through gestures due to limited communication ability. During an observation on 05/13/2026 at 10:07 AM, Resident #14 was observed lying in bed. His call light was on the floor under his IV pole. Resident #14's bed was positioned approximately two feet off the floor. During an observation 05/15/2026 at 2:00 PM, Resident #14's bed was observed approximately two feet above the floor. During an interview on 05/15/2026 at 2:08 PM with ADON B, she said interventions were put in place like more frequent rounds and monitoring after Resident #14 had a fall this week. She said not following interventions could place the resident at risk of falling again. During an interview on 05/15/2026 at 2:14 PM with the Administrator, he said following Resident #14's fall on Monday, interventions were put in place to prevent further incidents. He said staff were expected to follow care plan recommendations. He said he wasn't sure why Resident #14's bed had been observed in a higher setting than recommended or the call button was not within reach. He said staff were expected to check on residents at least every two hours. He said failure to follow these interventions could continue to place the resident at risk of additional falls and harm. During an interview on 05/15/2026 at 3:47 PM with the DON, he said interventions had been put in place to prevent further falls by Resident #14. He said in addition to care plan recommendations, staff were expected to increase rounding on the resident. He said checking on the resident about every thirty minutes would be appropriate. He said he wasn't sure why the resident's call button was observed on the floor and out of reach and his bed was not in the lowest position if rounding was being done. He said not following interventions could put the resident in danger. A record review of the facility Falls and Fall Risk Policy dated December 2007, it stated staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling and staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, interviews, and record review the facility failed to prepare food in a form designed to meet individual needs for 5 residents (Resident # 59, 51,88, 23, and 4) reviewed for puree diet. -On 5/13/26 and 5/14/26 the protein puree (A puree diet consists of foods that are blended into a smooth, pudding-like consistency to make eating and swallowing easier for people with chewing or swallowing difficulties) portions of lunch were not the correct texture. This failure had the potential to cause residents on a puree diet to aspirate, choke, or cause weight-loss due to difficulty in consuming meals. Record review of the facility therapeutic diet roster dated 5/12/26 revealed that Resident #'s 59, 51, 88, 23 and 4 required a puree diet. Record review of the menu dated 5/13/26 revealed baked chicken would be served. The menu for 5/14/26 revealed marinated pork loin would be served.Record review of the in-service titled Puree Consistency, dated 5/14/26 revealed that the DM provided training which stated All puree must be smooth without any piece that can be noticed on the tongue, this will prevent resident from choking or aspiration. Puree must look, feel like baby food. Always test and taste all puree to ensure that it is the correct consistency.Observation and interview on 5/13/26 at 10:33 am with the DM and [NAME] A revealed baked chicken puree procedure. [NAME] A followed procedure during pureeing by adding broth into the chicken to thin and using machine to thin. Once pureeing was completed the surveyor observed the texture of the baked chicken and asked if the chicken were pureed enough seeing that the texture could have been pureed a while longer. [NAME] A shook her head and said yes, she took the container of pureed chicken, which was covered in plastic wrap, shook the container and passed the container to the DM. The DM placed the puree chicken on the steam table, took the temperature probe, stirred around the chicken, and took the temperature. The DM said that the facility had 8 residents that required a puree diet, 2 with double portions. Observation of temperature, taste, texture of test tray on 5/13/26 at 12:58 pm with the DM. Surveyors found that the texture of the mashed potatoes and green beans had the texture of baby food. The pureed chicken had the consistency of a tuna or chicken salad and had residual strings or strands of meat when sampled for both surveyors who sampled the pureed baked chicken. The surveyors requested a lunch puree test tray for 5/14/26. Observation and interview on 5/14/26 at 11:30 am with the DM, Administrator and DON of the puree pork loin revealed that the pork loin appeared to be slightly lumpy with the appearance of cooked oatmeal. The puree pork loin was tested by the DM, Administrator, DON and 1 surveyor which all found the texture could be smoother and could see that a resident requiring a puree diet could have the potential to choke. Observation and interview on 5/14/26 at 11:45 am with the DM, Administrator and 2 surveyors, the texture appeared to be smooth like baby food. Both the Administrator and DM said that they could see the difference between the textures of the pureed pork loin, the 2 surveyors also said that there was a difference in the textures. Interview on 5/14/26 at 2:54 pm with the Dietician, she said she heard about puree chicken consistency and only saw the first consistency and second consistency on the pork loin today 5/14/26. She said, the second consistency of the pork loin was smoother, the first consistency of the pork loin could leave residue in the mouth could lead to choking if the residents were determined to need puree diet, Interview on 5/14/26 at 3:59 pm with the Administrator and DON, the Administrator said that they would address the textures of food and that the expectation was that textures were consistent for therapeutic diets. They said the DM was responsible for preparation of foods. During an interview on 5/15/26 at 9:06 am with the DM and [NAME] A , the DM translated for [NAME] A. [NAME] A said she gave the chicken to the DM on 5/13/26, she did not re-puree the chicken. Yesterday 5/14/26, [NAME] A did re-puree the pork after concerns about the texture. She said that she saw a difference in the first puree of pork and the second puree, the second one was really smooth, the first texture was a little thicker, you could see the difference by looking at it. The DM said she had an in-service on puree textures. [NAME] A said she understood that the importance (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the texture being smoother. She said if the texture were not smoother, residents could choke. The DM said she trained them (cooks) about aspirating and in the importance of textures. During an interview on 5/15/26 at 4:21 pm with the DON, he said when a specific diet was prescribed, it should be followed. He said puree texture was important to prevent aspiration or choking. Record review of the facility policy and procedure entitled Food and Nutrition Services, dated revised October 2017 read in part. Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Record review of the facility policy and procedure entitled Therapeutic Diets, dated revised October 2017, read in part.A ?therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: altered consistency diet.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 out of 7 residents (Resident #36) reviewed for infection control. Staff failed to ensure Resident #36's indwelling urinary catheter drainage spout was not touching the floor in the main dining room during lunchtime meal service. This failure could place residents at risk for cross contamination, infection and decline in health. Findings include: Record Review of Resident #36's admission record dated 05/15/2026, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included heart disease (an umbrella term used for conditions affecting the heart's structure and function), obstructive hydrocephalus (a condition where the normal flow of cerebrospinal fluid [a clear watery liquid that surrounds, cushions and protects the brain and spinal cord] is physically blocked within the brain and cause a buildup of pressure inside the skull), [NAME] Syndrome (a rare hormonal disorder caused by prolonged exposure to excessive levels of cortisol [the body's stress hormone] and obstructive (a blockage that impedes the normal flow of urine) and reflux (urine flowing backwards from the bladder to the kidneys) uropathy (any disease or condition affecting the urinary tract). Record review of Resident's #36's admission MDS dated [DATE] revealed a BIMS score of 9 that suggested moderate cognitive impairment. Section I and Section N revealed Resident #36 had no active infection diagnosis and had not received any medications including antibiotics for infection. Record review of Resident #36's physician order recap report dated 05/15/2026 revealed an order for Insert indwelling urinary catheter, 16 Fr [universal unit of measurement used to describe the outside diameter of a catheter tube], 10 ml balloon size due to urinary retention with closed drainage system every shift. The order was dated as active 04/28/2026 and had no end date. There were no orders for medications or treatments for infections. Observation on 05/14/2026 at 12:28 PM revealed Resident #36 in the main dining room for lunchtime meal service with her lunch tray in front of her. She was observed actively eating and sitting in a wheelchair. Her indwelling urinary catheter bag was hooked to the bottom of the wheelchair, and the drainage spout tubing was resting on the floor. The end of the tubing was uncapped. Observation and interview on 05/14/2026 at 12:34 PM of Resident #36 with RNA C who said Resident #36's catheter spout should not be touching the floor, and she would remove the resident from the dining room and try to fix it. RNA C said that she would try to fix it by hanging the indwelling urinary catheter bag higher on the back of the wheelchair. She said she would also let Resident #36's nurse know because she may need to change the catheter to prevent infection. RNA C said she was not sure who hung the indwelling urinary catheter bag on Resident #36's wheelchair and she thought Resident #36 had just come out of therapy before coming to the dining room. RNA C said they had not noticed when lunch started at 12:00 noon, that the spout from Resident #36's indwelling urinary catheter bag was touching the floor. RNA C said she did not know how long Resident #36's catheter spout had been touching the floor. Observation and interview with LVN B at 12:38 PM on 05/14/2026 in the main dining room who said Resident #36's indwelling urinary catheter bag was hanging too low on the back of her wheelchair, and the spout tubing should not be touching the floor. LVN B said she would notify LVN C who was the charge nurse assigned to Resident #36. She said LVN C could change the residents indwelling urinary catheter bag and tubing, so the resident did not get an infection from it touching and being on the floor. LVN B said while the indwelling urinary catheter bags should be hanging below the resident's bladder to prevent backflow, it should not be touching the floor. She said she did not know who placed the indwelling urinary catheter bag low enough to touch the floor or how long the catheter spout had been touching the floor because she had not noticed it until the surveyor brought it to her attention. Observation and interview with LVN C at 1:21 PM on 05/14/2026 who said Resident #36's indwelling urinary catheter bag tubing and spout (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should never have been touching the floor because it could cause her to get an infection. LVN C said they did not know who placed the catheter bag that low on the back of Resident #36's wheelchair or how long the indwelling catheter tubing and spout had been touching the floor. LVN C said Resident #36 had an order to change the catheter, which would include all parts of the indwelling urinary catheter, prn and she would also notify the residents MD and RP. Resident #36 refused surveyor observation of change of indwelling urinary catheter bag. Interview with the DON on 05/15/2026 at 09:38 AM who said Resident #36's indwelling urinary catheter tubing/spout, should not have been on the floor or touching the floor. The DON said they had already conducted in-service training with the licensed staff and direct care staff on infection control and indwelling urinary catheter care. The DON said if catheter tubing and spout were on the floor, it could spread infection throughout the facility and or cause Resident #36 to get an infection. The DON said they were the IP for the facility and responsible for the staff training on infection control, which included keeping resident urinary catheter bags, tubing and spouts off of the floor. The DON said they were unsure which CNA had placed Resident #36's indwelling urinary catheter bag low enough on the back of the wheelchair to touch the floor so they in-serviced everyone immediately after the incident was reported on 05/14/2026 by RNA C, LVN B and LVN C. Record review on 5/15/2026 at 10:10 AM of DON/IP in-service training dated conducted on 05/14/2026 by DON/IP and read in part: Urinary Catheter Bag Infection Prevention.Never allow the drainage bag or drainage spout to touch the floor. Record review of facility policy and procedure titled: Infection Prevention and Control Program dated 2001 revealed in part: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary andcomfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. The program is based on accepted national infection prevention and control standards. Record review of facility policy and procedure titled Catheter Care, Urinary and dated revised September 2014 read in part: Be sure the catheter tubing and drainage bag are kept off the floor.