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	06/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure the resident's environment remains as free of accident hazards as is possible and residents received adequate supervision to prevent accidents for 1 out of 5 residents (Resident # 1) reviewed for quality of care.The facility failed to ensure Resident # 1's head of bed was upright and elevated, and that Resident # 1 was closely supervised during and after administration of oral medications on 5/23/26.This failure places residents at risk of aspiration and choking when administering oral medications. Findings include: Record review of Resident # 1's Face Sheet revealed a [AGE] year-old female with an admission date of 3/29/2023. Diagnoses were hypertension (a chronic medical condition in which the force of blood against your artery walls is consistently too high), unspecified dementia (used when a patient exhibits a clear decline in cognitive abilities (such as memory loss or problem-solving), but the underlying cause or specific type of dementia (e.g., Alzheimer's, vascular) cannot be definitively determined), rheumatoid arthritis (systemic autoimmune disease in which the immune system mistakenly attacks the lining of the joints (synovium), causing painful inflammation, cartilage destruction, and bone erosion), dysphagia (difficulty or discomfort in swallowing), cognitive communication deficit (an impairment in the ability to communicate effectively that stems from underlying cognitive issues).Record review of Speech Language Discharge Summary for Resident # 1 dated 12/12/2025 reflected Interventions included instruction and training in safe swallow strategies to increase PO intake and decrease overall aspiration risk. Strategies indicated to facilitate safety and efficiency for oral intake were to alternate liquids or solids, rate modification (slow down/regulate), general swallow techniques, precautions upright during meals and upright for 30 minutes after meals with close supervision.Record review of Resident # 1's Care Plan goal dated 5/19/2026 indicated Resident # 1 will not choke or aspirate through next review date. Care Plan updated 6/1/2026 indicated Resident # 1 has nausea and vomiting and risk of aspiration related to diagnosis of difficulty swallowing (Dysphagia) with interventions of appropriate head of bed elevation during and after meals and medication administration. Approah did not include close supervision during PO intakeRecord review of MDS dated [DATE] for Resident # 1 revealed the ability to use utensils or to bring food or liquid to mouth and swallow required assistance to complete tasks.Record review of grievance dated 5/23/2026 for Resident # 1 read in part I seen on video a Medication Aide is giving medication while Resident # 1 is lying flat in the bed.Reported Resident # 1 began to vomit as seen on video cameraRecord review of progress note dated 5/23/2026 at 9:37 am for Resident # 1 read in part Resident was observed during morning rounds to have emesis (vomiting) on pillowcase on bed. Resident noted to have some residue around mouth area.Observation of recorded video dated 5/23/2026 at 7:43 am revealed Resident # 1 in bed. Bed observed to be in lowest position to the floor and head of bed was lower than 45 degrees, not upright. MA A walked into Resident # 1's room with two cups of pudding mixed with medication in left hand and a plastic cup of water in right hand. MA A walked to Resident # 1's nightstand on the left side of Resident # 1's bed. MA A placed plastic cup from right hand and one pudding cup from left hand onto nightstand. MA A did not raise Resident # 1's (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed higher from floor or head of bed upright before administration of pudding cup and water to Resident # 1. MA A was seen bent over and leaned in closer to Resident # 1's upper body near head with one pudding cup in left hand to assist feed Resident #1. MA A was seen placing pudding cup from left hand on to nightstand and picking up second pudding cup from Resident # 1's nightstand using right hand to assist feed Resident # 1. MA A was seen bent over and leaning towards Resident # 1's upper body near head. MA A was then seen picking up plastic cup of water with right hand and leaning over to Resident # 1 before placing plastic cup back on nightstand and continued with second pudding cup. MA A then grabbed all three cups and exited Resident # 1's room. MA A returned to Resident # 1's room, grabbed a Kleenex near door of room, looked in the direction of Resident # 1 and exited room again and closed door. MA A was seen in Resident # 1's room for approximately 4 minutesIn an interview on 6/9/2026 at 12:15pm LVN stated Resident # 1 was to sit up at 90 degrees and medications were to be crushed when given with water. LVN stated Resident # 1 needed to sit up at 90 degrees due to aspiration precautions. LVN stated MAR or care plan would indicate whether the resident head of bed was to be at 90 degrees or 45 degrees during PO medications and meals.In an interview on 6/9/2026 at 12:37pm CNA B stated Residents were to sit at a 45-to-90-degree angle to be sure the resident does not choke when given food or medication by mouth. CNA B said she has seen Resident # 1 at a 45-degree angle when staff administered medication. CNA B explained a 90-degree angle would be straight up and 45 is in between 0 and 90 for the head of the bed. CNA B stated Resident # 1 should be straight up after meals, and after given medication. CNA B stated policy was to ask the nurse on the floor about any position questions for residents however CNA B was trained to have residents at least 45-degree angle.In an interview on 6/9/2026 at 1:17pm Family Member stated Resident # 1 was often given medication using pudding or liquid to help Resident # 1 swallow the medication. Family Member stated Resident # 1 was typically in a higher position and upright when given food or medication. Family Member stated ADON A was aware of the concern regarding video dated 5/23/2026 of Resident # 1 not upright when given food or medication.Interview on 6/9/2026 at 1:43pm MA A stated she was PRN with the facility and would come in once in a while. MA A was expected to find out resident needs from the nurse on duty since MA A did not work with the residents daily. MA A stated the process of medication administration was to look at the MAR of which medication to give and if the resident takes the medication crushed or not. Check blood pressure if need and other vitals. Go into the resident's room, introduce self, and inform resident of the process or medication given, also align the resident in the right position. MA A said the correct position was to be sitting upright and the head should not be laid flat. MA A stated hands should be sanitized before going into resident's room. MA A stated Resident # 1's bed was not raised from the floor, but the head was raised enough for Resident # 1 to swallow. MA stated if she could not bend down to administer, she would raise the bed. MA A stated she did not give medication with Resident # 1 lying flat because they might choke. MA A stated she was told by LPN to stop administering medications on the floor and someone else would administer because Resident # 1's head was not raised and Resident # 1 vomited. MA A stated she was informed there were cameras in Resident # 1's room that saw Resident # 1's bed in a low position to the floor and head was not raised. MA A did not see Resident # 1 vomit as she saw Resident # 1 swallow the medication before MA A left Resident # 1's room. MA A stated the only report was to crush Resident # 1's medication and there were no instructions on HOB level. MA A was given in-service after the incident, however, and has not been at the facility since 5/23/2026.In an attempted interview on 6/9/2026 at 2:00 pm left voicemail for LPN with call back information.In an interview on 6/9/2026 at 2:12 pm ADON B stated the process of medication administration was to follow the rights, verify orders, and prepare the medications. Knock on door and introduce self and medications, verify resident, then give medications and make sure medications are swallowed and do not leave any medications at the bedside and HOB was elevated between 30 and 45 degrees. ADON B stated remembered someone told her (unable to remember who) that Resident # 1's HOB was not completely elevated and Resident # 1 got choked up a little. ADON B (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated said there is a risk of choking or aspiration and for digestion when HOB was not elevated to swallow medication correctly which was a nursing standard for at least 30 degrees.In an interview on 6/9/2026 at 2:38pm ADON A stated received a call from family member that MA A had the resident flat ADON A spoke to MA A and was told Resident # 1's bed was not completely flat, however was not as high as other MAs. ADON A asked MA A to go home for the day. ADON A stated Resident # 1's bed was at 30-degree angle but should have been 45 or higher. ADON stated order for HOB would not be needed but all residents are individualized with needs. ADON A stated Resident # 1 had a speech study in the past but would need to review when that was completed. ADON did not see vomit on Resident # 1's face however she did receive a report vomit was on Resident # 1's mouth. Resident # 1 would alternate with the use of pudding cups to help administer crushed medication and sips of water.Interview on 6/9/2026 at 3:18 pm with SLP said Resident # 1 was discontinued speech services as of 12/12/2025 as goals were met to the best of Resident #1's ability. SLP completed a swallow test on Resident # 1 on 5/29/2026 and recommended Resident # 1 to be upright 90 degrees during medication pass and meals and can lower head of bed to 45 degrees to be sure food digested. Resident # 1 has a narrow space to swallow and digest. Resident #1 was at risk of and higher chance of aspiration with the head of bed at a low angle. To maximize safety Resident # 1 head of bed was to be elevated during meals and PO for medication. SLP stated when Resident # 1 was discharged from speech services it was recommended to have Resident # 1 upright during oral intake including food however that would not exclude medication because Resident # 1 took medications orally by mouth. Resident # 1 took an extended time to swallow or eat and acknowledged it would take Resident # 1 the same rate with swallowing medications. SLP observed video dated 5/23/2026 and stated Resident # 1 was not flat however Resident # 1 was also not elevated.In an interview on 6/9/2026 at 3:35pm DON stated residents should be 30 to 45 degrees for any PO medications unless there are recommendations from physician or any other service. DON stated spoke to MA A and was told Resident #1 was not flat and HOB was elevated and MA A held the Resident #1's head up during PO for medication. DON stated there were orders or recommendations for Resident # 1's HOB to elevate higher than 30 degrees. DON stated PRN staff report to the nurse and complete morning huddle and review the resident file for any special recommendations. There was a swallow study requested for Resident #1 due to feeding assistance and takes time with meals to swallow. DON stated 30 degrees was not completely upright and there would be a risk for aspiration, choking or breathing difficulty.In an interview on 6/9/2026 at 3:55 pm Administrator said she was informed that MA A gave medications while Resident # 1 was laying down. Administrator stated that MA A was interviewed and stated Resident # 1 was not flat but was not elevated and elevated Resident # 1's head with MA's arm to administrator medication. Administrator stated Resident # 1 was not flat but was not at recommended HOB. Administrator stated there may be a risk of choking if HOB was not elevated during PO for medication.Record review of facility policy CMA Job Description dated 11/2016 read in part Intervene in any safety hazard or other potential hazard. Safety concerns are identified and appropriate actions are taken to assure patient safety. Observes patient/ resident needs while giving medications and notifies floor staff for assistance as appropriate.