STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676332	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Suites Pasadena	4900 East Sam Houston Parkway South Pasadena, TX 77505

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure residents were free of any significant medication error for 1 of 3 residents (Resident #1) reviewed for medication errors. The facility failed to ensure Resident #1 did not receive insulin without a physician order.The facility failed to ensure the RN adherence to the five rights of medication administration, including resident rights when administering medications to Resident #1. These failures could place residents at risk decline in health, adverse reactions, and hospitalization.Record review of Resident #1's face sheet revealed he is a [AGE] year-old male admitted [DATE], with an original admission date of 11/26/25. The patient has Parkinson's disease (a movement disorder affecting balance and stiffness), dysphagia (trouble swallowing), muscle weakness, and difficulty walking. Medical history also includes metabolic encephalopathy (temporary brain dysfunction causing confusion), emphysema and COPD (chronic lung diseases causing breathing difficulty), and gastroesophageal reflux disease (stomach acid reflux). The patient is PEGˆtube dependent for nutrition and medications (receives feedings through an abdominal tube). Additional conditions include hyperlipidemia (high blood fats) and a contracted right wrist (permanent tightening that limits movement). Advance directive is documented as Do Not Resuscitate. Record review of Resident #1's admission MDS (Minimum Data Set) assessment dated [DATE] revealed the resident was unable to complete 10-point ROS (Reactive Oxygen Species) due to cognitive deficit. The resident was nonverbal; requires assistance with ADLs. Nutrition via PEG documented. No care area trigger for diabetes; no insulin dependence indicated in MDS data elements for this assessment period. Record review of Resident #1's Care Plan dated 03/01/2026 revealed a focus on Resident #1's Hospice Care due to a diagnosis of Parkinson's disease. The review showed that, because of his Parkinson's, he experienced muscle rigidity. It noted that after he took his medications, if he did not want to participate in therapy or communicate with staff, he would place himself in a freezeˆlike state. The interventions were to administer medications as ordered. The record also showed that Resident #1 received antiˆanxiety medications related to an anxiety disorder, with interventions that included educating the resident about the risks, benefits, and potential side effects or toxic symptoms of the antiˆanxiety medications being administered. Record review of Resident #1's H&P contained no active insulin orders per physician order sheet dated 03/26. In the Record review eMAR for 03/08/2026, there are noted irregularities. a blood glucose reading of 132 mg/dL. Record review of a late entry was added for a medication administered by mouth. The exception notes indicate that staff corrected the entry and notified the Director of Nursing (DON) Record review of Resident #1's Physician Orders revealed the following active orders dated 03/11/26: BisacˆEvac Suppository 10 mg - For constipation. 1 suppository rectally daily as needed.MiraLax 17 g - For constipation. 1 scoop via Gˆtube daily mixed with 8 oz water.Hyoscyamine 0.125 mg - Reduces excess secretions. 1 tablet via Gˆtube every 4 hrs as needed.CarbidopaˆLevodopa 25ˆ100 mg - Treats Parkinson's symptoms. 2 tablets via Gˆtube four times daily.Ibuprofen Suspension - For pain/inflammation. 30 mL via Gˆtube every 8 hrs as needed.Ondansetron 4 mg - For nausea/vomiting. 1 tablet every 8 hrs as needed.SennaˆTabs - Laxative for constipation. 2 tablets via PIC tube every 12 hrs as needed.Acetaminophen 650 mg - For (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain/fever. 2 tablets via Gˆtube every 4 hrs.ZyrTEC 10 mg (Cetirizine) - For allergies. 1 tablet via Gˆtube once daily.Debrox Ear Drops - Softens and removes earwax. 10 drops in both ears at bedtime for wax for 1min.Esomeprazole 40 mg (Delayed Release) - For GERD/acid reflux. 1 capsule via Gˆtube daily; do not crush.Entacapone 200 mg - Supports Parkinson's medication. 2 tablets via Gˆtube four times daily.IpratropiumˆAlbuterol Nebulizer - Eases breathing for COPD/emphysema/SOB.Inhale 1 vial every 6 hrs as needed. Record review of a The Complaint/Grievance Report was completed by the DON and revealed that a nurse had administered the wrong medication to Resident #1. The physician was notified, the resident was monitored closely for signs and symptoms, and no adverse reactions were noted. The family was informed on 03/09/2026. During an observation on 03/11/2026 at 11:45 a.m., the Blood level chart showed a blood glucose value of 132 mg/dL at the time of the event. No subsequent hypoglycemia or hyperglycemia symptoms were documented during the shift. Resident #1 remained clinically stable, and no ER transfer occurred in connection with the insulin allegation. In an interview on 03/11/2026 at 10:22 a.m., the Administrator stated that she had been made aware of the incident on 03/10/2026 by the resident's family. She explained that the family had observed, through video camera surveillance, that Resident #1 had received insulin, even though he should not have been given that medication. She stated that the DON had spoken with regional leadership regarding steps and protocol to ensure compliance with guidelines. She added that the physician's orders were to monitor the resident for any adverse effects. During an interview on 03/11/2026 at 1:25 p.m., RN (A) stated that he had been employed at the community for three days. He reported that his mistake was not matching the resident's face with the correct client. He explained that his roommate was the individual who had required insulin, not Resident #1. He stated that approximately 0.5 units of insulin had been administered to Resident #1 at around 10:00 a.m., which was near the scheduled medication time.He indicated that once he realized the error, he immediately contacted the physician. The physician asked whether the resident's blood glucose had been checked and instructed that if the level fell below 70 mg/dL, the resident should be given orange juice. The physician then ordered blood glucose checks every 15 minutes, then every 30 minutes, then hourly, and if stable every 2 hours until the end of the shift. RN #1 stated that he informed the incoming staff of the monitoring plan and the medication error.He reported that there were no changes in Resident #1's condition during the shift and no adverse reactions. He notified the DON, who removed him from the floor and assumed his duties for the remainder of the shift. He added that hypoglycemia could occur when a person receives insulin without being diabetic. RN #1 stated that he immediately completed staff reˆeducation, oneˆonˆone competency validation, dualˆverification for insulin, and leadership rounding. During an interview on 03/11/2026 at 3:42 p.m., the Physician Assistant stated that she did not have any concerns regarding Resident #1's health needs. She reported that the physician's orders had been in place for ongoing monitoring and confirmed that Resident #1's fingerˆstick results had remained normal. She stated that 0.5 units of insulin would not have been a concerning amount for the resident. She further stated that she felt the facility had responded appropriately to the resident's care needs. During an interview with the Director of Nursing (DON) on 03/12/2026 at 2:02 p.m., she stated that resident #1 was always given his medications through his tube. She explained that RN (A) had mistakenly administered insulin approximately 0.5 units and had been immediately removed from the floor and reˆeducated on insulin administration and rights to medication administration. The DON stated that RN (A) acknowledged he had failed to verify resident's #1 identity. She reported that, she contacted the physician and notified the family. The DON stated that the physician's orders were to continue monitoring for adverse reactions, including hypoglycemia and hyperglycemia (Hypoglycemia refers to blood sugar dropping too low, while hyperglycemia refers to blood sugar rising too high), every 15 minutes, then every 30 minutes, then hourly, and then every two hours until the end of the shift. The DON stated that Resident #1 ate lunch and dinner and that his blood sugar levels remained stable throughout. She further stated that death, hypoglycemia, or other adverse reactions could have been potential consequences of Resident #1 receiving the insulin. Record review of the facility's (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedure on the Residents Rights stated that Residents have the right to receive the services and/or items included in the Plan of Care. Record review of the facility's policy and procedure on Administering Medications ((2025 Revision) read in part: .Review MAR to identify medication to be administered. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.