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	01/16/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observation, interview and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 33 of 33 residents reviewed for accidents, hazard and supervision. The facility failed to ensure adequate supervision of residents to prevent them from entering the construction area that had exposed wooden framing and loose life hanging electrical wiring. This failure places residents, staff and visitors at risk of accidents, electrical shock and fire hazards. Finding included Observation on 01\12\26 at 6:00 AM, revealed part of the facility, hall 100 and the end of 300 had a sign on the door that read do not enter During an interview on 01\12\26 at 7:00AM, the DON said part of the facility was under construction and all residents are on 600, 500 and 400 halls. She said the construction was on 100 and 200. During an interview with interim Administrator on 01\12\26 at 8:00 am, he said he was from another facility, and it was his understanding that construction was approved and the 100 and 200 halls was for a different company Observation on 1\13\2026 at 11:58AM, revealed the door that separated the 100 halls from the general area by the front desk was unlocked. The door by the dining room that separated the 300 halls from the 200 halls was unlocked. The dining room was on one side of the 300 halls next to the 200 halls under construction. The vending machine was next to the 200 hall which made it possible for anyone to go through the construction area that had exposed wooden framing, hanging electrical wiring, nails and wires. Observation of residents in dining area on 1\13\26 at 12:42pm, revealed there were approximately 20 residents eating lunch in the dining room near the construction area. Observation of Resident #34 on 01\13\26 at 1:15PM, revealed he walked into the dining area unsupervised to get a snack. Observation on 01\13\26 at 12:40PM revealed the door between the dining room and the enclosed patio was open. Observation revealed there were 6 beds with electrical cords hanging down on the bed. Two beds had mattress on them and 4 had nothing covering the bed springs. During an interview with the Interim Administrator on 1\13\2026 at 3:00pm, he stated that the only thing that kept the residents from the construction area was the do not enter sign. He admitted that he did not have any plans in place to prevent the residents from entering the restricted area. He said the residents could have been injured by the exposure to the construction. He stated that he had been here since yesterday 01\12\26 to help while they searched for an Administrator. He stated that he was not sure if staff had completed any in-services concerning the hazard of the construction area. In an interview with Resource Manager on 01\13\26 at 3:30PM, she said she started with the corporation in October 2025 to help the new DON. She stated they will implement every 15-minute rounds now that she is aware that the restricted area was an issue. She said she in-serviced the Maintenance Director today after our first meeting with them on the dangers of the unrestricted construction area and would try to keep residents away from the area. In an interview with MA J on 01\13\26 at 4:00pm, she stated she had been employed for two months and that they keep a close eye on the residents, so they do not go into the construction area. She stated that she was not sure what she would do if there was a fire. She denied any in-services concerning fire safety or evacuation changes. In an interview with the DON on 01\13\26 at 5:00PM, she said she had been (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	employed for one month. She stated she did not have any residents that were an elopement risk and with their low census of 34, staff are able to keep a close eye on the residents. She said it was basically wooden framing, but she was not aware of live electrical wiring hanging from the ceiling and on the ground IJPOR Observation and interview on 01\13\26 at 7:30PM, revealed CNA A sitting by the door between the dining room and 200 halls. During an interview, she said she was at the door to prevent Residents from wandering into the construction area. She said she would call for relief if she had to take a break or step out. Observation and interview on 01\13\26 at 8:30PM, revealed CNA B sitting by the door between 100 halls and the therapy room. During an interview, she said she was at the door to prevent Residents from wandering into the construction area. She said she would call for relief if she had to take a break. Observation and interview on 01\14\26 at 8:15AM, revealed CNA B sitting by the door between 100 halls and the therapy room. During an interview, she said she was at the door to prevent Residents from wandering into the construction area. She said she worked the night shift. She said she had an in-service last night, on monitoring the fire exits and fire doors during construction. She said they were told to always be by the doors and to call for relief during lunch and document any resident observed wandering around. Observation and interview on 01\14\26 at 9:30AM, revealed Staff C sitting by the door between 100 halls and the therapy room. During an interview, she said she was at the door to ensure that no one goes through the door to the construction area. She said anyone that desired to go to the 100 hall, and 200 halls had to be one of the construction workers, or the Maintenance Director. She said every other person had to get clearance. Observation revealed the only thing that prevented residents, staff and visitors from going to the construction site was a double door and the staff by the door. The doors were unlocked. Observation on 01\14\26 at 1:15 PM, revealed the patio door to the courtyard was open. Observation revealed there were 6 empty beds outside at the corner of the patio. The beds had bed electrical cord hanging from the beds. Rounds and observation of the patio area on 01/14/26 at 1:20PM revealed 5 doors on the construction side, hall 100 and 200 halls had unlocked and unsupervised doors that opened to the patio which indicated that anyone has access from the dining room, and therapy room to the construction site. During a walk round and interview with facility's interim Administrator on 01\14\26 at 2:40PM, he observed that the doors on 100 and 200 halls to the patio were unlocked. All residents, staff and visitors had access from the patio to the construction site 100 and 200 halls. He said no one had noticed that the doors were open to the patio. He said all doors from the construction site would be locked from inside and the construction site would not be accessible to anyone from outside.He said he would inform the Maintenance Director to lock all doors from inside to secure the doors and would ensure that all equipment on the patio was removed During an interview with interim Administrator on 01\14\26 at 3:00 PM, he said all beds and any equipment outside the patio area had been removed and all doors are secured from the inside, and no one can get into the construction site but would have the door monitor until the facility comes up with a solution. In an interview with Interim Administrator and Resource Manager on 01\14\26 at 4: 00pm, the Interim Administrator said, the recommendation was to get a heavy-duty plastic covering on the door by 01\15\26 until the facility found a permanent solution. He said meanwhile the facility would continue to have the doors monitored. The Resource Manager said she would complete all in-service by the end of the day 1\15\26. Observation and interview on 01\15\26 at 8:15 am revealed Staff G sitting by the door on 100 and halls. In an interview she said she was doing a fire watch to prevent residents, staff and visitors from going through the door because the doors are open to the construction site. She said she had an in-service on fire watch and ensured that all residents were monitored. She said she would call for assistance if she needed to leave her post. She said she came in this morning at 6:00 am to relieve the staff that worked the night shift, Staff G. Observation and interview on 01\15\26 at 8:20 am revealed Staff A sitting by the door on 200 halls and the dining room. In an interview she said she was doing a fire watch to prevent residents, staff and visitors from going through the door because the doors are open to the construction site. She said she would be there until she gets relief. In an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview with Maintenance Director on 1\15\26 at 1:50PM, he said someone had gone to a local hardware store to purchase some heavy-duty plastic covering to cover the doors on both hallways to ensure that Residents, staff and visitors had no access to the construction site. He said staff will continue monitoring the doors until all exits and entrance to the construction site are permanently sealed. Observation on 01\15\26 at 2:00pm, revealed Staff G sitting by the door on hall 100. Observation on 1\15\26 at 2:15pm revealed staff H sitting by 200 between the dining room [ROOM NUMBER] hall. Observation on 01\15\26 at 2:30pm, revealed construction staff were observed attaching a heavy-duty plastic covering on the doors on 100 halls. In an interview, the Maintenance Director said the heavy-duty plastic was a temporary fix and all doors should be completed by 5:00 pm and a permanent wall would be in place on 01\16\26. Observation on 01\15\26 at 4:30pm revealed construction workers placing a heavy duty -plastic covering on the door between the 200 halls and the dining room area. Observation and interview on 01\16\26 at 8:20am, revealed the 2 doors were covered with heavy-duty plastic covering and two staff were observed one on each door. Construction workers were observed removing the double doors behind the heavy-duty plastic covering that connects the 100 halls and the therapy department. In an interview with Construction worker A he said they are from a private company. He said the doors would be removed and a permanent wall would be installed by lunchtime. He said after lunch, he would start on hall 200 door. In an interview with facility Resource Manager on 01\14\26 at 11:45AM, she said the facility had completed in-service on fire exit and fire doors during construction with 60% of the facility staff and was calling all those that were scheduled off. She said she could not get some but will continue trying. In an interview on 01\16\26 at 9:00am, Resource Manager said she had completed in-service training with all staff and the doors between the construction site would be permanently sealed as recommended. Record review of Resident Matrix (facility's census and conditioning) dated 1\13\2026 revealed 26 residents were checked off as having dementia/Alzheimer's Disease diagnosis. Record review of the facility assessment dated 1\12\2026 revealed there were 19 residents that ambulated independently.Record review of the emergency evacuation plan dated 4\22\2025 revealed it did not have any changes due to the construction. On 01\16\26 at 11:00AM, facility was informed that the IJ was lowered while survey team continued to monitor the progress of a permanent solution to ensure the construction site was not easily accessible to Residents, staff and visitors. Records review of facility's policy on accidents and supervision dated 05\16\25 revealedPolicy:The resident environment will remain as free of accident hazards as is possible. Each resident will receiveadequate supervision and assistive devices to prevent accidents. This includes:1. Identifying hazard(s) and risk(s).2. Evaluating and analyzing hazard(s) and risk(s).3. Implementing interventions to reduce hazard(s) and risk(s).4. Monitoring for effectiveness and modifying interventions when necessary. Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazardsto minimize the likelihood of accidents.1. Identification of Hazards and Risks- the process through which the facility becomes aware of potentialhazards in the resident environment and the risk of a resident having an avoidable accident.a. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing andidentifying potential hazards in the environment, while taking into consideration the uniquecharacteristics and abilities of each resident.b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident.c. Various sources provide information about hazards and risks in the resident environment. Observation on 01\16\26 at 4:20 pm revealed a permanent wall between all area leading to the construction area were completed. IJ was lifted on 01\16\26 at 4:20PM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record reviews the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions in accordance with professional standards for 3 of 4 medication carts reviewed for medication storage in that: Medication Carts #1, 3, and 4 contained medications that did not have an open date written on the bottles. The failure to date opened medications placed residents at risk for receiving expired, contaminated, or ineffective medications which could result in medication errors, infection, delayed treatment or adverse drug outcome.Observation on 01/13/2026 at 10:15 a.m., of the Medication Carts #1, # 3, and #4 with DON and ADON, revealed the following medications that did not have an opened date written on them. Medication Cart #1Morphine sulphate oral solution 100mg per 5ml(20mg/ml). (Morphine sulphate is an opioid narcotic medication used to treat moderate to severe pain). Medication Cart #3 Three bottles of Levetiracetam 100 mg/ml solution (Levetiracetam is a medication used to treat and prevent seizures).One bottle of magnesia solution (magnesia solution is a liquid form of magnesium, an essential mineral used for medical treatment and supplement)One bottle Lactulose 10 gm/15 ml solution (Lactulose is a medication used primarily to treat constipation and conditions related to liver disease). Medication Cart #4Triamcinolone/acetonide cream (is a cream used to treat moderate to severe skin conditions)Hydrocortisone cream maximum strength (is a cream used to reduce inflammation, skin irritation and itching)Ketoconazole cream 2% (is a medication that is used to treat certain infections caused by fungus - group of micro-organisms).Nystatin and Triamcinolone Acetonide cream USP (Nystatin and triamcinolone topical (for the skin) is a combination medicine used to treat skin infections caused by fungus or yeast)One bottle of Lactulose 10gm/15 ml Solution (Lactulose is a medication used primarily to treat constipation and conditions related to liver disease).One bottle of Chlorhexidine Gluconate oral rinse, USP 0.12% (is an antiseptic that fights bacteria).Zinc Oxide ointment (is used primarily to protect, soothe and heal the skin, also used in the prevention and treatment of skin breakdown)Latanoprost Ophthalmic solution 0.005% (is used in adults to treat certain types of glaucoma - an eye disease that causes vision loss in one or both eyes, and other causes of high pressure inside the eye).Premarin Vaginal cream (Premarin Vaginal Cream is used in the vagina to treat the vaginal symptoms of menopause such as dryness, burning, irritation, and painful sexual intercourse).Magnesium Citrate saline laxative solution (is commonly used to relieve occasional Constipation - is a common condition where you have fewer bowel movements than normal). Olopatadine Hydrochloride Ophthalmic solution USP 0.1% (Olopatadine ophthalmic (for the eye) is used to treat eye itching caused by allergies).Lantus insulin 100 units/ml (Lantus is a man-made form of a hormone (insulin- a hormone that works by lowering levels of glucose (sugar) in the blood.)Two Nystatin cream (is used to treat skin infections caused by yeast).Two Voltaren topical gel (is used to treat joint pain caused by osteoarthritis - occurs when cartilage tissue that cushions a joint wear away slowly and causes the bones to rub together in the hands, wrists, elbows, knees, ankles, or feet).Morphine sulphate oral solution 100mg per 5ml(20mg/ml). (Morphine sulphate is an opioid narcotic medication used to treat moderate to severe pain). Interview with MA J on 1/13/2026 at 10:25 a.m.; She stated that she was not the staff member who opened the medications and reported that she had been off duty. She stated that upon returning to work, she observed the medications in that condition. MA J acknowledged that all medications must be dated upon opening in accordance with facility policy and safe medication administration practices. She stated that the medications had been opened prior to her return to work. When asked about the potential risk to residents if medications are opened and not dated, she stated that without an open date, staff would not be able to determine when the medication has expired. MA J further stated that administering (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired medications could cause residents to become ill. She explained that once medications expire, their strength and effectiveness may be reduced, which could result in harm to residents. Interview with DON on 1/13/2026 at 10:38 a.m.; The DON confirmed that all medications are required to be dated upon opening in accordance with CMS regulations and facility policy. She stated that all nursing staff and MA are aware of this requirement. The DON acknowledged that the facility failed to meet this regulatory requirement. She further stated that she would initiate an in-service education immediately for all staff to address the identified deficient practice and reinforce proper medication labeling and handling procedure. Review of the facility policy and procedure titled Medication Labeling and Storage revised on 5/16/2025 revealed: All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medication.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess each resident quarterly (every 3 months) using the MDS form specified by the state and approved by CMS for 1 (Resident # 23) of 6 residents reviewed for quarterly assessments. Resident #23's most recent quarterly assessment was completed on 9/29/2025. As of 1/14/2026 at 3:30 pm, the quarterly assessment that was due on 12/30/2025 was not completed. This failure could lead to residents not receiving necessary, complete, or correct care due to lack of current information.Findings include:Record review of Resident #23's face sheet dated 1/13/2026 showed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included Type 2 Diabetes mellitus with diabetic polyneuropathy(a type of nerve damage that occurs as a complication of diabetes, primarily due to prolonged high blood sugar levels most commonly affecting the legs and feet, leading to symptoms such as pain, numbness, or tingling) , malignant neoplasm of unspecified site of left female breast (malignant breast cancer of the left breast), unspecified asthma (a disease of the airways that makes it difficult to breathe, often triggered by allergens or irritants) , paranoid schizophrenia (a part of a spectrum of related conditions that involve psychosis), other seizures (a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings, and levels of consciousness), and essential hypertension (a type of high blood pressure that has no identifiable cause).Record review on 1/14/2026 at 3:30 pm revealed that Resident #23's last quarterly MDS assessment was completed on 9/29/2025. The next quarterly assessment was due on 12/30/2025 and hadn't been completed as of 1/14/2026 at 3:30 pm.Interview with the DON on 1/14/2026 at 4:45 pm revealed that all comprehensive care plans and assessments are created and updated by MDS A. The DON stated that inaccurate care plans place residents at risk by not receiving needed services or can delay needed services to residents.The DON stated she Resident #23's quarterly MDS is past due and should have been completed in December 2025. Interview with MDS B on 1/14/26 at 1:12 pm revealed the facility was in the middle of a CHOW (change of Ownership), which resulted in the discharge of all residents. The MDS B coordinator reported having many MDS assessments to complete and explained that she is the only staff member responsible for completing them. MDS B stated that she is working as quickly as possible to complete the assessments but acknowledged that she is currently behind. MDS B further stated that once the MDS assessments are completed, they are forwarded to the Registered Nurse (RN) for review and signature. She confirms that when the MDS assessment are not completed in a timely manner, it could result in care plans that are incomplete, inaccurate, or delayed, leading to unmet needs of the residents.Interview with MDS A on 1/15/2026 at 1:26 pm revealed that she began working at the end of October 2025 and is still in training for her role as MDS nurse coordinator. MDS A stated that there was not an MDS nurse coordinator at the facility at the time she was hired at the facility. MDS A stated creating a comprehensive care plan falls under her duties and is aware that some residents do not have accurate comprehensive care plans. MDS A confirmed her understanding that CMS requires comprehensive MDS assessments to be completed within 14 calendar days of admission and the comprehensive care plan is due 7 days after the comprehensive assessment is completed. She further stated that failure to complete the MDS within the required timeframe may result in loss of Medicare reimbursement for the facility. MDS A stated she is aware that Resident #23's quarterly MDS is past due and should have been completed last month in December 2025.Record review of the facility policy titled Conducting an Accurate Resident assessment dated [DATE] reads in part.the appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. This policy did not address the frequencies of MDS assessments.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to incorporate recommendations from a PASRR evaluation report into a resident's assessment, care planning, and transition of care for 1 (Resident #20) of 4 residents reviewed for PASRR services. The facility failed to submit a complete and accurate request for NFSS in the LTC online portal within recommended time frame after the IDT meeting. This failure could place residents who were PASRR positive at risk of not getting the PASARR services for a better quality of life and could lead to a decline in healthFindings included: Record review of Resident #20's face sheet dated 01\13\26 revealed a [AGE] year-old female, admitted to the facility on 06\03\25 and readmitted on 11\25\25. Her diagnoses included: Malignant neoplasm of endometrium neurocognitive disorder with lewy bodies (is a progressive brain disorder caused by abnormal protein clumps), generalized anxiety disorder, iron deficiency anemia, other specified disorders of bone density and structure, neuralgia and neuritis, unspecified intellectual disabilities, dementia, psychotic disturbance, mood disturbance, and anxiety, muscle weakness cognitive communication deficit, difficulty in walking, chronic respiratory failure, pressure ulcer of sacral region stage 4, and chronic kidney disease, unspecified hypertensive heart and chronic kidney disease with heart failure . Record review of Resident #20's MDS annual assessment dated 11\23\25 revealed a BIMS score of 4 indicated her cognition was severely impaired. Record review of Resident #20's care plan dated revision date 12\17\25 revealed Resident #20 was PASRR positive, for intellectual disability. Goal: Resident #20 will receive specialized services/equipment/habilitative, therapies as deemed necessary through assessment and evaluation during their stay Date Initiated: 12\17\2025. Record review of Resident #20's Individualized PASRR Care Plan dated 06\26\25 to 06\26\26 indicated Resident #20 was recommended for habilitative services, Speech therapy and occupational services. Record review of intake revealed several attempts were made by PASRR office to send NFSS form to PASRR office for processing. Record review of PASRR spread sheet revealed phone call was made to the facility on 09\15\25-no answer. E-mail was sent to the facility's Administrator on 09\24\25 no response. During an interview with interim Administrator-A and Resource Manager on 01\12\26 at 10:00AM, the Resource Manager said currently the facility does not have an Administrator. She said the interim Administrator- A was called in to assist and she would talk to the Rehab Manager. During an interview with RM and Rehab Director on 01\13\26 at 11:00AM, she said she was new to the facility and did not know how the PASRR process worked. She said she sent NFSS forms, but the forms were returned several times. She said the last one she sent was returned because the physician's signature did not match due to a change within the agency. She said Resident #20 continued to receive all recommended services. She said Resident #20's services did not stop. She provided therapy notes and documentationObservation on 01\12\26 at 9:00AM revealed Resident #20 was in her room. Attempt was made to have an interview, and she answered as many questions as she could. Her speech was unclear but attempted to answer. She was observed clean. Observation indicated she had a catheter with 200CC of clear urine in the bag. Observation indicated she had a specialized wheelchair. Record review of Facility policy dated 05\05\25 Titled Resident Assessment-Coordination with PASRR Program Revealed- Policy: This facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines:1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid manual for screening.a. PASRR Level I - initial pre-screening that is completed prior to admission1. Negative Level I Screen - permits admission to proceed and ends the PASRR process unless a possible serious (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental disorder or intellectual disability arises later.ii. Positive Level I Screen - necessitates a PASRR Level II evaluation prior to admission.b. PASRR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.6. The facility designee shall be responsible for keeping track of each resident's PASRR screening status and referring to the appropriate authority.Recommendations, such as any specialized services, from a PASRR level II determination and/or PASRR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.Any level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the person-centered comprehensive care plan for 1 (Resident #23) of 6 residents reviewed for comprehensive care plan revisions. The facility failed to update Resident #23's care plan to reflect the interventions needed to address Resident #23's medical, nursing, and psychosocial needs.This failure could put residents at risk of not receiving the appropriate care, services, or treatments they need. The findings include:Record review of Resident #23's face sheet dated 1/13/2026 showed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included Type 2 Diabetes mellitus with diabetic polyneuropathy(a type of nerve damage that occurs as a complication of diabetes, primarily due to prolonged high blood sugar levels most commonly affecting the legs and feet, leading to symptoms such as pain, numbness, or tingling) , malignant neoplasm of unspecified site of left female breast (malignant breast cancer of the left breast), unspecified asthma (a disease of the airways that makes it difficult to breathe, often triggered by allergens or irritants) , paranoid schizophrenia (a part of a spectrum of related conditions that involve psychosis), other seizures (a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings, and levels of consciousness), and essential hypertension (a type of high blood pressure that has no identifiable cause). Record review of Resident #23's care plan with an initiation date of 12/1/2025 showed two areas of focus for the resident which were impaired neurological function related to a seizure disorder and the potential for adverse effects related to antianxiety medications. There were no other identified conditions or focus noted on the resident's current comprehensive care plan. Review of the MDS dated [DATE] revealed Resident #23's active diagnoses of Diabetes Mellitus, Schizophrenia, Malignant neoplasm of unspecified site of left female breast. Record review of the MDS dated [DATE] also revealed that Resident #23 was taking diuretic, antiplatelet, hypoglycemic medications. Interview with MDS A on 1/15/2026 at 1:26 pm revealed that she began working at the end of October 2025 and is still in training for her role as MDS nurse coordinator. MDS A stated that there was not an MDS nurse coordinator at the facility at the time she was hired at the facility. MDS A stated creating a comprehensive care plan falls under her duties and she is aware that some residents do not have accurate comprehensive care plans.Record review of the facility policy titled Comprehensive Care Plans with an implementation date of 6/1/2025 and a revision date of 6/2/2025, reflected the Comprehensive Care Plan will describe, at a minimum, the following: The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicablephysical, mental, and psychosocial well-being.b. Any services that would otherwise be furnished, but are not provided due to the resident'sexercise of his or her right to refuse treatment.c. Any specialized services or specialized rehabilitation services the nursing facility will provideas a result of PASARR recommendations.d. The resident's goals for admission, desired outcomes, and preferences for future discharge.e. Discharge plans, as appropriate.f. Resident specific interventions that reflect the resident's needs and preferences and align withthe resident's cultural identity, as indicated. If the resident is non-English speaking, the facilitywill identify how communication will occur with the resident. The care plan will identify thelanguage spoken and tools used to communicate.g. Individualized interventions for trauma survivors that recognize the interrelation betweentrauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used toidentify ways to decrease the resident's exposure to triggers which re-traumatize the resident,as well as identify ways to mitigate or decrease the effect of the trigger on the resident. Interview with the DON on 1/14/2026 at 4:45 pm revealed that all comprehensive care plans and assessments are created and updated by MDS A. The DON stated that inaccurate care plans place residents at risk by not receiving needed services or can delay needed services to residents.

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	01/16/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services that meet professional standards of quality as outlined by the comprehensive care plan for 1 (Resident #17) of 6 residents reviewed for services. The facility failed to ensure recommendations made by the registered dietician were followed as indicated in Resident #17's comprehensive care plan and the active physician orders. This failure could place residents at risk of not having their individual needs met and not receiving adequate nutritional and medical intervention to maintain their health and prevent worsening health conditions Findings include:Record review of Resident #17's face sheet dated 1/14/2026 revealed a [AGE] year-old female with an initial admission date of 5/21/2021. Resident #17's diagnoses included moderate protein-calorie nutrition (a condition that is characterized by a lack of sufficient energy or protein to meet the body's metabolic demands, often resulting from inadequate dietary intake or malabsorption). Record review of Resident #17's active physician orders revealed an active physician order dated 9/29/2025 that reads, may follow registered dietician recommendations. Record review of Resident #17's current care plan in place initiated on 12/8/2025 revealed an intervention that states Registered Dietician to evaluate and make diet change recommendations PRN and provide and serve supplements as ordered. Record review of Resident #17's progress notes revealed a progress note from the Registered Dietician dated 1/2/2026 that lists recommendations of sugar free shakes twice a day, weekly weights for 4 weeks, zinc sulfate 220 mg twice a day, vitamin C 500 mg twice a day, and a MVI (multivitamin) daily.Record review of Resident #17's active physician orders on 1/12/2026 did not reflect the recommendations given on 1/2/2026 by the Registered Dietitian. Interview on 1/13/2026 at 2:15 pm with Registered Dietician revealed that she emails her recommendations to the DON, ADON, and the Dietary Manager. The Registered Dietician confirmed she emailed her recommendations on 1/2/2026 to the DON, ADON, and Dietary Manager. Interview on 1/13/2026 at 3:32 pm with the DON, revealed that the ADON enters recommendations from the Registered Dietician into resident orders. The DON stated the Registered Dietician recommendations were not entered as orders due to a system email issue. The DON stated there was a change of ownership, and she did not realize that it caused a break in the process of receiving emails. The DON stated the risk to the resident included delayed wound healing, and unintentional weight loss or gain. The DON also stated that skin breakdown could occur which could lead to loss of life. Interview on 1/13/2026 at approximately 3:45 pm with the ADON revealed that she did not realize her email account was not receiving emails timely. The ADON stated that entering recommendations from the Registered Dietician is part of her duties. The ADON stated that the risk to residents of not receiving Registered Dietician recommendations could affect wound healing. Record review on 1/13/2026 at 5:00 pm revealed that recommendations given by the Registered Dietician on 1/2/2026 are now reflected in Resident #17's active orders. Record review of the facility policy on Medication Orders dated 6/15/2025 read in part .documentation of Medication Orders. Enter the new order on the MAR or ensure the new order is in the electronic MAR .