

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER Solera at West Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Greenhouse Road Houston, TX 77084	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923</p> <p>Based on interview and record review the facility failed to ensure the resident's right to be free from abuse for 1 of 6 residents (Resident #1), in that:</p> <p>CNA C was seen on camera being verbally abusive aggressive towards Resident #1 which resulted in the resident feeling unsafe at the facility.</p> <p>This failure could place residents receiving care at risk of experiencing continued psychological distress and declining mental health.</p> <p>Findings included:</p> <p>Record review of Resident #1's clinical notes dated 3/20/24 at 1:29am by the Social Worker, resident is alert and oriented x4 (a measure indicating an individual is aware of their surroundings, knows who they are, where they are and what time it is, a positive sign of cognitive function).</p> <p>Record review of Resident#1's facesheet dated 3/21/24 revealed he was admitted on [DATE] with diagnoses of transverse myelitis (spinal cord inflammation, causing pain, muscle weakness and paralysis), paraplegia (the loss of the ability to move the legs and lower body), ocular hypertension (pressure increases within the eye and can cause damage and vision loss), anxiety disorder (group of mental illnesses that cause constant fear, worry and restlessness) and hyperlipidemia (abnormally high levels of lipids or fats in the blood).</p> <p>Record review of Resident #1's MDS dated [DATE] revealed that his BIMS (Brief Interview for Mental Status, an assessment to determine cognitive function) score was 13.</p> <p>Record review of Resident #1's care plan dated 3/8/2024 revealed:</p> <ul style="list-style-type: none"> -Resident has a diagnosis of Anxiety Disorders manifested by Verbal Distress -Resident has a diagnosis of Anxiety Disorder with physical manifestations of anxiety. -Resident requires extensive assistance with: turning/positioning in bed, transfers, dressing, toileting, locomotion on and off his wheelchair <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident is totally dependent on the staff for bathing</p> <p>Record review of the facility's grievance log revealed there was no record of the incident on 3/19/24.</p> <p>Record review of the facility's Incident/Accident report log date revealed no record of the incident on 3/19/24.</p> <p>Record review of Resident #1's Grievance Reports revealed that on 8/17/23 Resident #1's family member reported to the facility that a staff member was rude. The former DON met with Resident #1 alone, who stated he did not have an issue with the nurse but feels like she talks loudly at times. The DON stated she will provide education and guidance to the nurse on customer service. DON also provided her number to Resident #1 and told him to call with any concerns. On 12/28/23, Resident #1's family member said the facility did not allow resident to go to bed at his preferred time. Resident #1 told the staff that he does not have a problem. On 2/28/2024, Resident #1's family member said she believed a staff member bumped Resident #1's toes while transferring him and that the staff blocked the camera. The facility educated staff on ensuring no items are obstructing the camera's view going forward. The facility also conducted an interview to determine if there were incidents where Resident #1 could have been injured; therapy also evaluated Resident #1 for wheelchair safety.</p> <p>Interview with Resident #1's family member on 3/21/24 at 1:10pm, she said on 3/19/24 around 9:00pm she has video evidence of CNA F and CNA C being rude to Resident #1 and accusing him and his family member of being verbally and racially abusing staff members. She denied this and stated that she does raise her voice but has never been racist towards staff. She was difficult to follow as she required frequent redirection back to answering questions. She mentioned several incidents of inadequate care which ended in her asking Administration to limit certain staff from providing care to Resident #1.</p> <p>Additional interview with Resident #1's family member on 3/21/24 at 3:06pm, she stated that she reported this incident on 3/20/2024 as a grievance to the front desk. She said when the DON returned to the facility the morning of 3/21/2024, she went to Resident #1's room and discussed the incident with her around 1:00pm that day and after watching the videos told the family member the facility is looking into it.</p> <p>Interview with Resident #1 on 3/21/2024 at 3:20pm, he stated that he felt like he was not treated with dignity and respect regarding the incident with CNA C. He said he felt unsafe being at the facility.</p> <p>During an interview with CNA A on 3/22/2024 at 10:50am, she stated she had abuse in-services the previous week, including reporting injuries of unknown origins and who to report to including the state.</p> <p>Interview with CNA G on 3/21/24 at 3:20 PM, said that the facility uses 2 staffs for Hoyer lift transfer from bed to wheelchair and from wheelchair to bed . She had abuse training and knew who to report to including the state.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON on 3/21/2024 at 4:31pm, she said that in the video Resident #1 showed her, she witnessed an employee making inappropriate comments toward a resident. She said Resident #1's family member has grievances almost every day, and that it's not the resident but his family member who doesn't like a lot of staff. She is inconsistent about which staff she wants to provide care to Resident #1. The DON stated she has received reports of the resident's family member being verbally aggressive. She feels that it's unfair that the family member treats staff like this, but she tells staff that it's part of the job. She reviews the grievance log and investigates abuse and neglect.</p> <p>Interview with the Administrator on 3/21/24 at 4:46pm, he stated that he is the Abuse Coordinator at the facility. He has tried to set up a meeting with the resident and the Ombudsman but was told the request had to come from the resident or their representative. He said Resident #1's family member has refused to meet with the facility's Ombudsman.</p> <p>Interview with CNA H on 3/22/24 at 10:48 AM, said she had abuse training and knew who to report to including the state.</p> <p>Interview with CC.NA I on 3/21/24 at 3:55 PM, reflected that she worked for the facility for 3 years on Resident #1's hall. She had abuse training and knew who to report to including the state.</p> <p>Interview via telephone with C.CNA F on 3/22/24 at 10:15 AM, he said he had worked with facility for 6 months. He said he had weekly training on abuse and neglect.</p> <p>Attempted interview via telephone with the alleged perpetrator C.CNA C on 3/22/24 at 11:30AM and 12:00 PM with number provided and left message on voice mail and no response.</p> <p>Interview with the Administrator on 3/22/24 at 11:55am, he stated that Resident #1's wife has told 90% of the staff they don't want them to care for him, and that does not leave many people left. Resident's wife is also verbally abusive to staff, and that he records incidents in Administration notes .</p> <p>Record review of Resident #1's camera revealed that on 03/19/2024 between 9:13pm to 9:41pm, CNA F and CNA C were in resident's room providing care during a transfer from wheelchair to bed using a mechanical lift. During the transfer the video revealed:</p> <p>-At 9:17pm, CNA C addressed Resident #1, Is it your bath day today? I'm not giving you a bath today, shit.</p> <p>-At 9:20pm, C.NA C asked Resident #1, And nobody can come in here. What's your problem? What's going on? Ya'll call black people monkeys? Huh? When Resident #1 responded that blacks are all humans with whites, C.CNA C asked So why do you all call them monkeys? Your family does. That's not nice.</p> <p>-At 9:22pm, CNA C stated Resident #1 and his family member call black people monkeys and that's why nobody wants to come in to assist the resident. She then said that Resident #1 tells his family about negative stuff, and you know she don't play about [Resident #1].</p> <p>-At 9:32pm, CNA C said not even a nurse can even come in here, boy this is some dumb shit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923</p> <p>Based on observations and record reviews, the facility failed to ensure that residents received adequate supervision to prevent accidents for 1 of 6 residents (Resident #1) whose care was reviewed in that:</p> <p>CNA F did not transfer Resident #1 using a mechanical lift with two-person assist. CNA F transferred Resident #1 alone.</p> <p>This failure could place residents who required supervision at risk for injury.</p> <p>Findings included:</p> <p>Record review of Resident#1's facesheet dated 3/21/24 revealed he was admitted on [DATE] with diagnoses of transverse myelitis (spinal cord inflammation, causing pain, muscle weakness and paralysis), paraplegia (the loss of the ability to move the legs and lower body), ocular hypertension (pressure increases within the eye and can cause damage and vision loss), anxiety disorder (group of mental illnesses that cause constant fear, worry and restlessness) and hyperlipidemia (abnormally high levels of lipids or fats in the blood).</p> <p>Record review of Resident #1's MDS dated [DATE] revealed that his BIMS (Brief Interview for Mental Status, an assessment to determine cognitive function) score was 13. Further review of his MDS revealed that for chair or bed-to-chair transfers he is dependent on assistance, or helper does ALL the effort. Resident does none of the effort tot complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>Record review of Resident #1's care plan dated 3/8/2024 revealed:</p> <p>-Transfers (to/from: bed chair wheelchair, standing position) - Resident requires extensive assistance. -RESIDENT PREFERS TO BE PUT IN THE BED AT 8P AND UP BY 7AM</p> <p>Goal: Resident will complete transfers with the assistance of 1-2 people/lift devices as required. Staff will attempt to accommodate residents' preferences.</p> <p>Interventions: Resident to be out-of-bed in chair. Transfer using the transfer board/lift devices.</p> <p>Record review of Resident #1's clinical notes dated 3/20/24 at 1:29am by the Social Worker, resident is alert and oriented x4 (a measure indicating an individual is aware of their surroundings, knows who they are, where they are and what time it is, a positive sign of cognitive function).</p> <p>Record review of Resident #1's Electronic Monitoring form revealed it was signed by his family member on 2/3/2024 approving for camera installation and presence in his room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's camera recording dated 3/19/24 from 9:16pm to 9:37pm revealed that CNA F and CNA C were present in Resident #1's room during his transfer from wheelchair to bed. CNA F transferred Resident #1 alone using a mechanical lift between 9:22pm and 9:24pm. During the transfer, CNA C was sitting in a chair and did not assist CNA F.</p> <p>Observation of Resident #1 on 3/21/24 at 1:00 PM revealed the resident was sitting in an electric wheelchair while eating lunch.</p> <p>Observation of Resident #1 on 3/21/24 at 4:00 PM revealed the resident sitting on high-motorized wheelchair, resident had supra-pubic catheter (a hollow flexible tube used to drain urine from the bladder through a cut in the abdomen) intact with dressing dated 3/21/24 with 80mls of yellow urine in the bag.</p> <p>Record review of the website Caring.com regarding how to operate a mechanical lift revealed that Most . lifts require two people to operate them, and many residential care communities have policies that mandate two lift operators for safety reasons. Typically, during two-person operation, one person engages the unit's controls while the other person handles and guides the individual being transferred. However, with the proper equipment, a well-trained caregiver may operate the unit independently. Many fully mechanized lifts, including ceiling models, are specifically designed to be operated by a single person. However, one-person operation is only possible if the caregiver can roll the individual onto their side to position the sling or if the individual being transferred can perform this action themselves. (Can One Person Operate a Hoyer Lift? - Caring.com)</p> <p>Interview with Resident #1 on 3/21/2024 at 1:10pm, resident stated on 03/19/2024 in the evening, he had a one-person transfer with a mechanical lift.</p> <p>Interview with Resident #1's family member on 03/21/2024 at 1:10pm, they stated the evening of 03/19/2024 they were watching the camera in Resident #1's room and noticed he was transferred via mechanical lift with one-person. They stated when he was at the hospital there would always be two people assisting during the transfer.</p> <p>Interview with CNA G on 3/21/24 at 3:20 PM, she said she checks Resident #1's catheter every 2 hours and they use 2 staffs for mechanical lift transfer from bed to wheelchair and from wheel chair to bed. She had abuse training and knew who to report to including the state.</p> <p>Interview with the Administrator on 3/21/24 at 4:46pm, he stated that he hires companies to come in to train on equipment, including the mechanical lift.</p> <p>Interview with CNA A on 3/22/2024 at 10:50am, she stated that mechanical lifts require two people assisting for resident safety. She stated she had abuse in-services the previous week.</p> <p>Interview with CNA H on 3/22/24 at 10:48 AM, she said she checks Resident #1's catheter every 2 hours and they use 2 staffs for mechanical lift transfer from bed to wheelchair and from wheelchair to bed. She had abuse training and knew who to report to including the state.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with CNA I on 3/21/24 at 3:55 PM, reflected that she worked for the facility for 3 years on 200 Hall. She said Resident #1's family member always call her the B word. The wife threw water at her and said black bitch and would repeat it daily when CNA I works with Resident #1. She reported it to the DON and she was moved to another hall. CNA I said she could not recall the exact date when the wife threw water but that Resident #1 did not have electronic monitoring at that time. She had abuse training and knew who to report to including the state.</p> <p>Interview with CNA J on 3/21/24 at 4:18 PM, she said she worked for 3 months from 2:00PM to 10:00 PM on various halls, including Resident #1's hall. She had not seen Resident #1's family member verbally abusive to her but that she heard staff say that the family member would pour water on the floor and asked the staff to clean it up. She stated the facility uses 2 staffs to transfer a resident with a mechanical lift.</p> <p>Interview via telephone with CNA F on 3/22/24 at 10:15 AM, he said he had worked with facility for 6 months. He needed help to transfer Resident #1 from the wheelchair to bed via mechanical lift and he called CNA C who came to assist him, and she was talking to Resident #1. He did not pay attention to what he was saying, and that CNA C did assist him with the transfer via mechanical Lift. He said they should always use 2 staffs with mechanical lift transfer for safety and he had weekly training on abuse and neglect.</p> <p>Attempted interview with CNA C on 3/22/24 at 11:30AM and 12:00 PM with number provided and left message on voice mail with no response.</p> <p>Record review of the facility's policy Transfers: Method, Equipment, and Preparation, revised July 2014, stated If for some reason a Patient is unable to bear weight on his legs, it will be necessary for two people to transfer him in and out of bed.</p>