STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676450	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terra Bella Health and Wellness Suites	12262 Cityscape Ave Houston, TX 77047

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on interviews and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 1 (Resident #1) residents reviewed for environmental concerns in that: The facility failed to provide a safe, clean and sanitary resident room and wheelchair for Resident #1 on 04/20/24 when family member reported a strong smell of ammonia in the room. Resident's family member noticed the underlay that belonged in the resident's bed, and the resident's night gown were lying on the resident's wheelchair, soaking wet with urine. These failures place residents at risk of infection and safety hazards due to an unsafe, unsanitary and uncomfortable environment. Findings included: Record review of Resident #1's face sheet dated 06/10/24, revealed she was [AGE] year-old woman admitted to the facility on [DATE] with diagnoses of Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Dysphagia (difficulty swallowing), Cellulitis (deep infection of the skin caused by bacteria), Muscle wasting and atrophy (wasting or thinning of muscle mass). Record review of Resident #1's quarterly MDS dated [DATE], revealed the resident's BIMS score was 0, which indicated severe cognitive impairment. Resident #2 used a wheelchair and was dependent on staff for all ADL's. Record review of Resident #1's care plan revealed, she had contractures and was at risk for skin break down, increased pain from affected areas and injuries. Interventions included being provided pressure relieving devices on beds and chairs. She had impaired communication evidenced by reduced ability to understand others. Interventions included reducing or removing all interfering environmental stimuli. The resident had functional incontinence of bowel and bladder due to impaired cognition, related to Dementia. Interventions included monitoring for incontinence per routine rounds and as needed, changing briefs promptly and applying protective skin barrier. She required assistance with ADL's due to impaired cognition, impaired mobility and incontinence of bowel and bladder. Interventions included extensive 1-2 person assist with bed mobility, dressing, toileting and transfer. (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes did not reveal any incidents regarding soiled items in the resident's room. Record review of Grievance Summary, dated 04/20/24, revealed the following: Weekend Supervisor reports RP made c/o strong urine from the resident. She stated the source of the odor was her gown and bed pad . Summary of Actions Taken: Resident changed and cleaned up .staff member swapped out for another aide on the unit immediately by the weekend supervisor. In an interview with Family Member on 06/06/24 at 8:43 AM, said Family Member B arrived at the facility on the morning of Sunday, 04/21/24, and there was a strong smell of ammonia in the room. She said the Family Member B noticed the underlay that belonged in the resident's bed, and the resident's night gown were lying on the resident's wheelchair, soaking wet with urine. She said the Family Member B called her and told her what was going on. She said she told Family Member B to look for the Weekend Supervisor, but Family Member B could not find the supervisor. She said she called the weekend supervisor and asked her to go to the resident's room to see what was going on. She said the weekend supervisor went down to the resident's room, and she headed to the facility to see what was going on for herself. She said when she arrived at the facility, the resident had been changed, but her mattress and cover were soaking wet. She said she used the alcohol based and Clorox wipes the facility used to sanitize the mattress. She said she told the Weekend Supervisor she wanted to file a grievance. She said she did not know who was responsible for leaving the resident's room in that condition. She said she was told there was a new aide working that day. She said from what she could tell, the new aide changed the resident's brief, but put the resident back on the soaking wet mattress and cover. She said she did not know the new staff's name. She said she tried to have a conversation with the aide about what had occurred, but no longer felt comfortable speaking to her without facility management present. She said another aide that was working at the other end of the resident's hall introduced herself and informed her she would be the aide providing care to the resident for the rest of the shift. She said she wanted to know what really happened and who left the resident lying in urine and with urine-soaked items in her room. In an interview with the Social Worker on 06/10/24 at 11:20 AM, she said she became aware in the incident with Resident #1 because every grievance entered in the facility's new electronic filing system was automatically sent to her. She said the DON also verbally let her know the DON put the grievance from the resident's family member in the system, handled the situation and closed the grievance out in the system. She said the DON mainly gave her an FYI to let her know the grievance had been filed. She said if she was informed about the situation first, she would have been the one to enter the grievance, and let the DON handle it because it would have been a nursing concern. She said the family member did not discuss anything regarding the incident or grievance with her, other than asking for a copy of the grievance. She said she could not recall specifics from the grievance but could access the electronic form. She said the grievance showed the incident on 04/20/24, and not 04/21/24. She said the grievance form was completed by the DON. She said the grievance form said 'resident was changed and cleaned up, bed lowered, and staff member swapped out for another immediately. All care concerns addressed, apologies extended to the responsible party, and education had been provided to the responsible staff.' She said the Weekend Supervisor would have been the staff to address the immediate concerns, extend apologies and at least start education for staff, if it was necessary, since she was working when the incident occurred. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN A on 12:50 PM 06/10/24, she said she did recall there was an incident where the resident's sister asked her questions about the resident's room. She said she could not remember the exact date this occurred. She said she did work on the weekends sometimes too. She said she did work on 04/20/24 and 04/21/24. She said she came into work at 7:00 AM and started her rounds on her residents. She said the day Resident #1's family member was asking questions, she remembered rounding on the resident's room, and she did not notice any foul odors. She said the resident was also dry and clean when she saw her. She said later that morning, a family member asked RN A if the resident had been changed and mentioned a soiled sheet that was left on the resident's wheelchair. She said the Weekend Supervisor was also notified of the incident. She said there was a new aide working with the resident that day. She said she went and looked at the resident after being alerted by family member, and the resident was still dry and clean. She said the aide did forget to remove the soiled linen from the resident's wheelchair. She said the soiled sheet was the only thing left behind on the wheelchair. She said the resident's bed was not wet either. She said the new aide said she just forgot to pick the sheet up after getting the resident changed. She said she did not know what else was done because the Weekend Supervisor handled the situation. In an interview with the Weekend Supervisor on 06/10/24 at 1:14 PM, she said RN A was the nurse responsible for the resident's care on 04/20/24, and the aide working at the time was new. She said it was the aide's first time out on the floor after finishing orientation. She said got a telephone call from Resident #1's family member. She said the family member told her she needed to go and see how they (the staff) left the resident. She said she thought the family member was implying the resident was soaked in urine at that time. She said she went to Resident #1's room to speak to the family member at the facility. She said the family member told her the resident was clean, but the room smelled like ammonia or urine. She said the family member also said there was a nightgown and sheet soaked in urine. She said the nightgown was in the closet at this point, but the sheet was still in the wheelchair, when she made it to the resident's room. She said she called RN A into the resident's room to hear the family's concerns too. She said the family member's actual complaint was about the smell permeating through the room and the soiled sheet. She said the new aide told her she did not remember putting the soiled items on the resident's wheelchair, or in her closet. She said she was not able to determine who left the items left in the resident's wheelchair. the aide said she did not remember placing the items in the wheelchair or the closet that day. She said she could not track down how old the urine on the items in question, was. She said she spoke with the overnight aide who was new also. She said the overnight aide told her she left the resident clean and dry before handing the shift over to the aide on the morning of 04/20/24. She said the gown that was found soiled in urine, was the gown she placed on the resident to wear for the day on 04/20/24. She said the overnight aide told her Resident #1 had the gown on the last time she saw the resident before the end of her shift. She said the aide working the day shift on 04/20/24 could have been overwhelmed because it was her first time out on the floor. She said the new aide could have forgotten to grab those two items to take them to laundry. She said she did not recall beginning any inservices or training with aides, but she did the investigative groundwork. She said she did speak with RN A about doing a thorough check on the residents to ensure they were clean, dry and in good condition. She said she also spoke to RN A about following up with the aides if she found anything out of place with the residents while doing rounds. She said Resident #1 was at risk of biohazard waste exposure, but the resident was not compromised or in any sort of distress at the time of the incident. She said the resident was laying on her left side, peacefully in her bed. She said she did not feel the resident was placed at any sort of risk because there was no need for any sort of medical interventions due to the urine on the items in the room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA A on 06/10/24 at 1:44 PM, she said she did not remember the exact date the incident occurred. She said she was working on the back of the 400 hall when Resident #1's family member stepped out of the room and asked CNA A if she was the resident's aide and she told the family member no. She said the family member asked the CNA to come into Resident #1's room. She said the family member showed CNA A the pad that had urine on it. She said she got the pad and took it to the linen room to be washed. She said she also went ahead and changed the resident's brief too. She said when she changed the resident, she was not wet or soiled, nor was her bed. She said the issue was the wet pad. She said sometimes the pads were in the bed with the resident and sometimes they were in the wheelchair because they were for the resident to sit on. She said this happened around 9:00 AM or 10:00 AM. She said the aide that worked overnight would have been CNA B. She said she could not remember the new aide's name. She said the new aide no longer worked at the facility. In an interview with the Administrator on 06/10/24 at 2:10 PM, she said she could not remember the incident with Resident #1 off the top of her head, but she went through each of the grievances with the Social Worker. She said she was not sure whether any training or inservices were done following the incident on 04/20/24. She said they were using a new electronic system to file their grievances and they were in the process of training all of the departments to upload any re-education documents and curriculum to go along with re-education being mentioned in a grievance as part of a resolution. She said she would have to go and review documentation to verify whether the aides working at the time were re-educated on anything after the incident. She said the DON was no longer working at the facility and she was the one who handled this grievance specifically. She said she was glad the soiled items were not on the resident's body or bed. She said the items should have immediately been discarded or taken to laundry. She said whoever was providing care to the resident at the time, should have been bagged the linens and handled them. She said she was not there on the weekend, so she was not sure what was done to rectify the situation. She said the weekend supervisor would have handled everything from beginning to end; customer service with the family, beginning re-education, if necessary, and looking into what occurred. She said the Weekend Supervisor would have also followed up with the DON to ensure she was aware, and the situation was handled appropriately as well. She said there would have been an odor and she did not want the resident at risk of being exposed to the smell of urine. Record review of the facility's Policies and Procedures titled General Cleaning dated 03/2006 stated that: This routine procedure will clean and disinfect patient/resident rooms and patient/resident bathrooms thereby providing a clean, safe decontaminated environment for our patients/residents. When Used: This is a daily routine cleaning procedure. Spot cleaning may be repeated as required. Expected Results: Patient/resident rooms and bathrooms that are clean, sanitary odor free and safe .