

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2025
NAME OF PROVIDER OR SUPPLIER Terra Bella Health and Wellness Suites		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to protect the resident's right to be free from abuse, neglect, and exploitation for 1 of 5 residents (CR #1) reviewed for neglect.-The facility failed to have structures and processes in place to ensure CR #1's wound was identified, and interventions were implemented. CR #1, who had PAD (a specific form of PVD in which there is narrowing of blood vessels taking blood to the extremities, leading to low or no oxygen), diabetes and a previous right-side AKA, did not receive podiatry services and nail care from admission on [DATE] until she discharged to the hospital on [DATE] (9 months). CR #1's had a wound to her left big toe documented in weekly skin assessments from 01/29/25 until 06/17/25, and there were no interventions implemented prior to hospitalization. At the hospital, CR #1 was diagnosed with gangrene and osteomyelitis (bacterial bone infection), with a recommendation for a left side AKA and ultimately placed on hospice services. An Immediate Jeopardy (IJ) was identified on 07/10/2025. The IJ template was provided to the Administrator on 07/10/2025 at 12:44 PM. While the immediacy was removed on 07/14/2025 at 3:18 PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of decline in health, infection, amputation, and death. Findings included: Record review of CR #1's Face Sheet dated 06/22/25 revealed, a 69-year-old female who admitted to the facility on [DATE] at 12:45 PM with diagnoses which included: Alzheimer's Disease, unspecified dementia with anxiety, hypertension (high blood pressure), acquired absence of right leg above knee (right above the knee amputation) and type 2 diabetes with other circulatory complications. Diagnosis of open wound of left great toe without damage to nail was added on 06/15/25; and unspecified wound, left foot initial encounter was added on 06/16/25. There was no documented diagnosis of PVD. Record review of CR #1's Quarterly MDS dated [DATE] revealed, severely impaired cognitive skills for daily decision making, resident was unable to complete a brief interview of mental status, lower extremity functional limitation in range of motion. CR #1 needed substantial/maximal assistance to : roll left and right, move from sitting to lying and lying to sitting on side of bed, was totally depended on to transfer from chair to bed and vice versa, evaluation of her ability to walk 10 ft, toilet transfer, tub/shower transfer or go from sit to stand was not attempted due to her medical condition or safety concerns. Active diagnoses of anemia, hypertension, diabetes, hyperlipidemia (high cholesterol), Alzheimer's Disease, seizure disorder, depression; there were no diagnosis of PVD or any circulatory complications. Record review of CR #1's undated Care Plan revealed, Focus- risk of falls due to immobility, muscle weakness and diabetes; Problem- CR #1 will be free from injury; approach- encourage resident to use environmental devices such as hand grips, handrails etc. Problem start date of 06/13/25- CR #1 has a diabetic ulcer to the left great toe; Goal target date 09/13/25- resident's wound will decrease in size with no complications as evidenced by wound documentation; Approach start date 06/13/25- nurse to complete wound documentation daily, refer to wound care doctor as needed, wound team to evaluate wound(s), treatments and healing status weekly. Problem start date of 06/16/25- CR#1 has trauma to left great toe; Goal target date: 09/16/25- wound will decrease in size as evidenced by wound documentation with no complications and comfort will be maintained; Approach start date: 06/16/25- CNA to inspect skin, especially over bony prominences, during bathing and personal care. Nurse to complete wound observation weekly. There was no mention of podiatry care or services or her vascular disease. Record review of CR #1's Physician's Orders revealed, Start Date 09/18/24; Description- Consult: Podiatry, Ophthalmology, dental as needed .Record review of CR #1's Progress Notes from admission on [DATE] to discharge on [DATE] revealed, There was no documentation that CR #1 received podiatry care while at the facility with the following relevant entries included:-09/17/24 at 12:45 PM signed by LVN L- resident's skin is warm to touch, dry and no fresh injuries. The resident had an old scar from the above knew amputation. The resident requires assistance with feeding and is total care. -09/19/24 at 07:00 PM signed by Wound Nurse A- New admission skin assessment completed. Patient's skin intact and dry. Patient has a right knee amputation, old scar intact and dry, left lower leg has old scares, left great toe has old scab 0/8X0.5X0.1 cm, no exudate, no pain, no odor or s/sx of infection.-06/12/25 at 11:27 PM signed by LVN D: upon assessment, the resident's left great toes appears bruised. No signs or symptoms of pain noted. Foot pulses were felt, no sign of compromised circulation. Foot is warm and dry to touch -06/13/25 at 02:06 PM signed by Wound Care Nurse</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 5 residents (CR #1) reviewed for accuracy of assessments. - The facility failed to identify CR # 1's diagnosis of vascular diseases (narrowing of the blood vessels that result in oxygen not getting sent to the limbs also called PVD) and document it in her MDS(s) which resulted in CR #1 not having a plan of care for her diagnosis. These failures could place residents at risk of a compromised plan of care, worsening of health conditions, infection, injury, and amputation. Findings include: Record review of CR #1's Face Sheet dated 06/22/25 revealed, a 69-year-old female who admitted to the facility on [DATE] at 12:45 PM with diagnosis which included: Alzheimer's Disease, unspecified dementia with anxiety, hypertension (high blood pressure), acquired absence of right leg above knee (right above the knee amputation) and type 2 diabetes with other circulatory complications. Diagnosis of open wound of left great toe without damage to nail was added on 06/15/25; and unspecified wound, left foot initial encounter was added on 06/16/25. There was no documented diagnosis of PVD. Record review of CR #1's Quarterly MDS dated [DATE] revealed, severely impaired cognitive skills for daily decision making, resident was unable to complete a brief interview of mental status, lower extremity functional limitation in range of motion. Active diagnoses of anemia, hypertension, diabetes, hyperlipidemia (high cholesterol), Alzheimer's Disease, seizure disorder, depression; there were no diagnosis of PVD or any circulatory complications. Record review of CR #1's undated Care Plan revealed, Focus- risk of falls due to immobility, muscle weakness and diabetes; Problem- CR #1 will be free from injury; approach- encourage resident to use environmental devices such as hand grips, handrails etc. Problem start date of 06/13/25- CR #1 has a diabetic ulcer to the left great toe; Goal target date 09/13/25- resident's wound will decrease in size with no complications as evidenced by wound documentation; Approach start date 06/13/25- nurse to complete wound documentation daily, refer to wound care doctor as needed, wound team to evaluate wound(s), treatments and healing status weekly. Problem start date of 06/16/25- CR#1 has trauma to left great toe; Goal target date: 09/16/25- wound will decrease in size as evidenced by wound documentation with no complications and comfort will be maintained; Approach start date: 06/16/25- CNA to inspect skin, especially over bony prominences, during bathing and personal care. Nurse to complete wound observation weekly. there was no mention of podiatry care or services or her vascular disease. Record review of email communications between the Social Worker and Medical Records dated 07/09/25 revealed, CR #1 had no documented visits or services with podiatry. An observation of pictures of CR #1's left foot dated 06/13/25 at 03:14 PM revealed, resident's foot was dry and flaky. Toenails on her three lesser toes were long and curled around the tip of her toes; with an appearance that they had not been cut for months. Bruising was observed to the upper foot by the great toe and a thick deep callus with a dark/black hole in the center. Her great toenail was thickened and yellow but attached to the nail bed. An observation of pictures of CR #1's left foot dated 06/16/25 at 06:33 PM revealed, the skin on the tip of her left toe to be open. The wound to the tip was shiny and red, with dry blood on the nail bed under the nail. Her left great toenail appeared to be lifted off the nail bed with visible dry black blood under. An observation on 06/22/25 at 05:00 PM revealed, CR #1 lying in a hospital bed. The resident had no leg on the right side and her left foot was surrounded with a dressing, the tip of her great toe was exposed and red irritated skin with a circular callused area visible. CR#1 was confused and non-interviewable; she reference people and things that were not in the room. In an interview on 07/08/24 at 02:41 PM, the Hospital Podiatrist said CR #1 had significant history of PVD that resulted in her having an AKA on her right leg in 08/2024, and her vascular disease was so significant it caused her severe dementia. He said a resident with history of diabetes, PVD and a previous AKA should have had routine podiatrist visit. The Hospital Podiatrist said in the hospital CR#1 was diagnosed with osteomyelitis (bacterial bone infection) that needed to be treated with IV antibiotics in order to save the limb. He said routine podiatry would have prevented the acute traumatic event (toe infection) but due to her extensive PVD, CR#1 would have eventually needed an amputation in the future. The Hospital Podiatrist said from what he saw CR #1's left great toenail was lifted from the nail bed but there was no active or raging infection visible, the resident's WBCs were normal, and she did not have a fever during her entire stay. He said since an AKA would not better the CR#1's quality of life and the residents significant dementia, CR #1's family decided to place her on palliative (end of life) care. In an interview on 07/14/25 at 01:36 PM the MDS coordinator said she was responsible for completing MDS assessments for</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a residents' mental, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 Residents (CR #1) reviewed for care plans. - The facility failed to develop and implement a plan of care for CR #1's PAD (a specific form of PVD in which there is narrowing of blood vessels taking blood to the extremities, leading to low or no oxygen), which resulted in CR #1 not receiving podiatry care from admission on [DATE] till she discharged to the hospital on [DATE] (9 months) where she was diagnosed with a osteomyelitis (bacterial bone infection), with a recommendation for a left side AKA and ultimately placed on hospice services. An Immediate Jeopardy (IJ) was identified on 07/09/2025. The IJ template was provided to the Administrator on 07/09/2025 at 04:57 PM. While the immediacy was removed on 07/14/2025 at 3:18 PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not having their needs met, injuries, infections, unwanted hospitalization, amputation leading to a decrease in quality of life and death. Findings include: Record review of CR #1's Face Sheet dated 06/22/25 revealed, a 69-year-old female who admitted to the facility on [DATE] at 12:45 PM with diagnosis which included: Alzheimer's Disease, unspecified dementia with anxiety, hypertension (high blood pressure), acquired absence of right leg above knee (right above the knee amputation) and type 2 diabetes with other circulatory complications. Diagnosis of open wood of left great toe without damage to nail was added on 06/15/25; and unspecified wound, left foot initial encounter was added on 06/16/25. There was no documented diagnosis of PVD. Record review of CR #1's Quarterly MDS dated [DATE] revealed, severely impaired cognitive skills for daily decision making, resident was unable to complete a brief interview of mental status, lower extremity functional limitation in range of motion. CR #1 needed substantial/maximal assistance to : roll left and right, move from sitting to lying and lying to sitting on side of bed, was totally depended on to transfer from chair to bed and vice versa, evaluation of her ability to walk 10 ft, toilet transfer, tub/shower transfer or go from sit to stand was not attempted due to her medical condition or safety concerns. Active diagnoses of anemia, hypertension, diabetes, hyperlipidemia(high cholesterol), Alzheimer's Disease, seizure disorder, depression; there were no diagnosis of PVD or any circulatory complications. Record review of CR #1's undated Care Plan revealed, Focus- risk of falls due to immobility, muscle weakness and diabetes; Problem- CR #1 will be free from injury; approach- encourage resident to use environmental devices such as hand grips, handrails etc. Problem start date of 06/13/25- CR #1 has a diabetic ulcer to the left great toe; Goal target date 09/13/25- resident's wound will decrease in size with no complications as evidenced by wound documentation; Approach start date 06/13/25- nurse to complete wound documentation daily, refer to wound care doctor as needed, wound team to evaluate wound(s), treatments and healing status weekly. Problem start date of 06/16/25- CR#1 has trauma to left great toe; Goal target date: 09/16/25- wound will decrease in size as evidenced by wound documentation with no complications and comfort will be maintained; Approach start date: 06/16/25- CNA to inspect skin, especially over bony prominences, during bathing and personal care. Nurse to complete wound observation weekly. There was no mention of podiatry care or services, her circulatory complications or vascular disease. Record review of CR #1's Progress Notes from admission on [DATE] to discharge on [DATE] revealed, There was no documentation that CR #1 received podiatry care while at the facility with the following relevant entries. Record review of CR #1's Point of Care History from 09/17/24 to 06/17/25 revealed, no documentation of toenail care to CR #1. Record review of CR #1's Wound Management Detail Report dated 06/22/25 revealed there were no previously documented wounds prior to 06/13/25:06/13/25 at 11:16 PM signed by Wound Care Nurse A: Wound Type: Diabetic Ulcer; Wound location left big toe; 0.8X0.5 cm, with no odor or drainage; depth of injury- through the dermis (skin) and down to the subcutaneous (under the skin) tissue, muscle.06/16/25 at 06:08 PM signed by Wound Care Nurse B: Wound Type: Trauma; Wound Location: Left big toe; to left great toe measuring 1.2x2x0.1cm with moderate bright red sanguineous exudate (bloody fluid), mild swelling noted, purple discoloration to left great toe extending to foot, no odor, no s/sx of infection. Record review of CR #1 Hospital Records dated 06/17/25 revealed CR #1 had a right foot diabetic foot ulcer in 07/2024 and then an above the knee amputation. She</p>		

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<p>F 0687</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p>(continued on next page)</p>

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<p>F 0687</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health, and provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and assist the resident in making appointments with a qualified person for 1 of 5 residents (CR #1) reviewed for foot care - The facility failed to provide foot care or attain podiatry services for CR #1, a diabetic patient with severe PAD (a form of PVD in which narrowing of the blood vessels limit blood flow to the limbs) and a history of AKA from admission on [DATE] till she discharged on 06/17/25 to the hospital where she was diagnosed with osteomyelitis (a bone infection) that needed antibiotics, an AKA was recommended resulting in the family placing the resident on end of life care. An Immediate Jeopardy (IJ) was identified on 07/09/2025. The IJ template was provided to the Administrator on 07/09/2025 at 04:57 PM. While the immediacy was removed on 07/14/2025 at 3:18 PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for injuries, infections, unwanted hospitalization, an amputation leading to a decrease in quality of life and death. Findings Included: Record review of CR #1's Face Sheet dated 06/22/25 revealed, a 69-year-old female who admitted to the facility on [DATE] at 12:45 PM with diagnoses which included: Alzheimer's Disease, unspecified dementia with anxiety, hypertension (high blood pressure), acquired absence of right leg above knee (right above the knee amputation) and type 2 diabetes with other circulatory complications. Diagnosis of open wound of left great toe without damage to nail was added on 06/15/25; and unspecified wound, left foot initial encounter was added on 06/16/25. There was no documented diagnosis of PVD. Record review of CR #1's Quarterly MDS dated [DATE] revealed, severely impaired cognitive skills for daily decision making, resident was unable to complete a brief interview of mental status, lower extremity functional limitation in range of motion. CR #1 needed substantial/maximal assistance to : roll left and right, move from sitting to lying and lying to sitting on side of bed, was totally depended on to transfer from chair to bed and vice versa, evaluation of her ability to walk 10 ft, toilet transfer, tub/shower transfer or go from sit to stand was not attempted due to her medical condition or safety concerns. 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Foot pulses were felt, no sign of compromised circulation. Foot is warm and dry to touch.-06/13/25 at 02:06 PM signed by Wound Care Nurse A revealed, nurse informed writer that patients left great toe appears to have bruising, writer assessed and observed a diabetic ulcer to left, great toe 08X0.5cm, no exudate, no odor or s/sx of infection, no pain. cleansed with normal saline, patted dry with sterile gauze, applied skin prep and left open to air. Called and spoke with patient's family and discussed the assessment and plan of care. -06/15/25 at 07:05 AM signed by LVN D- during morning rounds, the aired reported that CR #1's big toe appeared to be bleeding and bruised. Upon assessment, observed active bleeding from the toe, with bruising</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 1 medication carts (100 Hall Nurse Cart) reviewed for medication storage . - LVN D failed to ensure the 100-200 Hall Nursing cart was locked when not under direct supervision of authorized staff. This failure could place residents at risk of adverse reactions to medications and misappropriation of medications. Findings included: An observation on 07/10/25 starting at 08:55 AM revealed, an unlocked and unattended nursing cart in front of room [ROOM NUMBER] and #115. The back of the cart was pushed against, and the drawers were exposed to the hallway. At 09:00 AM LVN D walked from behind the double doors that led to the hall with the dining area and kitchen and walked up to the unattended cart. In an observation and interview on 07/10/25 at 09:01 AM, inventory of the 100 Hall Nurse Cart with LVN D revealed, Drawer 1- OTC medications, syringes, prescription medication, & 30 lancets (a device with a small needle used to prick fingers to collect blood for blood sugar monitoring.), & 100 pen needles (needles attached to insulin pens). Drawer 2- liquid OTC and RX Only medications, solid form Resident prescription medications. Drawer 3- inhalation solutions, inhalers, and topical creams LVN D said nursing carts should be locked when unsupervised to prevent unauthorized access to the carts contents. She said unlocked carts could place residents at risk of injury and adverse drug reactions if they consumed medications from the cart. LVN D said she left her cart unattended because she was interrupted by a resident request during medication pass. In an interview on 07/11/25 at 09:29 AM, Wound Care Nurse B who was acting as the Interim DON at the time said nursing carts were to be locked when unsupervised to prevent unauthorized access by residents especially the cognitively impaired. She said unlocked nursing carts could place residents at risk for adverse drug reactions and overdose. Record review of the facility policy Medication Management revised 07/01/16 revealed, Security and Safety Guidelines: 1. Staff who are not authorized or permitted into the Medication Room or having access to a medication cart, are supervised by authorized personnel when accessing for non-clinical reasons. 2. The Medication room is always locked when not in use and in direct line of sight. 3. The medication cart is locked when not in use and in direct line in sight. 4. Keys to the medication room and cart are kept with the authorized staff and are the responsibility of the person assigned those keys.</p>		