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	11/26/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of the resident that one resident (Resident #1) of four residents reviewed for quality of care received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan.Resident #1 had a wound dressing that was wet during a shower procedure and was not changed prior to being sent to an appointment.The failure could place the resident at risk for not receiving necessary care and treatment.Findings included:Record review of the Face Sheet for Resident #1 revealed she was [AGE] years old and was admitted on [DATE]. Diagnoses included, but were not limited to, unspecified wound of her left foot, subsequent-encounter left heel infection, and cognitive communication deficit.In an interview via telephone on 10/14/2025 at 11:20 a.m., a family member said Resident #1 had a wound care doctor's appointment the previous day. She said when the resident arrived at the appointment, the resident's bandages were noted to be wet. She said both wounds on the left foot were wet.Three attempts to contact the wound care clinic were unsuccessful. The attempts were made via telephone: 10/14/2025 at 2:24 p.m., 10/15/2025 at 3:58 p.m., and 10/16/25 at 3:10 p.m.On 10/14/2025 at 3:06 p.m. wound care for Resident #1 was observed, provided by LVN A. The resident's left sock and kerlix gauze (wrap) was removed. The resident had two dry/intact dressings; one on top of the foot, and one on the heel. The resident exhibited an open area on the top of her foot, approximately 2 cm[JM1] diameter. It was superficial. The resident had an open area on her left heel. The resident complained of pain when her leg was lifted, and the Surveyor was not able to obtain a clear view. LVN A stopped the procedure and wrapped the resident's foot. She said she would return after the resident received pain medication. On 10/14/2025 at 3:52 p.m. LVN A provided wound care for Resident #1. There were no concerns with technique noted. The Physician's Orders dated 10/13/25 read, in part, .Avoid getting wound wet in showers/baths to prevent bacteria getting washed into wound. Cover with cast cover [available at most pharmacies] or take a sponge bath. Dressing was soaked on 10/13/2025, PLEASE DO NOT GET WOUND DRESSING WET IN SHOWER. PLEASE COVER WITH CAST COVER OR PLASTIC BAG ENSURING TAP WATER DOESN'T SOAK DRESSING.In an interview on 10/14/2025 at 4:12 p.m. CNA B said she assisted Resident #1 with a shower on 10/13/2025, prior to her wound care doctor's appointment. She said the resident's left leg/foot was wrapped in plastic during the shower. CNA B said the floor was wet in the resident's room when the resident was transferred to the wheelchair. In an interview on 10/15/2025 at 2:20 p.m., the DON said that if a wound dressing was left wet, the wound could become macerated (tissue breakdown). She said if the dressing was wet, the nurse should have changed it.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	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 one resident (Resident #2) of four residents reviewed received adequate supervision and assistance devices to prevent accidents, in that:Resident #2 was lifted in a mechanical lift by a single staff, although the lift requires two people.Resident #2 was suspended in the air in the and moved by a single staff. The resident was swinging, with her weight shifting side to side.The failure could place residents at increased risk for inadequate supervision.Findings include:Record review of the Face Sheet for Resident #2 revealed she was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dementia, contractures of both shoulders, and muscle wasting and atrophy.Record review of Resident #2's Quarterly MDS, dated [DATE] revealed the resident had severely impaired cognition. The resident had limited functional range of motion in both arms and both legs. The resident required maximum assist to go from sitting to lying positions, as well as lying to sitting position. She was dependent on staff for transferring from the chair to the bed and for bed-to-chair transfers.Record review of the Care Plan for Resident #2 dated 03/29/2025 revealed the resident required the for transfers. Review of a video clip dated 09/16/2025 at 12:15 p.m. from an in-room camera revealed an unidentified staff in Resident #2's room. There was a mechanical lift in the room. Resident #2 was in a shower chair facing the lift. The sling was under her. The staff person connected the mechanical sling to the lift. Resident #2 was then raised out of the shower chair and the shower chair was moved. The staff person then moved the mechanical lift approximately 10 feet towards the resident's bed, completing a 180 degree turn in the process. The resident remained approximately three feet above the ground. The resident was visibly swinging while suspended in the air.In an interview on 10/15/2025 at 2:20 p.m., the DON said there should be two staff for mechanical lift transfers. She said that if one person was used, the resident could fall during the transfer.Review of the facility policy Mechanical Lifts revised May 5, 2023, did not address the number of staff required for a mechanical lift transfer.