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	05/23/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 of 9 residents (CR #3) reviewed for resident rights. The facility failed to provide CR #3 a hot meal upon admission to the facility. CR #3 requested to receive the hot dinner meal being served to other residents; however, the facility did not provide the requested meal and later offered a sandwich and snacks, which she declined. As a result, CR #3's family had to provide her with a hot meal. This failure placed the resident at risk for loss of dignity, unmet nutritional needs, emotional distress, and diminished quality of life.Findings included: Record review of CR #3's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged on 5/8/2026 to the hospital. Her diagnoses included: Metabolic encephalopathy (brain dysfunction caused by chemical or metabolic imbalances in the body), protein-calorie malnutrition (inadequate intake or malabsorption of calories and protein), Type 2 diabetes mellitus (chronic metabolic condition where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels), Chronic kidney disease, stage 3b (kidneys are moderately to severely damaged and functioning at about 30% to 44% of their normal capacity). Record review of CR #3's admission MDS dated [DATE] revealed a BIMS score of 15 out of 15 indicating her cognition was intact. MDS further revealed resident required a therapeutic diet. Record review of CR #3 progress note dated 4/29/2026 at 5:11pm by LVN F revealed in part, .Received resident from ambulance transport at 2:00pm via stretcher. Resident is alert and oriented x 4. Diet: Renal/ Diabetic/ ADA & Cardiac House Diet with thin liquids. Resident now seen laying in bed, with bed wheels locked. No concerns voiced at this time. Patient care ongoing at this time. Record review of CR #3's physician order dated 4/29/2026 revealed a dietary order for Liberalized Renal; Special instructions: Renal; Cardiac/Diabetic. Interview on 5/22/2026 at 4:40pm, CR #3's family member stated CR #3 was admitted to the facility on [DATE] around 2:00pm. The family member stated the facility started to serve dinner around 5:00pm and CR #3 asked the staff if she was going to get a tray. CR #3 was told she was going to get a dinner tray and someone would bring it shortly. After some time passed no one brought CR #3's tray and she asked another staff member about getting her tray and was told by this time it was now the night shift (after 7:00pm) and the kitchen staff had already left. They attempted to give CR #3 a sandwich and some crackers, but CR #1 was upset because she wanted the hot meal that was being served to other residents. The family member stated she did later address the situation with staff and remembered talking to the ADON who told her that the kitchen did not get the communication of the resident diet order in time the day she admitted to have her in the system which was why she did not get served a hot tray. The family member said this was unacceptable because the resident was in the facility for several hours before dinner was served and CR #3 had even asked someone about the tray when they were being served and still did not get one. The family member said the ADON ultimately apologized that CR #3 did not get a hot tray and blamed it on staffing issues at the time. Interview on 5/23/2026 at 3:06pm, the Dietary Manager said if a resident is a new admit and they have not been (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered into the system yet to generate a meal ticket, nursing staff are expected to bring a diet communication slip with the physician diet order. The Dietary Manager said the kitchen staff will not prepare or provide the tray without having the order and this was upon her directive to avoid any errors in providing the wrong diet to a resident. The Dietary Manager said they typically serve dinner around 5:00pm - 5:30pm and they always make extra trays of all the different diet types in case additional trays are needed. The Dietary Manager stated by 7:00pm the Dietary Staff are already gone but there are cold foods and snacks always available for the nursing staff to come and get if needed. The Dietary Manger could not recall CR #3 or any situation that may have happened with her not getting a dinner tray. The Dietary Manager stated if the order was brought down to the kitchen for the tray, then a tray would have been provided. Interview on 5/23/2026 at 4:24pm, the ADON said she recalled looking into the situation with CR #3 not getting a tray and recalled the family being very upset. The ADON said as she investigated the matter she found that upon CR #3's admission around 2:00pm the resident said she was not hungry and had already ate. The ADON also said she found out CR #3 was offered a tuna sandwich, peaches with cottage cheese, and some soup during the second shift on 4/29/2026 but resident did not want that food. The ADON said she did look into why CR #3 did not get the regular dinner tray during dinner time and said the nurse said the diet order was brought to the kitchen by LVN F, so it was unclear why the kitchen did not provide a tray during dinner time. Interview on 5/23/2026 at 5:26pm, LVN F said she was the nurse who admitted CR #3 on 4/29/2026. LVN F recalled their being an issues with CR #3 getting her dinner tray and breakfast tray but she did not learn of the issue until the morning of 4/30/2026. LVN F said the morning of 4/30/2026 CR #3 did not get a breakfast tray and this was when she was informed that she also did not get a dinner tray the night before. LVN F said she immediately reprinted the order and brought it to the kitchen the morning of 4/30/2026 and CR #3 did get a breakfast tray. LVN F stated on 4/29/2026 she brought CR #3's diet order to the kitchen before dinner was served so she would be provided a tray. LVN F said she checked CR #3 during her final rounds for the shift and she did not mention that she did not get a tray that night before she left. LVN F said when she went to the kitchen on 4/30/2026 they stated they did not have the diet communication form from the day before she had brought down and stated it must have gotten misplaced. Interview on 5/23/2026 at 7:30pm, the Administrator did not know of an incident involving CR #3 not getting a dinner tray on 4/29/2026 but did recall there was a lot of issues with CR #3 refusing things and the facility attempting to meet her needs and preferences. The Administrator stated she attempted to speak with CR #3's family member regarding concerns but was cursed at by the family member. The Administrator stated the CNA who worked with CR #3 the day she was admitted no longer worked at the facility. Record review of the facility Resident Right's policy revised on 11/1/2017 revealed in part, .Facility staff: 3. Will support the patient/resident's right to have autonomy and choice about how he/she wishes to live his/her daily life, and receive care subject to the healthcare rules in accordance with state and federal rules and regulations and Facility Procedures.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 9 residents (Resident #1) reviewed for notification of changes. The facility failed to timely consult Resident #1's physician after she reported right leg/knee pain following a fall. Resident #1 complained of pain the evening of the fall and again the following morning; however, the physician was not consulted until more than 24 hours after the initial complaint. Resident #1 later required hospital evaluation, changes to her pain management regimen, and experienced a decline in functional abilities. An Immediate Jeopardy (IJ) was identified on 5/22/2026 at 2:10pm. While the IJ was removed on 5/23/2026, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated as the facility continued to monitor the implementation and effectiveness of their plan of removal. This failure placed residents at risk for delayed assessment and treatment, unmanaged pain, functional decline, and hospitalization.Findings included: Record review of Resident #1's facesheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Cerebral infarction (type of stroke that occurs when blood flow to a part of the brain is blocked or significantly reduced, depriving brain tissue of oxygen and vital nutrients), blindness in right eye, low vision in left eye, osteoarthritis (degenerative joint disease where the protective cartilage that cushions the ends of the bones wears away over time), Age-related osteoporosis (progressive condition where bones lose mass and structural strength as you age, becoming porous and highly fragile), Cognitive communication deficit, Fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, profound fatigue, sleep disturbances, and cognitive issues), and chronic pain. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 6 indicating severe cognitive impairment. Further review of the MDS revealed she had no behavioral symptoms or rejection of care, no scheduled pain regimen, had not received PRN pain medications, and had no reports of pain. Record review of Resident #1's care plan revealed a problem start date of 7/13/2024 and edited on 5/13/2026 for her having osteoarthritis, fibromyalgia, and neuropathy and was at risk for pain due to impaired mobility. Interventions included to administer pain medications as ordered by physician. Document effectiveness; Assess location, frequency, duration of pain and document. Report increased pain trend to MD; Monitor and record any non-verbal signs of pain (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc); Monitor for s/s of pain/discomfort; Nonpharmacological intervention reposition for comfort per routine rounds and PRN; Notify MD if inadequate pain relief. Record review of Resident #1's March and April 2026 MAR revealed physician order started on 3/7/2023 to EVERY shift check resident for level of pain utilizing numeric rating scale had rating of 0 out of 10 from 3/1/2026 - 4/30/2026. Record review of Resident #1 May 2026 MAR revealed physician order started on 3/7/2023 to EVERY shift check resident for level of pain utilizing numeric rating scale had rating of 0 out of 10 from 5/1/2026 - 5/12/2026 (7:00am - 7:00pm, day shift). Further review revealed on:5/12/2026 (7:00pm -7:00am, night shift) pain rating was 8 out of 10 marked by LVN B.5/13/2026 (day shift) - 0 out of 10 pain marked by RN A5/13/2026 (night shift) - 6 out of 10 pain marked by LVN C5/14/2026 (day shift) - 2 out of 10 pain marked by RN A5/14/2026 (night shift) - 2 out of 10 pain marked by LVN C5/15/2026 - 5/21/2026 - pain rating was 0 out of 10. Record review of Resident #1's March and April 2026 MAR revealed physician order started on 1/28/2026 for acetaminophen tablet; 325mg; 2 tabs oral every 8 hours as needed for mild pain was not administered. Record review of Resident #1's May 2026 MAR revealed physician order started on 1/28/2026 for acetaminophen tablet; 325mg; 2 tabs oral every 8 hours as (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	needed for mild pain was administered on:5/11/2026 at 5:16pm by LVN A for pain rate of 6 out of 10 and was marked effective.5/12/2026 at 11:46am by LVN A for pain rate of 4 using FACES scale (clinical self-assessment tool used to measure pain intensity) and was marked effective.5/12/2026 at 9:59pm by LVN B for pain rate of 8 out of 10 using FACES scale marked somewhat effective.5/13/2026 at 7:42am by LVN B for pain rate of 4 out of 10 using FACES scale marked somewhat effective.5/13/2026 at 6:35pm by RN A for pain rate of 6 out of 10 using FACES scale marked other - pain upon palpation Record review of Resident #1's progress note dated 5/11/2026 at 12:01pm by LVN A revealed, While assisting CNA to transfer resident from shower chair to bed, resident slowly started falling. We then assisted resident slowly to the floor. No verbal complaints of pain or discomfort noted. Upon assessment of resident no injuries nor bleeding present. Vital signs within normal reading. Neurochecks started per facility protocol. NP and RP notified. No new orders, Safety measurements in place. Record review of Resident #1's progress notes revealed no other entries on 5/11/2026 regarding 6 out of 10 pain noted on MAR for administration of PRN Acetaminophen at 5:16pm. Record review of Resident #1's progress note dated 5/12/2026 at 5:04am by LVN B revealed, Resident day 1/3 Post fall remain stable during this time. Denies pain or discomfort. Resident slept well throughout night with chest rise and fall and peri care provided with barrier cream applied q2h. Vital signs within normal limit. Neuros in place. Fall precautions in place. Call light and side table with belongings within reach. Record review of Resident #1's progress note dated 5/12/2026 at 2:34pm by LVN A revealed, Observation for day 2 post fall. Resident had minor pain and discomfort, PRN pain medication administered as ordered with noted relief. Neurochecks remain ongoing per protocol with no acute changes observed. Vital signs stable and within normal limits. Call light within reach. Safety measurements in place. Further review of the progress note revealed no assessment of how it was determined resident was in pain, the location of the pain, or physician notification regarding the development of pain after a fall. Record review of Resident #1's progress note dated 5/12/2026 at 9:56pm by LVN B revealed, Observation post fall. Resident had pain and discomfort right knee upon providing peri care at this time. PRN pain medication administered as ordered. Neurochecks remain ongoing per protocol. Vital signs stable and within normal limits. NP notified and informed, pending provider recommendations. Record review of Resident #1's progress note dated 5/12/2026 at 10:11pm by LVN B revealed, New order received for right knee Xray 2views. Order placed and called in. called POA. informed of new order/changes. Verbalized understanding. Record review of Resident #1's progress note dated 5/12/2026 at 11:34pm by LVN B revealed, New order received to change order to STAT right knee Xray 2views. order placed and called in. Record review of Resident #1's progress note dated 5/13/2026 at 4:40am by LVN B revealed, Upon return from lunch break, covering nurse reported that the X-ray technician arrived and obtained an X-ray of the patient's right knee as ordered. Record review of Resident #1's progress note dated 5/13/2026 at 6:10am by LVN B revealed, Upon rounding, nurse observed resident in pain. PRN pain medication was administered per physician order. Peri care was provided, and resident was repositioned for comfort with assistance of nursing staff using proper fracture precautions, including the log-roll technique and supportive positioning to avoid movement of the affected extremity. Record review of Resident #1's Right Knee x-ray results signed on 5/13/2026 at 6:22am revealed an impression of Acute non-displaced fracture of lateral femoral condyle (a crack in the outer, ball-shaped end of the thigh bone at the knee joint). Record review of Resident #1's progress note dated 5/13/2026 at 6:30am by LVN B revealed in part, .Received X-ray results. NP was informed immediately. New orders were received to send resident to the ER for fracture to lateral femoral of right knee via EMS transport. Nurse (writer) contacted EMS for transportation. Assigned CNA was informed not to move resident until EMS arrival. EMS provided an estimated time of arrival of 20 minutes for pickup. RP informed of the situation, and verbalized understanding. reported to oncoming nurse of resident changes and arrival of EMS transport. Record review of Resident #1's SBAR dated 5/12/2026 at 10:00pm completed by LVN B revealed a situation of swelling and pain to the right knee that started on (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	5/12/2026 and had gotten worse since it started. It was noted moving the right leg makes the symptoms worse and PRN acetaminophen makes the symptoms better. Further review of the SBAR functional status evaluation revealed decreased mobility to right leg and pain evaluation noted new pain to right knee with pain rating of 8 out of 10 with non-verbal signs of facial grimacing. Record review of Resident #1's progress note dated 5/13/2026 at 3:50pm by RN A revealed, Resident returned to the facility via stretcher accompanied by two EMS transporters following hospital evaluation related to suspected fracture to the lateral femoral area of the right knee. Per EMS transporter report, resident had no evidence of fracture noted during hospital evaluation. Upon return assessment, skin intact with no redness noted. Slight swelling observed to the right knee compared to the left knee. Resident unable to perform active ROM to lower extremities. During passive ROM attempt by writer, resident complained of pain to the right leg. PRN Tylenol administered as ordered for pain management. Incontinent care provided and resident tolerated care well. Resident in bed and made comfortable. NP notified of resident's return from the hospital and complaint of right leg pain. Awaiting new orders at this time. Resident continues to be monitored. Record review of Resident #1's progress note dated 5/13/2026 at 5:58pm by LVN D revealed in part, Resident seen by wound care nurse today for head to eval upon return from hospital. Skin remains intact. Edema noted to right knee. No treatment warranted at this time. Continue with weekly skin observation and notify wound care nurse for any changes or concerns in integrity. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 and discontinued 5/18/2026 for diclofenac sodium gel; 1 %; 5 cc; topical; twice a day for pain was administered 5/14/2026 - 5/18/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 and discontinued on 5/19/2026 for acetaminophen tablet; 325mg; 2 tabs oral three times a day for pain was administered at 7AM, 2PM, and 7PM on 5/13/2026 - 5/19/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 for lidocaine adhesive patch, medicated; 4 %; topical once a day to right knee for pain was administered on 5/14/2026 - 5/21/2026. Record review of Resident #1's physician order started on 5/13/2026 revealed to transfer x 2 assist utilizing a mechanical lift. Record review of Resident #1's progress note dated 5/14/2026 at 1:07am by LVN C revealed in part, .Resident continues to have moderate swelling to right knee, unable to perform ROM due to pain. Resident is on scheduled Tylenol which was given at time of assessment. Record review of Resident #1's progress note dated 5/14/2026 at 12:59pm by RN A revealed in part, .Resident remains stable and alert at this time, but continues to report mild pain with pressure applied. No redness noted. Moderate swelling observed to the right knee compared to the left knee. Diclofenac topical applied as ordered and tolerated well. Legs elevated with pillow for comfort and to reduce swelling. Resident made comfortable in bed. Vital signs obtained. Incontinent care provided and tolerated well. Resident resting comfortably in bed at this time. Record review of Resident #1's progress note dated 5/15/2026 at 6:34am by LVN C revealed in part, .Resident continues to have moderate swelling to right knee, unable to perform ROM due to pain. Resident is on scheduled Tylenol which was given at time of assessment. No inflammation observed. Record review of Resident #1's progress note dated 5/18/2026 at 6:10pm by RN B revealed in part, . Resident in no distress. Remain on scheduled Tylenol 650mg PO three times daily until 5/19/26 and Diclofenac sodium topical to right knee twice daily until 5/20/26 related to Right knee pain. Denies pain during the shift. New order received for cold compression therapy to right knee for 10 minutes each three times daily x 5 days. Cold compression initiated per order. Knee continued to be monitored. Resident tolerated treatment without difficulty. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 and discontinued 5/20/2026 for diclofenac sodium gel; 1 %; 5 cc; topical; twice a day for right knee pain was administered 5/18/2026 - 5/20/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 and discontinued 5/22/2026 for Apply Cold compression to right Knee for 10 minutes three times a day was administered 5/18/2026 - 5/21/2026. Record Review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 for (continued on next page)

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Record review of Resident #1's progress note dated 5/19/2026 at 12:13pm by social worker revealed RP was contacted to schedule a care plan meeting on 5/20/2026 to discuss residents fall. Record review of Resident #1's progress note dated 5/20/2026 at 2:41am by LVN C revealed, Resident continues to remain stable, no complaints of pain or discomfort during the night. Resident remains on Diclofenac to right knee BID until 5/20. Resident tolerates cold compress to right knee TID well, will end on 5/22. Resident is Day 2/3 of Meloxicam 7.5mg QD and Tizanidine 2mg QHS which she is tolerating well with no adverse reactions noted. Will continue to monitor. Record review of Resident #1's progress note dated 5/20/2026 at 11:48am by NP B revealed in part, .chief complaint: ADL and mobility dysfunction right knee pain and fall causing decline in function. long-term resident at current facility requires consult for right knee pain s/p fall. Patient was sent to ER for further imaging. STAT x-ray ordered in facility revealed fracture to lateral femoral of right knee. Imaging in ED negative for dislocation and fracture. Primary diagnosis right knee contusion. Patient now on therapy services for decline in ADLs, function, mobility s/p hospitalization. Rehab potential is fair to good. Physiatry/PM&R consult requested for management of decline in function with impaired mobility and self-care. Patient started on lidocaine patch to right knee. Pain is controlled at rest. However, with range of motion and movement patient shows signs of pain and cannot tolerate. right knee contusion status post fall, Risk of complication: HIGH. The patient's multiple medical issues necessitate frequent clinical evaluations, placing them at high risk for readmission without proper care. Neglecting regular monitoring and management may result in symptom exacerbation and complications, possibly requiring hospitalization. Continue joint mobilization and stretching as needed as well as modalities including hot and cold packs. Pain, stiffness, and reduced joint mobility may limit therapy participation and functional gains. Deconditioning and ADL dysfunction: Case discussed with therapy team regarding goals of rehab to return patient to prior level of functioning to increase independence with mobility and self-care. Phone interview on 5/21/2026 at 11:00am, RP stated she was called on 5/11/2026 and staff told her Resident #1 had to be lowered to the floor when she was being transferred to her bed. She was told there was no injuries and the incident was no big deal and she was being contacted as a formality. The RP stated she heard nothing until the following night on 5/12/2026 where a nurse (LVN B) contacted her saying Resident was complaining of knee pain and they contacted the NP who ordered an x-ray. The RP said the next morning on 5/13/2026 the nurse (LVN B) called her back and said the x - ray showed she had a fracture and they were sending her to the hospital. The RP said this prompted her to check the camera footage from 5/11/2026 when she had her fall because she was unsure how an injury could come from something she was told was nothing major. The RP said the camera footage showed the incident was not like how they described it and it showed two staff members attempting to lift her from her chair by her arms and the resident immediately going to the ground. She was also concerned because the resident was still visibly wet from her shower and naked which caused issues with the transfer because she stated you could see the staff hands slipping and them trying to grab towels to dry her after she slipped. The RP said there were multiple failed attempts of them trying to pull her from her arms once she was on the ground and it wasn't until the bed was lowered to the ground they were able to maneuver Resident #1 onto the bed. The RP stated she was told it was not until 5/12/2026 night that a CNA noticed Resident #1 was in pain but she questioned why it was the CNA who noticed she was in pain and not the nurse if the (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	nurse was supposed to be monitoring after a fall and completing assessments. The RP said she did have a care plan meeting with the staff on 5/20/2026 where they spoke about the transfer being incorrect and the actions they took to retrain the staff. The RP said she asked about why the nurse did not identify the resident was in pain if she was supposed to be completing post fall assessments and she was told that the nurses monitor for 72 hours after a fall and the pain was identified within this time frame so that meant the post fall assessments were properly being done. The RP said she had concerns on how the nurses were supposedly completing assessments because if they were checking the resident's range of motion then they should have been the ones that identified Resident #1 was in pain. The RP provided a copy of the video footage from Resident #1's witnessed fall on 5/11/2026. Record review of Resident #1 room video footage from 5/11/2026 at 11:35am, showed CNA A bring Resident #1 into the room in shower chair and positioned next to her bed. CNA A used a towel to dry off parts of Resident #1 and then leaves the area for a few minutes and returns with LVN A. The two staff get on both sides of the resident, LVN A faces the resident and wraps her left arm around Resident #1's left arm and places her right hand on her back. CNA wrapped her right arm around Resident #1's right arm while also holding the residents right upper arm with her left hand. LVN A and CNA A both lift Resident #1 from her chair with no gate belt and Resident #1 immediately slips down in front of the shower chair. CNA A while still holding onto Resident #1's right arm reaches over to the bed to grab the towel and attempts to dry Resident #1 arms off some more and then passes the towel to LVN A for her to also dry the resident some more while they are both still holding onto her arms. The resident was then lowered down completely to the ground where she appears sitting in front the shower chair and to the right of her bed. LVN A then goes and lowers the bed down and returns back over to the resident and the two staff attempt to pull her up from the ground by hooking their arms under her armpits and holding her upper arm. They pulled the resident from both her arms and her bottom lifted from the ground but not high enough to reach the bed and she immediately slips back down ground. LVN A then goes back to the foot of bed and lowers the bed down some more, then returned back with CNA A to attempt to transfer the resident again. Both staff grab Resident #1's arms and pulled her up where her bottom touched the side of the bed but slips back down off the side of the bed and goes back down while the staff are holding her, they try again to pull her up and she slipped back down off the side of the bed again. The two staff pull her up again and was able to get the top of her body on the bed. LVN A then picks up Resident #1's legs from the floor and brings them around to the bed so that her full body is on the bed at this time. Interview on 5/21/2026 at 1:28pm, CNA A said she gave Resident #1 a shower on 5/11/2026 and she and LVN A went to transfer Resident #1 back to her bed from the shower chair and had to lower her to the ground because they were not balanced. CNA A said when they lowered the resident to the floor she was sitting with her legs bent and to the side. CNA A said Resident #1 did not voice any pain during the transfer attempts and the lowering to the ground. CNA A said later in the shift around 4:00pm - 5:00pm Resident #1 did have some discomfort during perineal care (gentle cleaning of the genital and anal areas). CNA A said Resident #1 said ouch when she went to turn her. CNA A said she asked Resident #1 what was wrong but she did not say anything. CNA A said MA A was in the room tending to Resident #1's roommate when this happened and she was also aware the resident had discomfort during care. CNA A could not recall if she told the nurse herself about Resident #1 having discomfort, but she believed MA A did let the nurse know. Interview on 5/21/2026 at 3:34pm, LVN A said she recalled CNA A coming to get her to assist with transferring Resident #1 to the bed on 5/11/2026 around 11:50am and they had to assist Resident #1 to the ground due to complications with the transfer. LVN A said when they initially lowered Resident #1 to the floor she did not hit anything hard on the floor and stated they were standing on a fall mat where she was lowered to. LVN A said once lowered to the ground Resident #1 had her legs folded under and laying off to the side. LVN A said she did do an assessment after the incident and noted no injuries to Resident #1 and she stated she did check her range of motion and the resident had no complaints at the time of the incident. LVN A said (continued on next page)

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	676450	A. Building B. Wing	05/23/2026

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	she notified the NP of the incident and the NP texted her to continue to monitor the resident. LVN A said she did check back in on Resident #1 the remainder of the day shift and there were no complaints voiced by the resident and denied anyone reporting any pain concerns to her on 5/11/2026. LVN A said the following day on 5/12/2026 she did administer PRN Tylenol to the resident at the beginning of the shift. LVN A could not recall for sure what prompted her to give the PRN pain medicine but stated she believed Resident #1's roommate (Resident #2) called and said Resident #1 had been grunting in pain. LVN A said it was her right knee that was giving her issues because she recalled seeing resident's knee elevated with a pillow which she thinks was done by the CNAs. She said she recalled shifting when she went to touch the knee so she did not perform range of motion check. LVN A said she checked back with Resident #1 after she gave the medicine and it was effective and stated when she went to touch Resident #1's knee she did not shift. LVN A denied any visible swelling, redness, or skin tear to the knee. When asked more about how Resident #2 was the one to report Resident #1 was in pain LVN A said that she also remembered that maybe it was MA A who told her Resident #1 was in pain and when she went into the room Resident #2 confirmed she had heard Resident #1 groaning in pain. LVN A believed this was all on 5/12/2026 around 11:00am. LVN A said she did not notify the NP about the pain and stated she just gave the medication. LVN A could not say why she did not notify the NP about the pain and stated PRN medication was effective for the pain. LVN A was then shown the MAR by the surveyor and asked why the PRN Tylenol was given on 5/11/2026 at 5:16pm and LVN A could not recall giving the medication but stated the MAR did reflect that she gave the medication for a pain rating of 6 out of 10. LVN A was informed by surveyor that CNA A recalled the resident having discomfort during care around that time and perhaps that was why the medication was given, LVN A said this could maybe be why, but she did not recall for sure. Phone interview on 5/21/2026 at 4:18pm, MA A said she recalled on 5/11/2026 hearing Resident #1 holler out while she was tending to her roommate Resident #2. MA A said CNA A was attempting perineal care at the time and Resident #1 was saying her right leg was hurting. MA A said she did go over and assist CNA A with finishing perineal care and Resident #1 was able to voice that it was her leg that was hurting and pointed at her right knee when asked. MA A said when they finished with the care she did place a pillow under the resident's knee to help with the pain. MA A said she reported Resident #1 was in pain to LVN A and LVN A told her she was already aware Resident #1 was having pain. MA A said she was not sure if and when LVN A went to check on Resident #1 because she continued to care for other residents. MA A said she did later check on Resident #1 because she would hear her randomly yelling out like she was having muscle spasms. MA A said this was all very unusual for Resident #1 and not something she typically did which made her concerned. Interview on 5/21/2026 at 4:46pm, Resident #2 said she recalled when Resident #1 had to be assisted to the ground and stated she was in a lot of pain afterwards. Resident #2 said the same day of the fall she heard Resident #1 yelling in pain when they were trying to change her which she had never heard her do before. Resident #2 said after that Resident #1 would just be laying in bed with no one touching her and would randomly yell out and was groaning. Resident #2 said she did tell staff several times about how much pain Resident #1 was in and stated it felt like it took a few days of her being in pain before she went to the hospital. Resident #2 said she felt really bad that it took so long for them to address Resident #1's pain. Observation on 5/21/2026 at 4:50pm, Resident #1 was sleeping in bed. Bed was at the lowest setting. Surveyor attempted to greet the resident, but she remained resting with eyes closed. Interview on 5/21/2026 at 6:17pm, the Administrator and DON stated through their investigation they found issues surrounding Resident #1's transfer and shower procedure which were addressed and staff were in-serviced about. The Administrator and the DON did not voice any identification of issues regarding timely physician notification. Phone interview on 5/21/2026 at 6:45pm, NP said she recalled being notified on 5/11/2026 that Resident #1 had to be lowered to the ground and there were no injuries or concerns reported. She advised to continue to monitor the resident but stated to her knowledge the resident was fine and it was not even really a fall that (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	happened. NP said the next time she was notified about Resident #1 was the night of 5/12/2026 and LVN B called her saying Resident #1 was having knee pain so she ordered the x-ray for the knee. The NP said initially the x-ray showed a fracture, so she ordered to have her sent to the hospital, but the hospital sent her back saying their scans showed no fracture. The NP was informed by surveyor that Resident #1 had complained of knee pain prior to the night of 5/12/2026, the NP stated she only recalled being told about Resident #1 being in pain once which was the night of 5/12/2026. The NP said if a resident complains of acute pain after a fall the staff should let her know because depending on the pain it could be a sign of an injury. Interview on 5/21/2026 at 7:15pm, LVN B said when she came in for her shift on 5/11/2026 for the night shift, LVN A did report that Resident #1 had a fall where she was lowered to the ground during a transfer. LVN B said LVN A reported there were no injuries and the resident was fine. LVN B said there were no reports that Resident #1 had experienced pain or that PRN pain medication had to be administered. LVN B said the night of 5/11/2026 Resident #1 was fine, she typically does rounds with CNAs and said she did not observe nor did anyone report Resident #1 having pain the night of 5/11/2026. LVN B said CNA B worked with her on the night of 5/11/2026 and CNA C worked the night of 5/12/2026. LVN B said she came in on 5/12/2026 to work the night shift and did not recall LVN A reporting any concerns of Resident #1 having pain from the day shift or her having to administer pain medication. LVN B said it was reported Resident #1 was fine during the day shift. LVN B said during their first set of rounds the night of 5/12/2026 she was tending to Resident #1's roommate (Resident #2) while CNA C was attempting perineal care with Resident #1. LVN B said she heard Resident #1 yelling and CNA C asked her to take a look because the resident typically did not yell during care. LVN B said at that time Resident #2 mentioned that Resident #1 had been in pain all day. LVN B said she asked CNA C how she moved her that caused her to yell, and CNA C barely went to move Resident #1 right leg and she yelled out in pain. LVN B said she assisted CNA C with situating Resident #1 in bed, medicated her with PRN Tylenol, notified the NP and RP, and got orders for an x-ray to the knee. LVN B said early the next morning on 5/13/2026 she got the x-ray results which showed a fracture, she called the NP with the results, and she ordered to send Resident #1 to ER for evaluation. LVN B said Resident #1 did complain of pain again before she was transferred to the ER on [DATE] and had to medicate her with PRN Tylenol again. LVN B added that since she discovered Resident #1 was in so much pain, she told the CNA to not change her or move her until they got orders from the NP. Interview on 5/22/2026 at 11:41am, the DON said she had not heard about Resident #1 being in pain on 5/11/2026 and stated she would have to check into it. The DON said if the resident has a change in condition after a fall or just in general the Resident should be assessed and the provider should be notified about the change. The DON said a new onset of acute pain could be considered a change in condition, but it would depend on the assessment of the resident. On 5/22/2026 at 12:17pm, the RP sent a text message to surveyor noting she had reviewed more of Resident #1's room camera footage and forwarded a copy of video recording from 5/11/2026 at 4:30pm which showed, she is screaming out in pain. The RP noted she had a second video recording from 5/12/2026 at 9:30pm that also showed the resident in pain, and she believed this was when the pain was reported to her and the NP. Copies of the video were provided to the surveyor. Record review of video recording from Resident #1's room camera dated 5/11/2026 at 4:30pm revealed Resident #1 lying in bed and CNA A standing on the right side of the bed. Resident #1 begins yelling owe, owe, owe while CNA is preparin

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 that the resident environment remained free of accident hazards as was possible for 1 of 9 (Resident #1) reviewed for accidents, in that Resident #1 was lowered to the floor when staff attempted to transfer Resident #1 while she remained wet from her shower and utilized an inappropriate transfer technique. Following the incident, Resident #1 complained of knee pain, required hospital evaluation, was placed on a pain management regimen, and experienced a decline in functional abilities. This failure placed residents at risk for falls, injury, increased pain, hospitalization, and further decline in functional abilities.Findings included: Record review of Resident #1's facesheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Cerebral infarction (type of stroke that occurs when blood flow to a part of the brain is blocked or significantly reduced, depriving brain tissue of oxygen and vital nutrients), blindness in right eye, low vision in left eye, osteoarthritis (degenerative joint disease where the protective cartilage that cushions the ends of the bones wears away over time), Age-related osteoporosis (progressive condition where bones lose mass and structural strength as you age, becoming porous and highly fragile), Cognitive communication deficit, Fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, profound fatigue, sleep disturbances, and cognitive issues), and chronic pain. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 6 indicating severe cognitive impairment. Further review of the MDS revealed she was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) on staff for chair/bed-to-chair transfer, had no behavioral symptoms or rejection of care, no scheduled pain regimen, had not received PRN pain medications, had no reports of pain, and had no falls. Record review of Resident #1's care plan revealed a problem start date of 7/13/2024 and edited on 5/13/2026 for her having osteoarthritis, fibromyalgia, and neuropathy and was at risk for pain due to impaired mobility. Interventions included to administer pain medications as ordered by physician. Document effectiveness; Assess location, frequency, duration of pain and document. Report increased pain trend to MD; Monitor and record any non-verbal signs of pain (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc); Monitor for s/s of pain/discomfort; Nonpharmacological intervention Reposition for comfort per routine rounds and PRN; Notify MD if inadequate pain relief. Further review of the care plan revealed a problem start date of 7/13/2024 and edited on 5/13/2026 for risk for falls due to impaired vision, impaired mobility, incontinence of bowel and bladder and use of psychotropic medications. 5/11/2026 - witnessed fall during transfer. No apparent injuries indicated. The interventions included: Transfers x 2 assist utilizing a Hoyer Lift; Anticipate needs; Assure lighting is adequate and areas are free of clutter; Encourage to ask for assistance from staff; Encourage socialization and activity attendance as tolerated; Ensure call light is in reach, answer promptly; Monitor for incontinence per routine rounds and PRN; Therapy to eval and treat per orders. Further review of the care plan revealed a problem start date of 7/13/2024 and edited on 5/13/2026 for require assistance with ADL's due to impaired mobility, impaired vision, and incontinence of bowel and bladder. The interventions included: TRANSFERS: Assist x 2 utilizing a Hoyer Lift; Wheelchair for mobility; BATHING: Assist of 2; BED MOBILITY: Assist of 2; EATING: Assist of 1; Encourage independence, praise when attempts are made; Transfer rails to both sides of bed for bed mobility and transfers. Record review of Resident #1 May 2026 MAR revealed physician order started on 3/7/2023 to EVERY shift check resident for level of pain utilizing numeric rating scale had rating of 0 out of 10 from 5/1/2026 - 5/12/2026 (7:00am - 7:00pm, day shift). Further review revealed on:5/12/2026 (7:00pm -7:00am, night shift) pain rating was 8 out of 10 marked by LVN B.5/13/2026 (day shift) - 0 out of 10 pain marked by RN A5/13/2026 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(night shift) - 6 out of 10 pain marked by LVN C5/14/2026 (day shift) - 2 out of 10 pain marked by RN A5/14/2026 (night shift) - 2 out of 10 pain marked by LVN C5/15/2026 - 5/21/2026 - pain rating was 0 out of 10. Record review of Resident #1's May 2026 MAR revealed physician order started on 1/28/2026 for acetaminophen tablet; 325mg; 2 tabs oral every 8 hours as needed for mild pain was administered on:5/11/2026 at 5:16pm by LVN A for pain rate of 6 out of 10 and was marked effective.5/12/2026 at 11:46am by LVN A for pain rate of 4 using FACES scale (clinical self-assessment tool used to measure pain intensity) and was marked effective.5/12/2026 at 9:59pm by LVN B for pain rate of 8 out of 10 using FACES scale marked somewhat effective.5/13/2026 at 7:42am by LVN B for pain rate of 4 out of 10 using FACES scale marked somewhat effective.5/13/2026 at 6:35pm by RN A for pain rate of 6 out of 10 using FACES scale marked other - pain upon palpation Record review of Resident #1's progress note dated 5/11/2026 at 12:01pm by LVN A revealed, While assisting CNA to transfer resident from shower chair to bed, resident slowly started falling. We then assisted resident slowly to the floor. No verbal complaints of pain or discomfort noted. Upon assessment of resident no injuries nor bleeding present. Vital signs within normal reading. Neurochecks started per facility protocol. NP and RP notified. No new orders, Safety measurements in place. Record review of Resident #1's progress note dated 5/12/2026 at 5:04am by LVN B revealed, Resident day 1/3 Post fall remain stable during this time. Denies pain or discomfort. Resident slept well throughout night with chest rise and fall and peri care provided with barrier cream applied q2h. Vital signs within normal limit. Neuros in place. Fall precautions in place. Call light and side table with belongings within reach. Record review of Resident #1's progress note dated 5/12/2026 at 2:34pm by LVN A revealed, Observation for day 2 post fall. Resident had minor pain and discomfort, PRN pain medication administered as ordered with noted relief. Neurochecks remain ongoing per protocol with no acute changes observed. Vital signs stable and within normal limits. Call light within reach. Safety measurements in place. Record review of Resident #1's progress note dated 5/12/2026 at 9:56pm by LVN B revealed, Observation post fall. Resident had pain and discomfort right knee upon providing peri care at this time. PRN pain medication administered as ordered. Neurochecks remain ongoing per protocol. Vital signs stable and within normal limits. NP notified and informed, pending provider recommendations. Record review of Resident #1's progress note dated 5/12/2026 at 10:11pm by LVN B revealed, New order received for right knee Xray 2views. Order placed and called in. called POA. informed of new order/changes. Verbalized understanding. Record review of Resident #1's progress note dated 5/12/2026 at 11:34pm by LVN B revealed, New order received to change order to STAT right knee Xray 2views. order placed and called in. Record review of Resident #1's progress note dated 5/13/2026 at 4:40am by LVN B revealed, Upon return from lunch break, covering nurse reported that the X-ray technician arrived and obtained an X-ray of the patient's right knee as ordered. Record review of Resident #1's progress note dated 5/13/2026 at 6:10am by LVN B revealed, Upon rounding, nurse observed resident in pain. PRN pain medication was administered per physician order. Peri care was provided, and resident was repositioned for comfort with assistance of nursing staff using proper fracture precautions, including the log-roll technique and supportive positioning to avoid movement of the affected extremity. Record review of Resident #1's Right Knee x-ray results signed on 5/13/2026 at 6:22am revealed an impression of Acute non-displaced fracture of lateral femoral condyle (a crack in the outer, ball-shaped end of the thigh bone at the knee joint). Record review of Resident #1's progress note dated 5/13/2026 at 6:30am by LVN B revealed in part, .Received X-ray results. NP was informed immediately. New orders were received to send resident to the ER for fracture to lateral femoral of right knee via EMS transport. Nurse (writer) contacted EMS for transportation. Assigned CNA was informed not to move resident until EMS arrival. EMS provided an estimated time of arrival of 20 minutes for pickup. RP informed of the situation, and verbalized understanding. reported to oncoming nurse of resident changes and arrival of EMS transport. Record review of Resident #1's SBAR dated 5/12/2026 completed by LVN B revealed a situation of swelling and pain to the right knee that started on 5/12/2026 and had gotten worse since it started. It was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	noted moving the right leg makes the symptoms worse and PRN acetaminophen makes the symptoms better. Further review of the SBAR functional status evaluation revealed decreased mobility to right leg and pain evaluation noted new pain to right knee with pain rating of 8 out of 10 with non-verbal signs of facial grimacing. Record review of Resident #1's progress note dated 5/13/2026 at 3:50pm by RN A revealed, Resident returned to the facility via stretcher accompanied by two EMS transporters following hospital evaluation related to suspected fracture to the lateral femoral area of the right knee. Per EMS transporter report, resident had no evidence of fracture noted during hospital evaluation. Upon return assessment, skin intact with no redness noted. Slight swelling observed to the right knee compared to the left knee. Resident unable to perform active ROM to lower extremities. During passive ROM attempt by writer, resident complained of pain to the right leg. PRN Tylenol administered as ordered for pain management. Incontinent care provided and resident tolerated care well. Resident in bed and made comfortable. NP notified of resident's return from the hospital and complaint of right leg pain. Awaiting new orders at this time. Resident continues to be monitored. Record review of Resident #1's progress note dated 5/13/2026 at 5:58pm by LVN D revealed in part, Resident seen by wound care nurse today for head to eval upon return from hospital. Skin remains intact. Edema noted to right knee. No treatment warranted at this time. Continue with weekly skin observation and notify wound care nurse for any changes or concerns in integrity. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 and discontinued 5/18/2026 for diclofenac sodium gel; 1 %; 5 cc; topical; twice a day for pain was administered 5/14/2026 - 5/18/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 and discontinued on 5/19/2026 for acetaminophen tablet; 325mg; 2 tabs oral three times a day for pain was administered at 7AM, 2PM, and 7PM on 5/13/2026 - 5/19/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 for lidocaine adhesive patch, medicated; 4 %; topical once a day to right knee for pain was administered on 5/14/2026 - 5/21/2026. Record review of Resident #1's physician order started on 5/13/2026 revealed to transfer x 2 assist utilizing a mechanical Lift. Record review of Resident #1's progress note dated 5/14/2026 at 1:07am by LVN C revealed in part, .Resident continues to have moderate swelling to right knee, unable to perform ROM due to pain. Resident is on scheduled Tylenol which was given at time of assessment. Record review of Resident #1's progress note dated 5/14/2026 at 12:59pm by RN A revealed in part, .Resident remains stable and alert at this time, but continues to report mild pain with pressure applied. No redness noted. Moderate swelling observed to the right knee compared to the left knee. Diclofenac topical applied as ordered and tolerated well. Legs elevated with pillow for comfort and to reduce swelling. Resident made comfortable in bed. Vital signs obtained. Incontinent care provided and tolerated well. Resident resting comfortably in bed at this time. Record review of Resident #1's progress note dated 5/15/2026 at 6:34am by LVN C revealed in part, .Resident continues to have moderate swelling to right knee, unable to perform ROM due to pain. Resident is on scheduled Tylenol which was given at time of assessment. No inflammation observed. Record review of Resident #1's progress note dated 5/18/2026 at 6:10pm by RN B revealed in part, . Resident in no distress. Remain on scheduled Tylenol 650mg PO three times daily until 5/19/26 and Diclofenac sodium topical to right knee twice daily until 5/20/26 related to Right knee pain. Denies pain during the shift. New order received for cold compression therapy to right knee for 10 minutes each three times daily x 5 days. Cold compression initiated per order. Knee continued to be monitored. Resident tolerated treatment without difficulty. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 and discontinued 5/20/2026 for diclofenac sodium gel; 1 %; 5 cc; topical; twice a day for right knee pain was administered 5/18/2026 - 5/20/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 and discontinued 5/22/2026 for Apply Cold compression to right Knee for 10 minutes three times a day was administered 5/18/2026 - 5/21/2026. Record Review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 for meloxicam tablet (prescription nonsteroidal (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	anti-inflammatory drug that can be used to relieve pain, swelling, stiffness, and inflammation); 7.5mg; 1 tab oral once a day was administered 5/19/2026 - 5/21/2026. Record Review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 for Tizanidine tablet (a short-acting prescription muscle relaxer); 2mg; 1 tab oral at bedtime was administered 5/19/2026 - 5/20/2026. Record review of Resident #1's progress note dated 5/19/2026 at 1:40am by LVN E revealed, Writer verified new medication order from NP B as follows: Meloxicam 7.5mg PO daily and Tizanidine 2mg PO at bedtime for pain management, nerves and muscle spasticity. Spoke with RP regarding new medication orders, no voice concerned at this time. Plan of care ongoing. Record review of Resident #1's progress note dated 5/19/2026 at 12:13pm by social worker revealed RP was contacted to schedule a care plan meeting on 5/20/2026 to discuss residents fall. Record review of Resident #1's progress note dated 5/20/2026 at 2:41am by LVN C revealed, Resident continues to remain stable, no complaints of pain or discomfort during the night. Resident remains on Diclofenac to right knee BID until 5/20. Resident tolerates cold compress to right knee TID well, will end on 5/22. Resident is Day 2/3 of Meloxicam 7.5mg QD and Tizanidine 2mg QHS which she is tolerating well with no adverse reactions noted. Will continue to monitor. Record review of Resident #1's progress note dated 5/20/2026 at 11:48am by NP B revealed in part, .chief complaint: ADL and mobility dysfunction right knee pain and fall causing decline in function. long-term resident at current facility requires consult for right knee pain s/p fall. Patient was sent to ER for further imaging. STAT x-ray ordered in facility revealed fracture to lateral femoral of right knee. Imaging in ED negative for dislocation and fracture. Primary diagnosis right knee contusion. Patient now on therapy services for decline in ADLs, function, mobility s/p hospitalization. Rehab potential is fair to good. Physiatry/PM&R consult requested for management of decline in function with impaired mobility and self-care. Patient started on lidocaine patch to right knee. Pain is controlled at rest. However, with range of motion and movement patient shows signs of pain and cannot tolerate. right knee contusion status post fall, Risk of complication: HIGH. The patient's multiple medical issues necessitate frequent clinical evaluations, placing them at high risk for readmission without proper care. Neglecting regular monitoring and management may result in symptom exacerbation and complications, possibly requiring hospitalization. Continue joint mobilization and stretching as needed as well as modalities including hot and cold packs. Pain, stiffness, and reduced joint mobility may limit therapy participation and functional gains. Deconditioning and ADL dysfunction: Case discussed with therapy team regarding goals of rehab to return patient to prior level of functioning to increase independence with mobility and self-care. Phone interview on 5/21/2026 at 11:00am, RP stated she was called on 5/11/2026 and staff told her Resident #1 had to be lowered to the floor when she was being transferred to her bed. She was told there were no injuries and the incident was no big deal and she was being contacted as a formality. The RP stated she heard nothing until the following night on 5/12/2026 where a nurse (LVN B) contacted her saying Resident was complaining of knee pain and they contacted the NP who ordered an x-ray. The RP said the next morning on 5/13/2026 the nurse (LVN B) called her back and said the x - ray showed she had a fracture and they were sending her to the hospital. The RP said this prompted her to check the camera footage from 5/11/2026 when she had her fall because she was unsure how an injury could come from something she was told was nothing major. The RP said the camera footage showed the incident was not like how they described it and it showed two staff members attempting to lift her from her chair by her arms and the resident immediately going to the ground. She was also concerned because the resident was still visibly wet from her shower and naked which caused issues with the transfer because she stated you could see the staff hands slipping and them trying to grab towels to dry her after she slipped. The RP said there was multiple failed attempts of them trying to pull her from her arms once she was on the ground and it wasn't until the bed was lowered to the ground they were able to maneuver Resident #1 onto the bed. The RP said she did have a care plan meeting with the staff on 5/20/2026 where they spoke about the transfer being incorrect and the actions they took to retrain the staff. The RP provided a copy of the video (continued on next page)

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	676450	A. Building B. Wing	05/23/2026

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	footage from Resident #1's witnessed fall on 5/11/2026. Record review of Resident #1 room video footage from 5/11/2026 at 11:35am, showed CNA A bring Resident #1 into the room in shower chair and positioned next to her bed. CNA A used a towel to dry off parts of Resident #1 and then leaves the area for a few minutes and returns with LVN A. The two staff get on both sides of the resident, LVN A faces the resident and wraps her left arm around Resident #1's left arm and places her right hand on her back. CNA wrapped her right arm around Resident #1's right arm while also holding the residents right upper arm with her left hand. LVN A and CNA A both lift Resident #1 from her chair with no gate belt and Resident #1 immediately slips down in front the shower chair. CNA A while still holding onto Resident #1's right arm reaches over to the bed to grab the towel and attempts to dry Resident #1 arms off some more and then passes the towel to LVN A for her to also dry the resident some more while they are both still holding onto her arms. The resident was then lowered down completely to the ground where she appears sitting in front the shower chair and to the right of her bed. LVN A then goes and lowers the bed down and returns back over to the resident and the two staff attempt to pull her up from the ground by hooking their arms under her armpits and holding her upper arm. They pulled the resident from both her arms and her bottom lifted from the ground but not high enough to reach the bed and she immediately slips back down ground. LVN A then goes back to the foot of bed and lowers the bed down some more, then returned back with CNA A to attempt to transfer the resident again. Both staff grab Resident #1's arms and pulled her up where her bottom touched the side of the bed but slips back down off the side of the bed and goes back down while the staff are holding her, they try again to pull her up and she slipped back down off the side of the bed again. The two staff pull her up again and was able to get the top of her body on the bed. LVN A then picks up Resident #1's legs from the floor and brings them around to the bed so that her full body is on the bed at this time. Interview on 5/21/2026 at 1:28pm, CNA A said she gave Resident #1 a shower on 5/11/2026 and her and LVN A went to transfer Resident #1 back to her bed from the shower chair and had to lower her to the ground because they were not balanced. CNA A confirmed that Resident was still wet from her shower which added complications as well with gripping the resident. CNA A said when they lowered the resident to the floor she was sitting with her legs bent and to the side. CNA A said Resident #1 did not voice any pain during the transfer attempts and the lowering to the ground. CNA A said later in the shift around 4:00pm - 5:00pm Resident #1 did have some discomfort during perineal care (gentle cleaning of the genital and anal areas). CNA A said Resident #1 said ouch when she went to turn her. CNA A said she asked Resident #1 what was wrong but she did not say anything. CNA A said MA A was in the room tending to Resident #1's roommate when this happened and she was also aware the resident had discomfort during care. CNA A could not recall if she told the nurse herself about Resident #1 having discomfort, but she believed MA A did let the nurse know. Interview on 5/21/2026 at 3:34pm, LVN A said she recalled CNA A coming to get her to assist with transferring Resident #1 to the bed on 5/11/2026 around 11:50am. LVN A said when they went to transfer Resident #1 to the bed she was not dried off all the way from her shower which caused complications with transfer. LVN A said typically Resident #1 could assist a little with the transfer and stated she had bilateral foot drop so she could not use her legs but she would usually be able to use upper body strength to hold onto them when they transfer her. LVN A said this time the resident could not assist at all. LVN A said when they initially lowered Resident #1 to the floor she did not hit anything hard on the floor and stated they were standing on a fall mat where she was lowered to. LVN A said once lowered to the ground Resident #1 had her legs folded under and laying off to the side. LVN A said it took them a few tried to get Resident #1 from the floor to the bed but was able to get the top of her body on the bed and then picked her legs up. LVN A said she did do an assessment after the incident and noted no injuries to Resident #1initially. LVN A said she did check back in on Resident #1 the remainder of the day shift and there was no complaints voiced by the resident and denied anyone reporting any pain concerns to her on 5/11/2026. LVN A said the following day on 5/12/2026 she did administer PRN Tylenol to the resident at the beginning of the shift. LVN A could not recall for sure what prompted (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	her to give the PRN pain medicine but stated she believed Resident #1's roommate (Resident #2) called and said Resident #1 had been grunting in pain. LVN A said it was her right knee that was giving her issues because she recalled seeing residents knee elevated with a pillow which she thinks was done by the CNA's. She said she recalled shifting when she went to touch the knee so she did not perform range of motion check. LVN A said she checked back with Resident #1 after she gave the medicine and it was effective and stated when she went to touch Resident #1's knee she did not shift. LVN A denied any visible swelling, redness, or skin tear to the knee. Phone interview on 5/21/2026 at 4:18pm, MA A said she recalled on 5/11/2026 hearing Resident #1 holler out while she was tending to her roommate Resident #2. MA A said CNA A was attempting perineal care at the time and Resident #1 was saying her right leg was hurting. MA A said she did go over and assist CNA A with finishing perineal care and Resident #1 was able to voice that it was her leg that was hurting and pointed at her right knee when asked. MA A said when they finished with the care she did place a pillow under the resident's knee to help with the pain. MA A said she reported Resident #1 was in pain to LVN A and LVN A told her she was already aware Resident #1 was having pain. MA A said she was not sure if and when LVN A went to check on Resident #1 because she continued to care for other residents. MA A said she did later check on Resident #1 because she would hear her randomly yelling out like she was having muscle spasms. MA A said this was all very unusual for Resident #1 and not something she typically did which made her concerned. Interview on 5/21/2026 at 4:46pm, Resident #2 said she recalled when Resident had to be assisted to the ground and stated she was in a lot of pain afterwards. Resident #2 said the same day of the fall she heard Resident #1 yelling in pain when they were trying to change her which she had never heard her do before. Resident #2 said after that Resident #1 would just be laying in bed with no one touching her and would randomly yell out and was groaning. Resident #2 said she did tell staff several times about how much pain Resident #1 was in and stated it felt like it took a few days of her being in pain before she went to the hospital. Resident #2 said she felt really bad that it took so long for them to address Resident #1's pain. Observation on 5/21/2026 at 4:50pm, Resident #1 was sleeping in bed. Bed was at the lowest setting. Surveyor attempted to greet the resident but she remained resting with eyes closed. Interview on 5/21/2026 at 6:17pm, the administrator and DON stated through their investigation they found issues surrounding Resident #1's transfer and shower procedure which were addressed and staff we in-serviced to correct the issue surrounding the fall. Phone interview on 5/21/2026 at 6:45pm, NP said she recalled being notified on 5/11/2026 that Resident #1 had to be lowered to the ground and there were no injuries or concerns reported. NP said the next time she was notified about Resident #1 was the night of 5/12/2026 and LVN B called her saying Resident #1 was having knee pain so she ordered the x-ray for the knee. The NP said initially the x-ray showed a fracture so she ordered to have her sent to the hospital but the hospital sent her back saying their scans showed no fracture. Interview on 5/21/2026 at 7:15pm, LVN B said when she came in for her shift on 5/11/2026 for the night shift, LVN A did report that Resident #1 had a fall where she was lowered to the ground during a transfer. LVN B said LVN A reported there were no injuries and the resident was fine. LVN B said during their first set of rounds the night of 5/12/2026 she was tending to Resident #1's roommate (Resident #2) while CNA C was attempting perineal care with Resident #1. LVN B said she heard Resident #1 yelling and CNA C asked her to take a look because the resident typically did not yell during care. LVN B said at that time Resident #2 mentioned that Resident #1 had been in pain all day. LVN B said she asked CNA C how she moved her that caused her to yell, and CNA C barely went to move Resident #1 right leg and she yelled out in pain. LVN B said she assisted CNA C with situating Resident #1 in bed, medicated her with PRN Tylenol, notified the NP and RP, and got orders for an x-ray to the knee. LVN B said early the next morning on 5/13/2026 she got the x-ray results which showed a fracture, she called the NP with the results, and she ordered to send Resident #1 to ER for evaluation. LVN B said Resident #1 did complain of pain again before she was transferred to the ER on [DATE] and had to medicate her with PRN Tylenol again. LVN B added that since she discovered Resident #1 was in so (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	much pain, she told the CNA to not change her or move her until they got orders from the NP. On 5/22/2026 at 12:17pm, the RP sent a text message to surveyor noting she had reviewed more of Resident #1's room camera footage and forwarded a copy of video recording from 5/11/2026 at 4:30pm which showed, she is screaming out in pain. The RP noted she had a second video recording from 5/12/2026 at 9:30pm that also showed the resident in pain, and she believed this was when the pain was reported to her and the NP. Copies of the video were provided to the surveyor. Record review of video recording from Resident #1's room camera dated 5/11/2026 at 4:30pm revealed Resident #1 lying in bed and CNA A standing on the right side of the bed. Resident #1 begins yelling owe, owe, owe while CNA is preparing supplies and not yet turning resident. The video shows MA A immediately come from the other side of the curtain and ask Resident #1 what was wrong. MA A tells Resident #1 she has to help CNA A change her and she was sorry if it was going to hurt. CNA A then rolls Resident #1 onto her right side while MA A is holding her in place so CNA A can clean Resident #1 and change her brief. Resident #1 did yell out again when she was turned and she could be heard moaning as she was held in place to be cleaned. The staff went to roll Resident #1 back on to her back and she yelled out again several times and could be heard moaning again. CNA A gathers some supplies off of the bed and then they turned Resident #1 back on to her left side to remove remaining supplies off the bed. CNA A leaves the camera view and MA A was left holding Resident #1 in place and attempted to ask Resident #1 where the pain was coming from on her right leg. MA A was observed rubbing the resident right hip and asking if it was her hip that was hurting her. A response from Resident #1 could not be heard in the recording. CNA A returned to the camera view with more supplies and a brief was placed under Resident #1, MA A was heard telling Resident #1 we are about to turn you again, it's going to hurt. The staff turned Resident #1 onto her back where she continued to yell out several times and then rolled her onto her right side to open her brief up to close it, the resident was also heard whimpering while on her side. Resident #1 was finally rested on her back for them to close her brief in the front where she yelled out some more when she was turned to lay flat on her back. Record review of video recording from Resident #1's room camera dated 5/12/2026 at 9:30pm, CNA C is seen providing perineal care to Resident #1 and she nudged Resident #1's right leg and the resident said ouch. The CNA immediately stops and calls LVN B's name who appears in the recording from behind a curtain, CNA C asked LVN B if she knew why Resident #1 was screaming and ouching and stated she had never done that with her before. CNA C then stated that Resident #2 had also told her Resident #1 had been screaming a lot. LVN B was observed to come over and assess Resident #1 to determine where the pain was coming from, she touched different areas of Resident #1's lower extremities and she yelled out when she touched her right knee. LVN B could be heard telling CNA C that Resident #1 had a recent fall and CNA C confirmed Resident #1 had not yelled out or said ouch with her before. On 5/28/2026 at 1:09pm, RP reached out to surveyor via text message and noted that Resident #1 had previously had issues with not wanting to leave her room or attend activities but over the past few months she had gotten better and had been getting up and going to dining room and attending activities in the facility which she felt was helping with her depression. RP noted since the incident she has only gotten out of bed to go to appointments and when staff do move her for care she winces in pain and say ow all the time now. The RP added, She is sleeping a lot and not eating as much the last few days. She's a

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 9 residents (Resident #1) reviewed for pain management. The facility failed to timely identify Resident #1's pain following a fall as a change in condition, failed to appropriately assess the pain, and failed to ensure ongoing monitoring and communication of the resident's pain status. Resident #1 was observed yelling in pain during care and received pain medication for more than 24 hours before the pain was fully assessed and later required hospital evaluation, a pain management regimen, and experienced a decline in functional abilities. An Immediate Jeopardy (IJ) was identified on 5/22/2026 at 2:10pm. While the IJ was removed on 5/23/2026, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not an Immediate Jeopardy and a scope of pattern as the facility continued to monitor the implementation and effectiveness of their plan of removal. This failure placed residents at risk for delayed assessment and treatment, unmanaged pain, functional decline, and hospitalization Findings included: Record review of Resident #1's facesheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Cerebral infarction (type of stroke that occurs when blood flow to a part of the brain is blocked or significantly reduced, depriving brain tissue of oxygen and vital nutrients), blindness in right eye, low vision in left eye, osteoarthritis (degenerative joint disease where the protective cartilage that cushions the ends of the bones wears away over time), Age-related osteoporosis (progressive condition where bones lose mass and structural strength as you age, becoming porous and highly fragile), Cognitive communication deficit, Fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, profound fatigue, sleep disturbances, and cognitive issues), and chronic pain. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 6 indicating severe cognitive impairment. Further review of the MDS revealed she had no behavioral symptoms or rejection of care, no scheduled pain regimen, had not received PRN pain medications, had no reports of pain, and had no falls. Record review of Resident #1's care plan revealed a problem start date of 7/13/2024 and edited on 5/13/2026 for her having osteoarthritis, fibromyalgia, and neuropathy and was at risk for pain due to impaired mobility. Interventions included to administer pain medications as ordered by physician. Document effectiveness; Assess location, frequency, duration of pain and document. Report increased pain trend to MD; Monitor and record any non-verbal signs of pain (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc); Monitor for s/s of pain/discomfort; Nonpharmacological intervention Reposition for comfort per routine rounds and PRN; Notify MD if inadequate pain relief. Record review of Resident #1 March and April 2026 MAR revealed physician order started on 3/7/2023 to EVERY shift check resident for level of pain utilizing numeric rating scale had rating of 0 out of 10 from 3/1/2026 - 4/30/2026. Record review of Resident #1 May 2026 MAR revealed physician order started on 3/7/2023 to EVERY shift check resident for level of pain utilizing numeric rating scale had rating of 0 out of 10 from 5/1/2026 - 5/12/2026 (7:00am - 7:00pm, day shift). Further review revealed on:5/12/2026 (7:00pm -7:00am, night shift) pain rating was 8 out of 10 marked by LVN B.5/13/2026 (day shift) - 0 out of 10 pain marked by RN A5/13/2026 (night shift) - 6 out of 10 pain marked by LVN C5/14/2026 (day shift) - 2 out of 10 pain marked by RN A5/14/2026 (night shift) - 2 out of 10 pain marked by LVN C5/15/2026 - 5/21/2026 - pain rating was 0 out of 10. Record review of Resident #1's March and April 2026 MAR revealed physician order started on 1/28/2026 for acetaminophen tablet; 325mg; 2 tabs oral every 8 hours as needed for mild pain was not administered. Record review of Resident #1's May 2026 MAR revealed physician order started on 1/28/2026 for acetaminophen tablet; 325mg; 2 tabs oral every 8 hours as needed for mild pain was administered (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	on:5/11/2026 at 5:16pm by LVN A for pain rate of 6 out of 10 and was marked effective.5/12/2026 at 11:46am by LVN A for pain rate of 4 using FACES scale (clinical self-assessment tool used to measure pain intensity) and was marked effective.5/12/2026 at 9:59pm by LVN B for pain rate of 8 out of 10 using FACES scale marked somewhat effective.5/13/2026 at 7:42am by LVN B for pain rate of 4 out of 10 using FACES scale marked somewhat effective.5/13/2026 at 6:35pm by RN A for pain rate of 6 out of 10 using FACES scale marked other - pain upon palpation Record review of Resident #1's progress note dated 5/11/2026 at 12:01pm by LVN A revealed, While assisting CNA to transfer resident from shower chair to bed, resident slowly started falling. We then assisted resident slowly to the floor. No verbal complaints of pain or discomfort noted. Upon assessment of resident no injuries nor bleeding present. Vital signs within normal reading. Neurochecks started per facility protocol. NP and RP notified. No new orders, Safety measurements in place. Record review of Resident #1's progress notes revealed no other entries on 5/11/2026 regarding 6 out of 10 pain noted on MAR for administration of PRN Acetaminophen at 5:16pm. Record review of Resident #1's progress note dated 5/12/2026 at 5:04am by LVN B revealed, Resident day 1/3 Post fall remain stable during this time. Denies pain or discomfort. Resident slept well throughout night with chest rise and fall and peri care provided with barrier cream applied q2h. Vital signs within normal limit. Neuros in place. Fall precautions in place. Call light and side table with belongings within reach. Record review of Resident #1's progress note dated 5/12/2026 at 2:34pm by LVN A revealed, Observation for day 2 post fall. Resident had minor pain and discomfort, PRN pain medication administered as ordered with noted relief. Neurochecks remain ongoing per protocol with no acute changes observed. Vital signs stable and within normal limits. Call light within reach. Safety measurements in place. Further review of the progress note revealed no assessment of how it was determined resident was in pain, the location of the pain, or physician notification regarding the development of pain after a fall. Record review of Resident #1's progress note dated 5/12/2026 at 9:56pm by LVN B revealed, Observation post fall. Resident had pain and discomfort right knee upon providing peri care at this time. PRN pain medication administered as ordered. Neurochecks remain ongoing per protocol. Vital signs stable and within normal limits. NP notified and informed, pending provider recommendations. Record review of Resident #1's progress note dated 5/12/2026 at 10:11pm by LVN B revealed, New order received for right knee Xray 2views. Order placed and called in. called POA. informed of new order/changes. Verbalized understanding. Record review of Resident #1's progress note dated 5/12/2026 at 11:34pm by LVN B revealed, New order received to change order to STAT right knee Xray 2views. order placed and called in. Record review of Resident #1's progress note dated 5/13/2026 at 4:40am by LVN B revealed, Upon return from lunch break, covering nurse reported that the X-ray technician arrived and obtained an X-ray of the patient's right knee as ordered. Record review of Resident #1's progress note dated 5/13/2026 at 6:10am by LVN B revealed, Upon rounding, nurse observed resident in pain. PRN pain medication was administered per physician order. Peri care was provided, and resident was repositioned for comfort with assistance of nursing staff using proper fracture precautions, including the log-roll technique and supportive positioning to avoid movement of the affected extremity. Record review of Resident #1's Right Knee x-ray results signed on 5/13/2026 at 6:22am revealed an impression of Acute non-displaced fracture of lateral femoral condyle (a crack in the outer, ball-shaped end of the thigh bone at the knee joint). Record review of Resident #1's progress note dated 5/13/2026 at 6:30am by LVN B revealed in part, .Received X-ray results. NP was informed immediately. New orders were received to send resident to the ER for fracture to lateral femoral of right knee via EMS transport. Nurse (writer) contacted EMS for transportation. Assigned CNA was informed not to move resident until EMS arrival. EMS provided an estimated time of arrival of 20 minutes for pickup. RP informed of the situation, and verbalized understanding. reported to oncoming nurse of resident changes and arrival of EMS transport. Record review of Resident #1's SBAR dated 5/12/2026 at 10:00pm completed by LVN B revealed a situation of swelling and pain to the right knee that started on 5/12/2026 and had gotten worse since it started. It was noted moving the right leg (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	makes the symptoms worse and PRN acetaminophen makes the symptoms better. Further review of the SBAR functional status evaluation revealed decreased mobility to right leg and pain evaluation noted new pain to right knee with pain rating of 8 out of 10 with non-verbal signs of facial grimacing. Record review of Resident #1's progress note dated 5/13/2026 at 3:50pm by RN A revealed, Resident returned to the facility via stretcher accompanied by two EMS transporters following hospital evaluation related to suspected fracture to the lateral femoral area of the right knee. Per EMS transporter report, resident had no evidence of fracture noted during hospital evaluation. Upon return assessment, skin intact with no redness noted. Slight swelling observed to the right knee compared to the left knee. Resident unable to perform active ROM to lower extremities. During passive ROM attempt by writer, resident complained of pain to the right leg. PRN Tylenol administered as ordered for pain management. Incontinent care provided and resident tolerated care well. Resident in bed and made comfortable. NP notified of resident's return from the hospital and complaint of right leg pain. Awaiting new orders at this time. Resident continues to be monitored. Record review of Resident #1's progress note dated 5/13/2026 at 5:58pm by LVN D revealed in part, Resident seen by wound care nurse today for head to eval upon return from hospital. Skin remains intact. Edema noted to right knee. No treatment warranted at this time. Continue with weekly skin observation and notify wound care nurse for any changes or concerns in integrity. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 and discontinued 5/18/2026 for diclofenac sodium gel; 1 %; 5 cc; topical; twice a day for pain was administered 5/14/2026 - 5/18/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 and discontinued on 5/19/2026 for acetaminophen tablet; 325mg; 2 tabs oral three times a day for pain was administered at 7AM, 2PM, and 7PM on 5/13/2026 - 5/19/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/13/2026 for lidocaine adhesive patch, medicated; 4 %; topical once a day to right knee for pain was administered on 5/14/2026 - 5/21/2026. Record review of Resident #1's physician order started on 5/13/2026 revealed to transfer x 2 assist utilizing a mechanical lift. Record review of Resident #1's progress note dated 5/14/2026 at 1:07am by LVN C revealed in part, .Resident continues to have moderate swelling to right knee, unable to perform ROM due to pain. Resident is on scheduled Tylenol which was given at time of assessment. Record review of Resident #1's progress note dated 5/14/2026 at 12:59pm by RN A revealed in part, .Resident remains stable and alert at this time, but continues to report mild pain with pressure applied. No redness noted. Moderate swelling observed to the right knee compared to the left knee. Diclofenac topical applied as ordered and tolerated well. Legs elevated with pillow for comfort and to reduce swelling. Resident made comfortable in bed. Vital signs obtained. Incontinent care provided and tolerated well. Resident resting comfortably in bed at this time. Record review of Resident #1's progress note dated 5/15/2026 at 6:34am by LVN C revealed in part, .Resident continues to have moderate swelling to right knee, unable to perform ROM due to pain. Resident is on scheduled Tylenol which was given at time of assessment. No inflammation observed. Record review of Resident #1's progress note dated 5/18/2026 at 6:10pm by RN B revealed in part, . Resident in no distress. Remain on scheduled Tylenol 650mg PO three times daily until 5/19/26 and Diclofenac sodium topical to right knee twice daily until 5/20/26 related to Right knee pain. Denies pain during the shift. New order received for cold compression therapy to right knee for 10 minutes each three times daily x 5 days. Cold compression initiated per order. Knee continued to be monitored. Resident tolerated treatment without difficulty. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 and discontinued 5/20/2026 for diclofenac sodium gel; 1 %; 5 cc; topical; twice a day for right knee pain was administered 5/18/2026 - 5/20/2026. Record review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 and discontinued 5/22/2026 for Apply Cold compression to right Knee for 10 minutes three times a day was administered 5/18/2026 - 5/21/2026. Record Review of Resident #1's May 2026 MAR revealed physician order started on 5/18/2026 for meloxicam tablet (prescription nonsteroidal anti-inflammatory drug that can be used to relieve pain, (continued on next page)

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	676450	A. Building B. Wing	05/23/2026

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

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Record review of Resident #1's progress note dated 5/19/2026 at 12:13pm by social worker revealed RP was contacted to schedule a care plan meeting on 5/20/2026 to discuss residents fall. Record review of Resident #1's progress note dated 5/20/2026 at 2:41am by LVN C revealed, Resident continues to remain stable, no complaints of pain or discomfort during the night. Resident remains on Diclofenac to right knee BID until 5/20. Resident tolerates cold compress to right knee TID well, will end on 5/22. Resident is Day 2/3 of Meloxicam 7.5mg QD and Tizanidine 2mg QHS which she is tolerating well with no adverse reactions noted. Will continue to monitor. Record review of Resident #1's progress note dated 5/20/2026 at 11:48am by NP B revealed in part, .chief complaint: ADL and mobility dysfunction right knee pain and fall causing decline in function. long-term resident at current facility requires consult for right knee pain s/p fall. Patient was sent to ER for further imaging. STAT x-ray ordered in facility revealed fracture to lateral femoral of right knee. Imaging in ED negative for dislocation and fracture. Primary diagnosis right knee contusion. Patient now on therapy services for decline in ADLs, function, mobility s/p hospitalization. Rehab potential is fair to good. Physiatry/PM&R consult requested for management of decline in function with impaired mobility and self-care. Patient started on lidocaine patch to right knee. Pain is controlled at rest. However, with range of motion and movement patient shows signs of pain and cannot tolerate. right knee contusion status post fall, Risk of complication: HIGH. The patient's multiple medical issues necessitate frequent clinical evaluations, placing them at high risk for readmission without proper care. Neglecting regular monitoring and management may result in symptom exacerbation and complications, possibly requiring hospitalization. Continue joint mobilization and stretching as needed as well as modalities including hot and cold packs. Pain, stiffness, and reduced joint mobility may limit therapy participation and functional gains. Deconditioning and ADL dysfunction: Case discussed with therapy team regarding goals of rehab to return patient to prior level of functioning to increase independence with mobility and self-care. Phone interview on 5/21/2026 at 11:00am, RP stated she was called on 5/11/2026 and staff told her Resident #1 had to be lowered to the floor when she was being transferred to her bed. She was told there was no injuries and the incident was no big deal and she was being contacted as a formality. The RP stated she heard nothing until the following night on 5/12/2026 where a nurse (LVN B) contacted her saying Resident was complaining of knee pain and they contacted the NP who ordered an x-ray. The RP said the next morning on 5/13/2026 the nurse (LVN B) called her back and said the x - ray showed she had a fracture and they were sending her to the hospital. The RP said this prompted her to check the camera footage from 5/11/2026 when she had her fall because she was unsure how an injury could come from something she was told was nothing major. The RP said the camera footage showed the incident was not like how they described it and it showed two staff members attempting to lift her from her chair by her arms and the resident immediately going to the ground. She was also concerned because the resident was still visibly wet from her shower and naked which caused issues with the transfer because she stated you could see the staff hands slipping and them trying to grab towels to dry her after she slipped. The RP said there were multiple failed attempts of them trying to pull her from her arms once she was on the ground and it wasn't until the bed was lowered to the ground they were able to maneuver Resident #1 onto the bed. The RP stated she was told it was not until 5/12/2026 night that a CNA noticed Resident #1 was in pain but she questioned why it was the CNA who noticed she was in pain and not the nurse if the nurse was supposed to be monitoring after a fall and completing assessments. The RP said she did (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	have a care plan meeting with the staff on 5/20/2026 where they spoke about the transfer being incorrect and the actions they took to retrain the staff. The RP said she asked about why the nurse did not identify the resident was in pain if she was supposed to be completing post fall assessments and she was told that the nurses monitor for 72 hours after a fall and the pain was identified within this time frame so that meant the post fall assessments were properly being done. The RP said she had concerns on how the nurses were supposedly completing assessments because if they were checking the resident's range of motion then they should have been the ones that identified Resident #1 was in pain. The RP provided a copy of the video footage from Resident #1's witnessed fall on 5/11/2026. Record review of Resident #1 room video footage from 5/11/2026 at 11:35am, showed CNA A bring Resident #1 into the room in shower chair and positioned next to her bed. CNA A used a towel to dry off parts of Resident #1 and then leaves the area for a few minutes and returns with LVN A. The two staff get on both sides of the resident, LVN A faces the resident and wraps her left arm around Resident #1's left arm and places her right hand on her back. CNA wrapped her right arm around Resident #1's right arm while also holding the residents right upper arm with her left hand. LVN A and CNA A both lift Resident #1 from her chair with no gate belt and Resident #1 immediately slips down in front of the shower chair. CNA A while still holding onto Resident #1's right arm reaches over to the bed to grab the towel and attempts to dry Resident #1 arms off some more and then passes the towel to LVN A for her to also dry the resident some more while they are both still holding onto her arms. The resident was then lowered down completely to the ground where she appears sitting in front the shower chair and to the right of her bed. LVN A then goes and lowers the bed down and returns back over to the resident and the two staff attempt to pull her up from the ground by hooking their arms under her armpits and holding her upper arm. They pulled the resident from both her arms and her bottom lifted from the ground but not high enough to reach the bed and she immediately slips back down ground. LVN A then goes back to the foot of bed and lowers the bed down some more, then returned back with CNA A to attempt to transfer the resident again. Both staff grab Resident #1's arms and pulled her up where her bottom touched the side of the bed but slips back down off the side of the bed and goes back down while the staff are holding her, they try again to pull her up and she slipped back down off the side of the bed again. The two staff pull her up again and was able to get the top of her body on the bed. LVN A then picks up Resident #1's legs from the floor and brings them around to the bed so that her full body is on the bed at this time. Interview on 5/21/2026 at 1:28pm, CNA A said she gave Resident #1 a shower on 5/11/2026 and she and LVN A went to transfer Resident #1 back to her bed from the shower chair and had to lower her to the ground because they were not balanced. CNA A said when they lowered the resident to the floor she was sitting with her legs bent and to the side. CNA A said Resident #1 did not voice any pain during the transfer attempts and the lowering to the ground. CNA A said later in the shift around 4:00pm - 5:00pm Resident #1 did have some discomfort during perineal care (gentle cleaning of the genital and anal areas). CNA A said Resident #1 said ouch when she went to turn her. CNA A said she asked Resident #1 what was wrong but she did not say anything. CNA A said MA A was in the room tending to Resident #1's roommate when this happened and she was also aware the resident had discomfort during care. CNA A could not recall if she told the nurse herself about Resident #1 having discomfort, but she believed MA A did let the nurse know. Interview on 5/21/2026 at 3:34pm, LVN A said she recalled CNA A coming to get her to assist with transferring Resident #1 to the bed on 5/11/2026 around 11:50am and they had to assist Resident #1 to the ground due to complications with the transfer. LVN A said when they initially lowered Resident #1 to the floor she did not hit anything hard on the floor and stated they were standing on a fall mat where she was lowered to. LVN A said once lowered to the ground Resident #1 had her legs folded under and laying off to the side. LVN A said she did do an assessment after the incident and noted no injuries to Resident #1 and she stated she did check her range of motion and the resident had no complaints at the time of the incident. LVN A said she notified the NP of the incident and the NP texted her to continue to monitor the resident. LVN A (continued on next page)

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