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	12/23/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on interview and record review, the facility failed to ensure the coordination of assessments with the Pre-Admission Screening and Resident Review (PASRR) program was provided for 1 of 4 residents reviewed for PASRR screenings (Resident #104). The facility did not correctly identify Resident #104 as having mental illness in her PASRR Level 1 Screening. This failure could place residents with documented mental illness diagnoses at risk of not receiving needed care and services in the appropriate setting. Findings included: Record review of Resident #104 's face sheet, not dated revealed a [AGE] year-old female with diagnoses of metabolic encephalopathy (a disorder that affects brain function), depression, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). Record review of physician orders dated 11/19/24 indicated Resident #104 was prescribed Mirtazapine 7.5 mg once daily and Sertraline 50mg once daily for depression. Record review of the most recent comprehensive MDS dated [DATE] indicated Resident #104 had a BIMS of 9 which indicated moderate cognitive impairment. Resident #104 had active diagnoses of anxiety disorder and depression and was taking an antidepressant. Record review of Resident #104's care plan dated 11/15/24 indicated Resident #104 received antidepressant medication r/t dx depression. Approaches included: assess/record effectiveness of drug treatment, monitor and report signs of sedation, hypotension, or anticholinergic symptoms, monitor resident's mood and response to medication, and psych consult for medication management and GDR. Record review of the PASRR level 1 screening from the facility dated 10/04/24 indicated Resident #104 was negative for mental illness, intellectual disability, and developmental disability. Interview with Resident #104 on 12/17/24 at 10:03 am, she said her only concern was a wound on her belly, she said the wound was healing. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the MDS Coordinator on 12/19/24 at 11:05 am, she said she had worked at the facility for 6 months. She said the process for PASRR was they conducted their assessment according to the information form the PASRR from the hospital had. If there was a discrepancy found, they fill out form 1012 and verify with physician if the resident had the correct diagnoses. The MDS Coordinator said she would fill out form 1012 for Resident #104, and she was not sure why Resident #104's PASRR was missed. She said there was supposed to be another MDS Nurse that would look behind and then the Corporate MDS nurse would assist. She was the only MDS Coordinator currently at this facility. The MDS Coordinator said the risk to the resident would be they would not qualify for services they need. Interview with the Corporate MDS Nurse on 12/19/24 at 11:58 am, she said the hospital issued the initial PASRR and if the facility identified a positive PASRR for a resident then they would fill out form 1012. She said Resident #104 was receiving psych services from the facility. The Corporate MDS Nurse said the MDS nurses should check for accuracy of the resident's records. Record review of the PASRR Documentation Policy dated 11/1/17 read in part . 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs, and 3) receive the services they need in those settings .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observation, interview and record review, the facility failed to ensure that a residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings, for 1 (Resident #85) of 6 residents that were reviewed for feeding tubes. The facility failed to ensure RN A verified G-tube (Gastrostomy tube a surgically placed tube directly into the stomach to deliver food and medicine) placement. RN A failed to aspirate (the act of withdrawing fluid from the stomach to check G-tube placement and measure stomach content) prior to administering water flushes and medications. RN A failed to administer G-tube water flushes and medications by gravity (the use of gravity to move the water flushes and medications through the G-tube into the resident). This failure could place residents at risk for adverse reactions, inadequate therapy, and a decreased quality of life. Finding included: Record review of Resident #85's face sheet undated reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #85 had diagnoses which included: nontraumatic subarachnoid hemorrhage (bleeding in the brain without trauma), dysphagia (swallowing difficulties), aphasia (language disorder that makes it difficult to speak), cognitive communication deficit, and gastrostomy status. Record review of Resident #85's quarterly MDS assessment dated [DATE] revealed his BIMS score was not completed. Resident #85's cognitive skills for daily decision making were scored as modified independence, which indicated some difficulty in new situations only. The resident was always continent of bowel and bladder. The MDS revealed Resident #85 required supervision for the resident to sit to stand, chair to bed transfer and walk 10 feet. The MDS identified Resident #85's active diagnoses were neurological conditions, aphasia and dysphagia. Record review of Resident #85's care plan last review dated 12/11/2024 revealed: Problem Category: Nutritional Status. Resident #85 received enteral nutrition (feeding by G-tube) support to meet 100% energy, protein and hydration needs. Goal: prevent weight loss, dehydration, aspiration, choking, nausea, vomiting and diarrhea Approach: Resident received enteral nutrition support Glucerna 1.2 at 65cc an hour for 22 hours with water flush 225 cc every 6 hours. Record review of Resident #85's Physician Order Report dated 11/17/2024-12/17/2024 revealed placement verification. Check Residual. If residual was 150ml or less reinsert volume into stomach and continue feeding. If residual was greater than 150ml, hold feeding and notify physician. Every Shift. Order start dated 03/07/2023. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #85's Enteral Administration History dated 12/01/2024-12/17/2024 reflected every shift. Continued review of the administration record revealed RN A documented she checked the G-tube residual on the first shift 7:00AM-7:00PM on 12/17/2024. During an observation on 12/17/2024 at 1:38 PM of medication administration for Resident #85 revealed RN A checked the resident's vital signs. RN A washed her hands. The RN crushed Resident #85's Metoprolol (blood pressure medication) 25 mg one half tablet. RN A added 10ml water to the medication cup. RN A measured 2 medication cups with 30 ml water to flush the G-tube before and after the medication. Resident #85 was awake and alert sitting up straight in bed. The resident was non-verbal. RN A withdrew the 30ml of water with the syringe and slowly pushed the water using the syringe plunger into the G-tube. RN A withdrew the medication using the syringe. The medication was administered slowly into the G-tube using the syringe plunger. The water flush was withdrawn using the syringe. RN A did not aspirate for stomach content prior to administering the resident's flushes and medication. RN A did not allow the flushes and medication to flow by gravity. RN A slowly administered the water flush to the G-tube by the syringe plunger. Resident #85 was sitting up watching TV. Observation of the resident after the medication administration revealed the resident tolerated the procedure. The resident pulled up his pants to cover his abdomen. Resident #85 got himself up out of bed to walk in the room. During an observation on 12/17/2024 at 3:00 PM revealed Resident #85 sitting up in bed alert. During an interview on 12/17/2024 at 3:11 PM RN A stated she did check Resident #85's residual earlier in the morning. RN A stated she did not check it when she administered the Metoprolol. RN A stated she knew she should have checked the residual again before she administered the medication. RN A stated the residual was to be checked to make sure the resident's food and medications were digested. RN A added checking the residual was to make sure there was not too much in the resident's stomach. RN A stated she did use the plunger to administer the flushes and the medication because the resident's g-tube clogged so easily. RN A stated it was hard to get a good gravity flow. RN A stated she knew when administering anything in the tube it was to go by gravity. RN A added by using the plunger it could put force on the tube. It could push more air in the resident. RN A stated she would go back to basic nursing procedure and follow protocol next time. During an interview on 12/18/2024 at 1:07 PM the DON stated RN A reported to her yesterday that she made errors when administering the medications to Resident #85. The DON stated she reported first she did not aspirate for the residual, second she did not administer the medication by gravity. The DON stated the g-tube was to be aspirated to make sure the tube was in the correct place, to make sure there was not too much in the resident's stomach. The risk of not aspirating to check residual was not knowing if the tube was in the correct place and placing too much fluid in the resident's stomach. The DON stated flushes and medications administered by G-tube were to be administered by gravity, not pushed with the plunger. The risk of pushing with the plunger was putting too much force on the tube. There was a risk of aspiration from pushing the medications in. The DON stated an inservice with RN A and the other nurses was done on 12/17/2024. The nurses would be monitored to make sure the medications were given correctly. The DON stated the nurses were responsible for administering the medications correctly. The nurses were aware to check residual and administer medications to the g-tube correctly. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/18/2024 at 1:38 PM the Administrator stated her expectations for administering medications were the physician's orders were followed. The administrator state she expected best practice and protocol were followed. The Administrator stated she did not have a clinical background and was not sure of the risk. The administrator stated inservices have been conducted to reeducate the staff. The Administrator stated the facility followed the Lippincott Nursing Procedures 9th edition as the policy. Record review of the facility policy revision dated May 5, 2024 titled Enteral Feeding- Administering Medications read in part Policy; The licensed nurse will administer medications prescribed by the physician to be given by enteral tube, using the appropriate method according to recognized standards of practice. The licensed nurse will verify correct tube placement on those devices that are not inserted directly into the gut, per current clinical standards of practice .Cross Reference: Lippincott Nursing Procedures 9th Ed., Enteral Tube Drug Instillation, pages 303-305. Record review of Lippincott Nursing Procedures titled Enteral Tube Drug Instillation undated read in part . Implementation . Verify enteral tube placement . Aspirate tube contents and inspect visual characteristics. A picture in the policy identified the use of gravity .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47709 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 for 1 kitchen . A 13.7 quart container of brown sugar was not labeled and not sealed in the facility kitchen. This deficient practice could place residents who received meals from the main kitchen at risk for food borne illness. Findings included: Observation in the facility kitchen on 12/17/2024 at 08:25 am revealed one 13.7-quart clear full-size container of 25lb brown sugar was left open to air and not labeled. In an interview with the [NAME] on 12/18/2024 at 11:34 am, he said if the container of brown sugar is left open anything can fall inside. He said chemicals and pests can fall inside of the sugar. He said if the sugar is left open the sugar can become contaminated. He said once the sugar is contaminated the residents can become sick. He said making sure the container is labeled and the lid is completely closed can prevent contamination. He said by properly storing the items it would prevent the need to throw away sugar. In an interview with the Dietary Manager on 12/18/2024 at 11:41 am, she said she noticed the brown sugar lid was not covered on the container. She said she noticed the container of brown sugar was not labeled. She said by the brown sugar being left open anything can fall in and cause contamination. She said by leaving the brown sugar open it can cause the residents to become extremely sick. She said she expected her workers to follow policy and procedures. In an interview with the Administrator on 12/23/2024 at 3:18pm, she said the staff in the kitchen should have the brown sugar in the container labeled and stored per policy. She said by the sugar being open to air it can cause the residents to become sick. She said she expected the kitchen staff to store and label all foods properly following policies and procedures. Record review of the facility's Nutrition Policies and Procedures dated June 2023 reflected .Policy: Food will be received and stored by methods to minimize contamination and bacterial growth Dry Storage Guidelines: 2. Tightly seal opened packages to prevent contamination or place food in covered containers .3. Containers holding food or food ingredients that are removed from their original packages such as cooking oils, flour, sugar, herbs, and spices are identified with the common name of the food.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 47709 Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpsters reviewed for garbage disposal. The facility failed to ensure 1 of 2 dumpster lids was secured. This failure could place residents at risk of infection for exposure to germs and diseases carried by rodents from improperly disposed garbage. Findings included: Observation on 12/17/24 at 8:47am, revealed the facility's dumpster area, which was in the back area of the facility. The dumpster on the left side: lid was wide open. Interview on 12/18/2024 at 11:35am, with the Cook, he said if the lid is not closed on the dumpster, it can draw bugs, flies, rodents, roaches, and raccoons. The cook said if the pest was to roam around the dumpster the pest could possibly go toward the facility. The cook said if pests would surround the facility, it would become a safety issue for the residents. Interview on 12/18/2024 at 11:41am, with the Dietary Manager, she said all the workers know they are supposed make sure the lid is always closed. She said if the dumpster lid is not closed gnats, bugs or any pest can surround the dumpster. She said when the pests and rodents surround the dumpster, they could possibly get to the facility which could cause a problem with the residents. Record review of the Facility's Nutrition Policies and Procedures dated 6/20/2023 reflected Policy: .Waste will be disposed of in a manner to prevent transmission of disease, nuisance or breeding place for insects and feeding places for rodents and other mammals .Procedures: 5. Always cover waste containers and close dumpsters . 7. Keep area around refuse dumpsters clean, odor free and without cracks. Record review of the Facility's Food-Related Garbage and Rubbish Disposal policy, revised April 2006 revealed . 2. All garbage and rubbish containers shall be provided with tight-fitting lids or covers and must be covered when stored or not in continuous use. 5. Garbage and rubbish containing food wastes will be stored in a manner that is inaccessible to vermin. 7. Outside dumpsters provided by garbage pick-up services will be kept closed and free of surrounding litter.