STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676310	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solera at West Houston	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on interviews, and record review, the facility failed to ensure residents were free from mental and emotional abuse for 1 resident (Resident #1) reviewed for abuse. The facility failed to prevent CNA A from committing emotional and mental abuse by aggressively pulling Resident #1's blanket off of her and using profanity at LVN A outside of the resident's room. This failure placed resident at risk of possible emotional and mental anguish, abuse, and neglect. The noncompliance was identified as past noncompliance (PNC) and began on 04/08/2024 and ended on 04/08/2024. The facility corrected the noncompliance before the investigation began on 05/15/2024 at 11:24 a.m. Findings Included: Record review of Resident #1's face sheet dated 04/12/2024 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included cystitis (an infection of the bladder that almost always follows a bacterial infection in the urine), Guillain-Barre syndrome (immune system attacks the nerves inability to move the legs, arms and/or face (paralysis), type 2 diabetes mellitus (body has trouble controlling blood sugar and using it for energy) with unspecified complications, hyperlipidemia (restriction on blood flow), unspecified major depressive disorder, single episode, unspecified, neuropathy (muscle weakness, pain, cramps, and numbness), muscle weakness, contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff. permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), unspecified hand, and syndrome unrelated to migraine (head pain). Record review of Resident #1's annual MDS assessment dated [DATE] revealed a BIMS score of 11 (suggests moderately impaired cognition). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan with a print date of 05/15/2024 revealed, Problems: Resident was at risk for psychosocial wellbeing related to history of conflicts with family, friends, roommate, other patients, or staff. Goals: Resident was to have fewer than 0-3 conflicts with family, friends, roommate, other patients, or staff over the next 90 days. Interventions: Approach with warm, positive attitude with each contact: All staff. Assist resident to set realistic expectations regarding activities of daily living (ADL's). Provide emotional support as needed (PRN). She resident she was accepted: All staff. Have social worker (SW) available to speak with the resident if needed: SW. Problems Disciplines Frequency Resident received antidepressant drugs on a regular basis. Goals Symptoms of depression will be controlled/managed with minimal side effects over the next 90 days. Psychological mental health services to evaluate and treat as indicated. Problems: Urinary continence: Resident was always incontinent. Skin would remain intact during the next 90 days. Check for incontinence; change if wet/soiled. Clean skin with mild soap and water. Apply moisture barrier starting 04/09/2024. Check skin for areas of redness. Report any changes to the nurse. One (1) time daily starting 04/09/2024. Patients who relied on nursing staff for positioning would be turned and repositioned every 2 hours and as needed. Use pads/briefs to manage incontinence. During an interview on 05/15/2024 at 12:26 p.m. CNA B stated that on 04/07/2024 at 11 p.m. she was working the 3rd shift when CNA A asked her to assist with Resident #1. She stated when she entered resident's room, Resident #1 needed repositioning in bed. She stated that her and CNA A repositioned the resident and found that the resident and her bedding were wet. She stated that the resident denied that her or her bedding were wet and refused to allow staff to change her or the bedding. She stated that CNA A attempted to convince and explain to the resident that she did not want to leave the resident in a soiled brief and bedding, but the resident repeatedly refused. She stated that CNA A and resident went back and forth about the soiled bedding. She stated with some encouragement, resident agreed to have her brief changed, and they left the room. She stated shortly thereafter, the resident pushed the call light and asked that LVN A come speak to her. She stated that she did not witness any profanity, yelling, or covers that were ripped off of resident. She stated that she was to report all allegations of abuse: physical, verbal, financial and emotional to the unit manager and/or the Executive Director (ED). She stated they had ANE training in the last month and all the time, randomly. During an interview on 05/15/2024 at 12:40 p.m. LVN B stated that on 04/07/2024 at 11 p.m. Resident #1 reported that CNA A used profanity and yelled at her when providing patient care, which was considered verbal abuse. She stated it could be considered emotional abuse if the resident experienced destress from the verbal abuse. She stated she spoke to CNA A outside of the resident's room and CNA A denied using profanity but stated that the resident had been difficult during patient care and that she could not deal with the resident. She stated she began coaching CNA A about not using profanity and yelling in front of the resident when CNA A began yelling and cussing at her. She stated on the morning of 04/08/2024, she reported the incident to the DON. She stated other forms of abuse were physical and financial abuse and that she had in-services on ANE a few times a year and as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/2024 at 12:52 p.m. the Family member stated that Resident #1 had a diagnosis of dementia and often had forgotten words and events but was also clear and articulate at times and remembered and spoke accurately. She stated on the evening of 04/08/2024, she was visiting with Resident #1 when the resident told her that on 04/07/2024 the resident pushed the call light in the late evening and CNA A came into the room to assist. She stated that the resident told CNA A that she needed the covers removed from her feet. She stated that the resident had a neuropathy diagnosis and weight from the blankets often caused the resident pain in her feet and legs. She stated that the resident needed staff to remove the blanket because she did not have the physical mobility to remove the blankets herself. The resident told her when she asked CNA A to remove the blankets, CNA A stated she did not know why anyone would want to remove blankets from their legs, snatched the blankets off the resident and began to exit the resident's room as the resident's blankets fell to the floor. She stated that the resident told her that another staff (LVN A) came back into the room, picked up the resident's covers and apologized for CNA A's actions. She stated when LVN A left the resident's room the resident told her she heard a verbal commotion in the hall outside her room for what sounded like CNA A and LVN A speaking roughly and using profanity. She stated after the resident shared the information; she reported the incident to the unit manager LVN B. She stated the following day, she received a call from the ED who informed her that CNA A would no longer assist the resident and that he would investigate the allegation. She stated that she came to the facility on [DATE] during the 10 p.m. to 6 a.m. shift and CNA A was not on shift. She stated that she spoke to LVN A who told her that CNA A was rude and aggressive towards the resident. She stated that CNA B approached her speaking rude and aggressive and stated that the resident was the one who had spoken rough and rude to her and CNA A. During an interview on 05/15/2024 at 02:55 p.m. Resident #1 stated that she could not recall the details, but she had a traumatic incident with a CNA (CNA A) whose name and description she could not recall that caused her to feel terrified. She stated that she had pressed the call light to have the staff remove a blanket from atop her legs. She stated CNA A came into the room with a bad attitude and spoke to her kind of ugly. She stated the CNA came into her room, threw her blanket off to the side of the bed, walked out, and her blanket fell to the floor. She stated another CNA (CNA B) came into the room and picked up the cover and was very nice to her. She stated that she had not seen CNA A since that evening and things had been fine since. She stated the CNA may have been having a hard time, but she should not have brought that to her. She stated that the ED came by to check on her a few days later and assured her that he had taken care of the situation. During an interview on 05/15/2024 at 03:01 p.m. the Housekeeper stated that she would report any reports of ANE to the ED and that she had an been in-serviced on ANE a few months ago. She stated verbal, physical, sexual, emotional, and financial were all forms of abuse. She stated resident abuse could cause depression, behaviors, and secultion and refusal to accept meals or participate in activities. During an interview on 05/15/2024 at 03:08 p.m. CNA C stated that if she witnessed ANE, she would notify the ED immediately. She could not recall the last in-service on ANE but were provided all the time and maybe within the last 2-weeks. She stated verbal, physical, sexual, emotional, and financial were all forms of abuse. She stated abuse could cause depression and an ability for resident to thrive. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/2024 at 03:12 p.m. LVN C stated that that if she witnessed or received a report of ANE she would immediately report it to the unit manager. She stated that in-service on ANE within the last few weeks. She stated verbal, physical, sexual, emotional, and financial were all forms of abuse. She stated abuse could cause failure to thrive, depression, and seclusion. During an interview on 05/15/2024 at 03:35 p.m. the DON stated that on 04/08/24 during the morning meeting LVN B reported that in the late hours of 04/07/2024 when CNA A and CNA B were providing patient care to Resident #1 there was a ruckus in the room. She stated that LVN B told her that CNA A and LVN A were arguing back and forth outside of the Resident's room. She stated that it was also reported by LVN A (exact date and time unknown) that CNA A had communicated with her rudely and disrespectfully, using profanity and yelling at her when confronting her about the ruckus in the resident's room. She stated she could not recall what was exactly stated between CNA A and LVN A. She stated that the SW spoke to the resident. She stated that staff were not to speak about a resident's care or diagnosis outside of their room so that the resident, family, or other residents would not think that the staff were speaking about them negatively. She stated that the facility was the resident's home, and they should not have to hear anyone yelling or having a disagreement outside of their bedroom door, and there were no expectations. She stated when such an event took place, it should be reported to their unit manager. She stated that CNA A was terminated for breaking company policy when engaging with LVN A. She stated it was all staff's responsibility to report ANE to herself or to the ED. She stated staff were in-serviced on ANE In-services randomly, routinely, and as needed. She stated verbal, physical, sexual, emotional, and financial were all forms of abuse. She stated abuse could result in failure to thrive and a decline in emotional and physical health. During an interview on 05/15/2024, at 03:50 p.m. the SW stated that she was asked by the DON to speak to Resident #1 regarding an incident that took place on 04/07/2024. She stated that the resident told her that CNA A and LVN A were arguing outside her room. She stated that the resident reported that that CNA A needs to get her stuff in order before coming to care for her and that she would rather CNA A not take care of her. She stated the resident never stated that any of the staff yelled or used profanity. She stated after interviewing the resident she selected a random sample of residents and preformed safety surveys. She stated she asked questions to ensure that the residents felt safe in the facility and staff were taking care of their needs. She stated she had no complaints. She stated that if she received or witnessed a report of ANE she would intervene to ensure the resident was safe and the perpetrator was removed and then report the incident to the DON and ED immediately. She stated she had received an in-service on ANE within the last 5 months. She stated verbal, physical, sexual, emotional, and financial were all forms of abuse. She stated abuse could cause the resident to withdraw, have behaviors, become depressed, refuse care and meals, decline in health. During an interview on 05/15/2024 at 03:55 p.m. LVN C stated that she was not on shift 04/07/2024 but received a message from CNA A that Resident #1's bedding and brief were soiled, and the resident had refused changing. She stated on 04/08/2024 she spoke to CNA A on the phone who explained that the resident refused changing and she was able to convince the resident to be changed, but not the bedding. She stated when she returned to shift on 04/09/2024 she learned during the morning meeting CNA A and LVN A had fussed in front of the resident on 04/07/2024. She stated that CNA A and LVN A did not care for each other. She stated on 04/09/2024, she spoke to Resident #1 who could not remember everything about the changing incident on 04/07/2024. She stated that ANE in-services were provided randomly and as needed. She stated staff received an ANE in-services a few weeks ago. She stated verbal, physical, sexual, emotional, and financial were all forms of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/2024 at 04:07 a.m. ED stated that Resident #1's Family visited the resident all the time. On 04/08/2024, Resident #1 reported to the Family that staff were loud in the resident's presence, were performing poor care and customer service, and felt it was borderline verbal abuse. He stated he initiated a grievance on the Family's behalf and began an investigation of the incident. He stated that CNA A was suspended during the investigation that began on 04/08/2024. He stated during an interview on 04/08/2024, Resident #1 stated that CNA A needed to check her attitude at the door as she had acted inappropriate while providing care. He stated that the resident did not articulate exactly what CNA A had done. He stated he asked the SW to assess the resident and initiated a referral for an assessment by mental health services. He stated he interviewed CNA A who admitted that she had acted inappropriately near resident's room while speaking to LVN A loudly but denied any inappropriate actions in the resident's room. He stated that he interviewed LVN A and determined that CNA A had raised her voice and spoke uncooperatively and unprofessional on the evening of 04/07/2024 while outside the resident's room. He stated that on 04/12/2024 it was determined that CNA A's behavior represented poor customer services and workplace behavior and she was terminated. He stated that CNA A had no previous negative interactions noted in her employee file. He stated that all staff including CNA A received on-going in-services on ANE and customer service. He stated verbal, physical, sexual, emotional, and financial were all forms of abuse. Record review of CNA A's Background Screening dated 11/21/22 02:02 a.m. Record review of CNA A's signed acknowledgement of receipt of Safety Policy dated 11/21/2022, Texas Employee Misconduct Registry Acknowledgement dated 11/21/2022, Employee Injury Acknowledgement 11/21/2022, Arbitration Policy and Acknowledgement dated 11/21/2022, and Nonexempt Employee Handbook dated 11/21/2022. Record review of CNA A's Misconduct Registry/Licenses Verification dated 01/24/2024. Active Medication Aide licenses through 07/25/2024. Employability check dated 07/28/2024. The following evidence was completed by the facility to correct the noncompliance prior to the investigation: 1. Record review of Resident #1's Grievance report dated 04/08/2024, the Family member stated that CNA A was rough with sheets. Tossed sheets off the resident. LVN A came into the resident's room and CNA A started cussing at LVN A. Patient felt staff were very unprofessional. The ED met with the resident at length and discussed incident. The resident stated when she used her call light CNA A came promptly to assist saying she was going to do this and that but that the resident only pushed the call bell to have the blanket moved. The resident then reiterated she was in healthcare her whole life and that the CNA's were just dumb, that they need more education. The resident stated that when CNA A left the room, she heard someone say something to someone in the hall that she should listen better and not have been disrespectful. The ED asked if the resident felt abused, Resident replied, no. 2. Record review of 04/08/2024 In-Service Training Report revealed: CNA A Personal Attendance Record on ANE conducted by DON for all staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Homelike Environment revised date of February 2021 revealed: Policy Statement. Residents were provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. Record review of Resident Rights Policy Statement dated of February 2021 revealed: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence: b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation. d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms; e. self-determination.