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	04/25/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 (Resident #1) of 17 residents reviewed for food form. The facility failed to ensure Resident #1 was served a pureed (blended or mashed to a smooth pudding like consistency) lunch tray on 03/28/2025 as ordered by her physician. Resident #1 was served a mechanical soft (soft chopped, ground foods) lunch tray. This failure could place residents at risk of consuming foods that could cause aspiration (food or liquids enter the airway) or choking. Findings included: Record review of Resident #1's face sheet (undated) revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included dysphagia (difficulty swallowing foods or liquids). Record review of Resident #1's annual MDS assessment (a standardized assessment to collect data on residents' health, functional status and care needs) dated 02/05/2025 revealed Resident #1 rarely or never made herself understood. Resident #1 rarely or never had the ability to understand others. Resident #1's BIMS (test used to evaluated cognitive function) was unable to be scored. The resident's Cognitive Skills for Daily Decision Making was scored at three which indicated her cognition was severely impaired. The resident rarely or never made decisions. The MDS revealed Resident #1 required substantial to maximum assistance to eat. Resident #1's active diagnoses included dysphagia. The MDS read Resident #1's Nutritional Approaches were mechanically altered diet included pureed. Record review of Resident #1's care plan problem 'start' dated 02/06/2025 and edited 03/14/2025 revealed the following: Problem: Resident #1 was at risk of choking and aspiration related to difficulty swallowing. Goal: Resident #1 would not choke or aspirate. Approach: Monitor Resident #1's diet consistency. Speech Therapy to evaluate as needed. (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan problem 'start' dated 02/06/2025 and edited 04/15/2025 revealed the following: Problem: Resident #1 received regular pureed diet. Goal: Resident #1 would have adequate nutrition and fluid intake. Approach: Serve diet as ordered Record review of Resident #1's nurses progress notes by RN A dated 03/28/2025 read in part .Entered Resident #1's room. Observed the resident was delivered the wrong consistency tray. The tray was removed. The tray was taken to the kitchen. The dietary manager was notified. The CNA told the ADON she may have had four bites. The food was removed from Resident #1's mouth. had no signs or symptoms of coughing, choking, gagging, wheezing, difficulty breathing, vomiting or drooling. The resident's physicians' team was notified. Record review of Resident #1's physician order report dated 04/01/2025- 04/30/2025 revealed pureed diet with diagnosis of dysphagia. The Order was dated 02/27/2024. In a phone interview on 04/23/2025 at 11:09 AM, the RD stated he was notified Resident #1 was delivered a diet that was not pureed. The RD stated Resident #1 had not swallowed the food. The RD stated the tray was removed, and the issue was corrected. The risk to the resident was aspiration. During a phone interview on 04/23/20255 at 12:01 PM, Resident #1's family member stated one day Resident #1 received a mechanical soft tray in place of a pureed diet. Resident #1's family member stated her mouth was cleaned with a towel. In a phone interview on 04/25/2025 at 8:15 AM, the Dietary Aide stated the cook put the food on the plates. The Dietary Aide stated she was rushed, she read the ticket wrong and picked up a mechanical soft plate not the pureed plate for Resident #1. The Dietary Aide stated she was the one responsible for putting the incorrect plate on the tray. The Dietary Aide stated this occurred during lunch when fixing the hall trays. She continued the interview and stated the risk to the resident was choking, she would slow down and fix Resident #1's tray first. During an interview on 04/25/2025 at 11:08 AM, CNA C stated the lunch trays were delivered. CNA C stated she believed the trays were already checked by RN A because she did not see the nurse in the hall when she took the tray off the cart. Most the time they communicated orally. CNA C stated she removed the tray for Resident #1 and went to her room. CNA C stated Resident #1 was sitting up in her chair and she gave her one bite. CNA C continued she attempted to give the resident a second bite, but she squeezed her lips together. CNA C stated RN A came in the room and stated the resident had the wrong tray. The CNA stated RN A checked the resident. The resident was alert, breathing good and not coughing. CNA C stated RN A removed the tray from the room and the ADON came into the room. CNA C stated she thought the RN did check the trays. CNA C stated she did not see the ticket on the tray. CNA C stated the nurses review the resident's care with the CNA's in the morning. The CNA continued and stated she the risk to the resident was aspiration . (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/2025 at 11:17 AM, RN A stated she was in a resident's room when the lunch trays arrived. RN A stated she left the resident's room and saw the lunch cart on the 400 hall. RN A stated she went in to Resident #1's room, she saw CNA C was feeding the resident the wrong diet with the correct meal ticket. RN A stated she removed the tray and assessed the resident. RN A stated Resident #1 was not having any changes in her level of alertness or breathing. RN A stated she reported to the ADON and took the tray to the kitchen and reported to the dietary manager. RN A stated she returned to the room the ADON was with the resident. RN A reported they cleaned the resident's mouth to remove any food. RN A stated she did not swallow anything. RN A stated the pureed diet arrived and the resident ate her lunch. RN A stated the nurse was responsible for making sure the correct diet was provided to the resident. RN A stated the kitchen provided the meals to the units, the nurse was to check the tray with the meal ticket before the CNA passed the tray to the resident. Risk to the resident was aspiration, choking and death. During an interview on 04/25/2025 at 11:54 PM, the Dietary Manager stated when the kitchen staff prepared the tray for Resident #1 our staff put the wrong plate on the tray. The Dietary Manager stated the nurses on the floor were to make sure the trays and the tickets were correct before it was served. The Dietary Manager stated the dietary aide was responsible for making sure the correct plate was with the correct meal ticket. The Dietary Manager stated the Dietary aide was rushed. The Dietary aide was in-serviced and disciplined. The Dietary Manager stated the risk was choking and stated she takes pictures of the trays before leaving her kitchen. During an interview on 04/25/2025 at 12:01 PM, the ADON stated RN A was in a room with another resident when the lunch trays arrived on the unit. The ADON stated the RN saw the trays were being passed. The ADON stated RN A notified her of the incident and she went into the room Resident #1 was sitting up in the chair we cleaned her mouth. The ADON stated the resident was assessed, she was at her normal alertness, she had no tearing, shortness of breath, facial redness, drooling, or breathing changes. She ate her normal tray when it arrived. The ADON stated responsibility for making sure the correct tray and meal ticket matched started in the kitchen, then the nurses on the units and the CNA before feeding the resident. The ADON stated the physician was notified, they got a stat (immediate) chest x-ray, respiratory assessment, swallowing assessment, speech assessment and MBSS (modified barium swallowing study) (A special x-ray to evaluate swallowing function and if food is getting into the lungs). In an interview on 04/25/2025 at 12:16 PM, speech therapist stated she was called in to evaluate Resident #1 because the resident received the wrong food. The speech therapist stated the ticket was correct but the plated food was not. The speech therapist stated she had been assessing the resident since this occurred. The risk to the resident could have been aspiration. During a phone interview on 04/25/2025 at 12:36 PM, Resident #1's physician stated the physicians were notified of the incident on 03/28/2025. The physician stated a chest x-ray was ordered, speech therapy and swallowing studies were ordered. The physician stated the risk to the resident could have been an aspiration event. In an interview on 04/25/25 at 1:44 PM, the DON stated she was told that this occurred prior to her employment. The DON stated the plan was to double check the meal before serving to prevent this again. The DON stated the risk could have been aspiration or choking. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/25/2025 at 2:02 PM, the Administrator she stated the dietary aide did not put the plate on the tray that matched the ticket. The Administrator stated the tray was not checked prior to the CNA starting to feed the resident. The Administrator stated it was caught and handled immediately. The Administrator stated responsibility for the correct diet was with dietary services, the nurses, and the CNA. The Administrator stated the risk was choking.