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	02/07/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity, for 1 (Resident #1) of 5 reviewed for privacy and dignity in that: The wound care nurse announced outside of Resident #1's door that she needed to go in to do wound care on his sacrum. This failure could place residents at risk for embarrassment and lower self-esteem. Findings Included: Record review of Resident #1's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses : Quadriplegia(loss or impairment of movement in all four limbs), chest pain, cardiovascular disorder(heart condition that include diseased vessels), lack of coordination, methicillin resistant staphylococcus aureus infection(bacterial infection that is resistant to several antibiotics), bipolar(a disorder associated with episodes of mood swing), insomnia(a common sleep disorder) ,essential hypertension (a chronic, life-long condition of elevated blood pressure), bilateral hand contracture((a condition that causes the skin in the palm to thicken and tighten), muscle wasting and atrophy of right and left shoulders (a condition where the muscles in the shoulder gradually shrink and lose muscle mass) , neuromuscular dysfunction of bladder(condition where the nerves controlling bladder function are damaged). Record review of Resident #1's MDS assessment dated [DATE] revealed: Section C500- Brief Interview of mental status was coded as 15 (which represented cognitively intact). Section GG0115- Functional Limitation in Range of Motion: Upper body and lower body extremities was coded (2)- impairment on both sides. Section GG0120- Functional Abilities revealed eating, oral care, toileting, showers and upper/lower body dressing was coded as (1) dependent. Section M0200- Skin Condition revealed A. Resident has a pressure ulcer; B. Formal assessment instrument; C. Ostomy were all checked for all applied. Risk for pressure ulcer 1. Yes (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unhealed pressure sore 1. Yes 1. Number of stage 4 pressure ulcers had (1) meaning one stage 4 2. Number of stage 4 pressure ulcers present upon admission (1) Section M1200-Skin Condition revealed Resident #1 to have pressure reducing device for bed, pressure ulcer care provided and application of nonsurgical dressing. Record review of Resident #1's care plan dated 1/20/2025 revealed: Problem: Pressure Ulcer/injury- Resident #1 has a Stage 4 pressure injury to his sacrum Goal: Resident #1 ulcer will decrease in size and will not exhibit signs of infection as evidenced by wound documentation for 90 days. Approach: Assess, evaluate, and treat pain each shift, prior to dressing changes and during wound care. EBP during wound care or close contact with wound. PPE required: gloves, gowns, face protection if procedure has risk of splashes or sprays. Licensed nurse to complete wound observation weekly. Observation and interview on 2/7/2025 at 11:08 am revealed the Wound care nurse entered Resident #1's room and announced the wound care she would be providing and asked if he was okay for the Surveyor to observe the care. He agreed. Then, she went back to her cart that was located outside of his room. After she prepared all the supplies to provide the wound care, she knocked on the half-opened door and announced from the hallway before entering the room, that she was coming in to do the wound care on his sacrum. An interview with the Wound Care Nurse on 2/7/2025 at 11:49 am revealed when she was asked about announcing Resident #1's care from the hallway, at first, she denied that she had said anything. Then, she said, I did? She said it was never okay to discuss a resident's care from the hallway. She said it could cause him to be embarrassed. She said she was just nervous. She said when Resident #1 did not respond for her to enter, she repeated her announcement. She stated she did not want to enter his room without the resident saying it was okay to enter. An interview with Resident #1 on 2/7/2025 at 11:54 am revealed he did not know she had announced his wound care from the hallway. He said he must not have heard her. He said he would not want everyone on his hall to know his business. An interview with the Administrator on 2/7/2025 at 5:07 pm she said she would have to ask the WCN if she had indeed announced his care from the hallway, but that would be a dignity concern. She said it could cause the residents embarrassment. She said she could not speak on the incident because she needed to speak with the nurse about it. Record review of Resident Rights policy Section XI revised June 2017 revealed the facility will provide the patient/resident with his/her right to privacy and security. 1. Provided the patient/resident with visual and auditory privacy in at least the following activities: B. In conversations C. During treatment.

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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** 25263 Based on observation, interview, and record review, the facility failed to establish and 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 one of five residents (Resident #1) reviewed for infection control and prevention, in that: -The facility failed to ensure the Wound Care Nurse properly performed clean wound treatment for Resident #1 on 02/07/2025. This failure placed residents with pressure ulcers at risk for infection, prolonged healing, and hospitalization . Findings included: Record review of Resident #1's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses : Quadriplegia (loss or impairment of movement in all four limbs), chest pain, cardiovascular disorder (heart condition that include diseased vessels), lack of coordination, methicillin resistant staphylococcus aureus infection (bacterial infection that is resistant to several antibiotics), bipolar (a disorder associated with episodes of mood swing), insomnia, essential hypertension (a chronic, life-long condition of elevated blood pressure), bilateral hand contracture (a condition that causes the skin in the palm to thicken and tighten), muscle wasting and atrophy of right and left shoulders (a condition where the muscles gradually shrink and lose muscle mass) , neuromuscular dysfunction of bladder (condition where the nerves controlling bladder function are damaged). Record review of Resident #1's MDS assessment dated [DATE] revealed: Section C500- Brief Interview of mental status was coded as 15, which indicated, cognitive intactness. Resident #1 was totally dependent on staff for all activities of daily living. Section GG0115- Functional Limitation in Range of Motion: Upper body and lower body extremities was coded (2)- impairment on both sides. Section GG0120- Functional Abilities revealed eating, oral care, toileting, showers, and upper/lower body dressing was coded as (1) dependent. Section M0200- Skin Condition revealed A. Resident has a pressure ulcer; B. Formal assessment instrument; C. Ostomy were all checked for all applied. Risk for pressure ulcer 1. Yes Unhealed pressure sore 1. Yes 1. Number of stage 4 pressure ulcers had (1) meaning one stage 4 2. Number of stage 4 pressure ulcers present upon admission (1) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section M1200 Skin Condition- revealed to have pressure reducing device for bed, pressure ulcer care provided and application of nonsurgical dressing. Section H0100 revealed he is incontinent of bowel and bladder. Record review of Resident #1's care plan dated 1/20/2025 revealed: Problem: Pressure Ulcer/injury- Resident #1 has a Stage 4 pressure injury to his sacrum Goal: Resident #1 ulcer will decrease in size and will not exhibit signs of infection as evidenced by wound documentation for 90 days. Approach: Assess, evaluate, and treat pain each shift, prior to dressing changes and during wound care. EBP during wound care or close contact with wound. Personal Protective Equipment (PPE) required: gloves, gowns, face protection if procedure has risk of splashes or sprays. Licensed nurse to complete wound observation weekly. Record review of wound treatment order for Resident #1 dated 1/15/2025-1/30/2025 revealed: Daily treatment: Stage 4 pressure injury to sacrococcygeal- Negative Pressure Wound Therapy (NPWT) dressing change every Monday & Thursday by wound care nurse. Pro re nata (PRN) Wound Treatment- Stage 4 pressure injury sacral - Cleanse with normal saline, pat dry with sterile gauze, apply alginate with silver and cover wound with bordered foam. Record review of resident # 1's wound management measurement reveals the following measurements: 01/16/2025. Length 7 cm, width 5 cm and depth 1.1 cm. 01/23/2025. Length 7 cm, width 5 cm, and depth 1.8 cm. 01/30/2025 Length 7 cm, width 4.5 cm, and depth 1.5 cm 02/06/2025. Length 6 cm, width 4 cm, and depth 2 cm. During an observation of Resident #1's wound care on 02/07/2025 at 11:08 am, the Wound Care Nurse was assisted by LVN A. She checked the orders. Knocked on the door, went in introduced herself and explained she will be doing wound care. She cleansed the sterile field on the over-bed table. Allowed the sterile field to air dry. Applied a drape on the sterile field. Gathered the required supplies with the same gloves she uses to open the treatment cart drawers. She doffed her gloves, she sanitized her hands but was not letting them dry off. She sanitized the scissors and pen she used. Put on treatment gown. Knocked on the door a second time to go in with the sterile field. This time still standing outside the door, she said, I am coming to do your treatment on the sacral area. Privacy provided by closing door and window. Performed hand washing, and don gloves. LVN A, also performed hand washing and donned gloves. LVN A, rolled Resident # 1 on his left side, reposition the indwelling catheter foley bag and removed the wedge from underneath the resident. Wound Care Nurse, with clean gloves, took off the old dressing and discarded it in a trash. She doffed gloves, sanitized hands; not letting her hands dry. She donned gloves with difficulty because she did not let the sanitizer dry. Wound care nurse cleaned the wound in a circular motion, using separate moist gauzes for each area. Wound care nurse dried from outer to inner part of the wound. She did not doff her gloves to don clean gloves to apply wound treatment and dressing. She used the same gloves from patting the wound bed to applying treatment and dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Wound care nurse on at 02/07/2025 at 11:57 am, after wound treatment for Resident # 1, she denied that she followed the facility protocol. She agreed she did not change her gloves. She stated she used the same gloves used in drying and touching the wound bed to apply treatment and dressing because that was how she was taught. She stated the facility's pre-mock survey nurse told her she did not have to change her gloves if it was the same wound. She said the consequences of not changing gloves during wound care could re-infect the wound causing prolonged healing time. She also agreed that she made an error not allowing her sanitized hands to dry prior to donning gloves. During an interview with the Nurse Consultant on 02/07/2025 at 01:52 pm, she stated she had been in that position for two years . She said she came to the facility 2-3 days a week. She said, I would think they would do hand hygiene, change gloves after cleansing the wound bed, prior to applying treatment and dressing. She said the facility was following a policy which came from a nursing book. She said the Wound Care Nurse should be following the company's policy. Record review of facility's wound care checklist dated 7/1/2013 provided by the Nurse consultant revealed the following performance criteria: Explain procedure to resident, provide privacy, wash hands, put on disposable gloves and PPE as necessary. Position resident comfortably, drapes to expose only wound site. Instructs resident not to touch wound supplies. Assembles equipment. Removes all dressing. Inspects wound, notes any odors, measures as needed. Discards old dressing and gloves appropriately. Wash hands. Prepares sterile field on over-bed table. Prepares dressing. Puts on sterile gloves. Cleanses wound as ordered, from least contaminated to most. Uses dry gauze to pat wound bed from center outwards. Applies dressing. Dispose soiled equipment and supplies properly. Assist resident to comfortable and safe position. Remove gloves and PPE, wash hands. Document as appropriate.