

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  12/30/2024
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 - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44915</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 8 (Resident #1) residents reviewed for abuse and neglect.</p> <p>The facility failed to ensure that Resident #1 was free from sexual abuse when staff observed Resident #1 being touched inappropriately by CR #2 on 12/26/2024.</p> <p>The noncompliance was identified as Past Non-Compliance. The IJ began on 12/26/2024 and ended on 12/27/2024. The facility corrected the noncompliance before the survey began.</p> <p>This failure placed residents at risk of experiencing abuse and neglect.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 12/27/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with anxiety disorder, unspecified, Malignant neoplasm of uterus (A cancerous tumor), Unspecified kidney failure (A condition where the kidneys are not functioning properly), Hypothyroidism (When the thyroid gland doesn't make enough thyroid hormones to meet your body's needs, Unspecified Dementia, Unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, heart failure.</p> <p>Record review of Resident #1's quarterly MDS (minimum data set) assessment dated [DATE] revealed she had difficulty communicating some words or finishing thoughts but was able if prompted or given time; she missed some part/intent of the message but comprehended most conversation; she had a BIMS score of 7 (severe cognitive impairment); she did not exhibit any behavioral symptoms or rejection of care; she was partial dependent on staff (helper did less than half the effort. Helper lifts or holds trunk or limbs and provides more than half the efforts) for toileting hygiene, showers, and personal hygiene; she required partial/moderate assistance from staff (helper did more than half the efforts Helper lifts or holds trunk or limbs but provides more than half the effort.) for chair/bed-to-chair transfers, (helper does more than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort).</p> <p>Record review of Resident #1's care plan revised 12/21/2024 revealed:</p> <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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>* Communication: Resident is sometimes understood in ability to express ideas and wants. Goal included: Resident will communicate requests, needs, and feelings over the next 90 days. Interventions included: Allow adequate time to express self; complete word or sentence if Resident is unable to do so. Ask short simple questions that can be answered, yes or no. If restless, assess for pain/discomfort or other physical needs (fluid, hunger, incontinence).</p> <p>* Resident is Short-term memory impaired-unable to recall after 5 minutes. Goal included: Resident will participate in ADLs and facility routines/activities over the next 90 days. Interventions included: Encourage/help Resident participate on recreational activities. Maintain consistent routine; introduce change slowly to reduce confusion. Provide clocks, calendars, and a schedule of facility routines. Provide direct guidance when Resident is unable to follow through with instructions. Re-orient to time, location, events, and activities as needed. Use cues to enhance participation in self-care. Report any decline in ability to participate/perform ADL care.</p> <p>Record review of Resident #1's nursing progress notes for December 2024 revealed:</p> <p>* On 12/26/2024, at 9:30 p.m. DON wrote, Received call from RP, caregiver of Resident #1, stating person was in Resident's room near the bed. Spoke with RP again requesting permission to transport Resident to hospital or sexual assault exam. RP states from her view of the camera, the person was not able to open Resident legs wide enough to get full access to Resident's genitalia for sexual intercourse. RP states taking Resident to hospital and revealing to her touching was inappropriate and nonmedical would be more upsetting to Resident than the act of touching by the male perpetrator.</p> <p>* On 12/27/2024, at 12:00 a.m. LVN A wrote, Call from DON, telling staff to go at once to Resident #1's room. DON stated, he received a call from Resident #1's RP. RP stated a person was in Resident #1's room near the bed. Staff and LVN A ran to Resident #1's room, only to find male resident standing over female resident (Resident #1). Assisted male resident out of female resident's room and explained to him, he is not to be in other resident's room and especially not a female resident's room. Assessed female resident at this time to make sure she was alright and free from any injuries. Female resident was lying in bed on her back with shirt pulled up and her breast exposed, diaper open and diaper was located under female resident. DON calls again letting staff know, he spoke with Resident #1's RP. At this time DON requested permission to transport female resident to hospital for sexual assault exam. DON stated, RP said from her view of the camera, the person was not able to open Resident #1's leg wide enough to get full access to Resident #1's genitalia for sexual intercourse. RP also stated, taking Resident #1 to hospital and revealing to her the touching was inappropriate and nonmedical would be more upsetting to mom than the act being touch by the male resident. Police called and are in building talking to staff and female Resident's RP who are here at the facility at this time. DON made aware of police wanting to send resident to the hospital and family member refusing.</p> <p>Record review of Resident #1's EMR (electronic medical record) dated 12/27/2024 revealed, Neuro-checks were completed.</p> <p>Record review of CR #2 face sheet dated 12/27/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with Sepsis, unspecified organism. Anxiety disorder, hemiplegia, essential (primary) hypertension, disease of stomach and duodenum, unspecified, unspecified Dementia, moderate, with agitation, major depressive disorder.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of CR #2's quarterly MDS assessment dated [DATE] revealed he had the ability to express ideas and wants, clear comprehension in ability to understand others, sees fine detail, such as regular print in newspaper/books.; he had a BIMS score of 12; he did not have any history of elopement, wandering or inappropriate behaviors.</p> <p>Record review of CR #2's nursing progress notes for December 2024 revealed:</p> <p>On 12/27/2024, at 1:21 a.m. RN D wrote, Report received from the outgoing nurse that CR #2 was found in the female resident's room with the diaper pulled down and the female breast exposed. The nurse redirected him to his room. The family called, no response. DON notified.</p> <p>On 12/27/2024, at 4:25 a.m., RN D wrote, The Sheriff's Officers and the investigator Deputy from Sheriff's Department came in for the investigation, carried out the DNA test from the resident, and transferred CR #2 to the County jail. Family Member unable to contact with several attempts. DON notified and able to speak with Deputy Investigator.</p> <p>On 12/27/2024, at 11:42 a.m., ED (executive director) wrote, CR #2's family returned the facility's calls from 12/26/2024 regarding incident. ED spoke to family and notified of incident and CR #2's current location. CR #2's family stated, oh my thank you for letting us know. ED asked if this type of behavior had ever happened before. Family stated, no. ED asked if the family had any questions and family stated, no. ED thanked family member for her time and instructed to reach out to him if she had any further questions or concerns.</p> <p>Observation of Resident #1 on 12/27/2024, at 3:56 p.m. revealed she in her room lying in bed with RP at bedside. There were no concerns observed. Resident #1 was dressed and alert but not interview-able. The bed was in low position, call light was in reach and hydration was present. There was no environmental concerns or foul odors. RP asked to step out of the room, and she refused interview with Resident.</p> <p>Interview with Resident #1's RP on 12/27/2024 at 3:57 p.m. she stated she viewed the electronic monitoring of Resident #1, and she observed an unknown male (CR#2) at 9:33 p.m. in Resident#1's room. RP stated during the observation, the male resident was observed touching Resident #1 inappropriately. RP stated she contacted the DON and at 9:34 p.m., staff entered the room and removed the male resident (CR#2) from Resident #1's room. She stated the facility called the police and charges were filed. She stated the facility offered to send Resident #1 to the hospital, but she declined. She stated the resident have Dementia and she think that the male resident that entered her room was a physician that came to examine her, and she would like to keep things that way. She stated the resident hallucinates at times and she thinks bringing up the incident and telling her what really happened would do more harm to the resident. She stated she did not have any concerns with the facility. She stated the facility did everything they were supposed to do and reacted immediately when she informed them of what was going on in the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN E on 12/27/2024 at 4:09 p.m., she stated he worked yesterday (12/26/2024) on 100 hall from 2:00 p.m.-10:00 p.m. She stated there was an incident with a Resident on resident, between CR #2 and Resident #1. She stated the DON called at 9:30 p.m. and stated the RP of Resident #1 saw a male in the room on camera. The assigned nurse (LVN A), CNA C, and another nurse, LVN B, went to the room (Resident #1's room). She stated CR #2 was standing over Resident #1 and her breast and brief exposed and he was fondling breast. She stated the residents were separated and head to toe assessments were completed. CR #2 was placed on 1:1 supervision with CNA C. She stated Law enforcement came and CR #2 was arrested. She stated Resident #1 was moved to another room to be closer to the nurse station. LVN E stated CR #2 has dementia but is alert and oriented x3. She stated he had not had behaviors before of wandering into rooms or inappropriate sexual behaviors. She stated she last saw CR #2 at the nurse station around 8:30 p.m. drinking coffee. She stated they round every two hours. She stated she did not see CR #2 go into the room of Resident #1. She stated she had been trained on abuse neglect, she was knowledgeable on types of abuse, to include sexual abuse. She stated if abuse is suspected it should be reported to the DON and ED immediately. She stated she was also trained if resident on resident abuse; to separate immediately, assess residents, and report.</p> <p>In an interview with LVN A on 12/27/2024 at 4:12 p.m., she stated she rounded around 8:00 p.m. and CR #2 was seen at the nursing station drinking coffee in the bistro. She stated she stated she left the hall around 8:30 p.m. to do a new admission and CR #2 was still at the bistro. She stated she returned to the hall around 9:00 p.m. to chart and CR #2 was no longer at the bistro. She stated 9:30 p.m. the DON called and reported that the RP of Resident #1 informed that a male was on the camera in the room fondling Resident #1. LVN A, LVN B, CNA C went to Resident #1's room. LVN A stated the door was closed and the wheelchair was blocking it, but she pushed it open. She stated CR #2 was fully cloth and standing over Resident #1. Resident #1's breast was exposed, and her brief was open. CR #2 had his hand between Resident #1's legs and his other hand on Resident #1 breast. LVN A stated she asked CR #2 what he was doing and he was startled and tried to cover Resident #1 with the sheet. LVN A stated she was not aware that CR #2 could stand up on own because he is usually in a wheelchair and has to be transferred. LVN A stated LVN B and CNA C transferred CR #2 to his wheelchair and took him to his room. CNA C remained with CR#2 until Law enforcement arrived. She stated she and LVN B completed a head to toe assessment on Resident #1 and there were no injuries. LVN A reported she contacted Law enforcement while LVN B called the medical director and RP's. She stated the DON called the ED. She stated the RP of Resident #1 came to the facility and she refused to have Resident #1 transferred of to hospital for medical evaluation. LVN A stated Law enforcement arrived about 11:00 p.m. She stated that CR #2 was arrested right before 1:00 a.m. LVN A stated CR #2 did not have behaviors of wandering in rooms or inappropriate touching prior to the incident. LVN A stated the staff rounds every two hours and she did not see CR #2 go into Resident #1's room. LVN A stated she had been trained on abuse neglect, she was knowledgeable on types, to include sexual abuse; and if resident on resident abuse to separate immediately, assess residents, and report. LVN A stated abuse should be reported to the DON and ED immediately.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA C on 12/27/2024 at 4:25 p.m., she stated she stated she stated she worked at the facility on last night (12/26/2024). She stated she was assigned to 300 and 400 halls. She stated there was an incident on last night in which she was informed by the DON to go to Resident #1's room due to a male resident being in the room. She stated when she entered the room, she observed the male resident- CR#2 standing over Resident #1. She stated Resident #1's shirt up above her breast in which her breast was exposed and her diaper was exposed. She stated it is unknown if CR #2 lifted the resident's shirt or the resident lifted her own shirt since she did not witness it. She stated she had never observed anything like that in the facility. She stated it was her first time working with the resident. She stated CR #2 was removed from the room and placed on one to one until law enforcement arrived. She stated she checks on the residents every two hours. She stated she has been trained on abuse and neglect and was knowledgeable about the different types of abuse. She stated any concerns of abuse is reported to the ED who is the abuse coordinator. She stated if there is resident on resident abuse, she is trained to separate them immediately, assess and report it.</p> <p>In an interview with CNA F on 12/27/2024 at 4:41 p.m., she stated she worked on 12/26/2024 and she was assigned to hall 700. She stated she last worked hall 200, 2 months ago. She stated she was informed by staff of the incident that occurred between Resident #1 and CR #2. She stated she was familiar with CR #2 due to working with him in the past and stated he was alert and oriented. She stated he did not have behaviors of going into rooms of residents or inappropriate behavior prior to this incident. She stated she had been trained on abuse and neglect, she was knowledgeable on types to include sexual abuse, and should be reported to DON and ED immediately. She stated she was trained if resident on resident abuse to separate immediately and report. She said that they must round every 2 hours, but she does 30 minutes.</p> <p>In an interview with CNA G on 12/27/2024 at 4:47 p.m., she stated she did not work on yesterday (12/26/2024) or the day prior (12/25/2024). She stated she had been trained on abuse and neglect, she was knowledgeable on types, and abuse should be reported to the DON and ED immediately. She stated she was trained if resident on resident abuse occurs to separate immediately and report. She said that they have to round every 2 hours, but she does 30 minutes. She stated she returned to work today and during morning report she was told that a male resident on 300 halls abused another female resident. She stated she was informed the male resident was touching the female resident inappropriately. She stated that the male resident was arrested, and female resident room was changed. She stated the staff had abuse and neglect in-service because of it. She stated they round every two hours. Male resident is usually in w/c and can ambulate on the hall but did not observe him wandering in other rooms or have inappropriate behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA H on 12/27/2024 at 4:55 p.m., she stated she had worked at the facility for 4 months. She stated her hall assignments rotate. She worked last night (12/26/2024) on hall 200 from 2:00 p.m.-10:00 p.m. She stated the DON called to check Resident #1 room because the family saw a male in the room. She stated the nursing staff went to the room. She stated the male was the resident in room with Resident #1 She stated the male resident had open the diaper of the female residents. She stated she did not know what happened to the male resident or female resident; she just know that the police were called. She stated she was not at the facility when police came. She stated the male resident is usually in a wheelchair and can ambulate on the hall but she did not ever observe him wandering in other rooms or have inappropriate behaviors. She stated she had been trained on abuse and neglect, she was knowledgeable on types to include sexual abuse, she stated abuse and neglect should be reported to the DON and ED immediately. She stated she was trained if resident on resident abuse to separate immediately and report. She said that they have to round every 2 hours, but she does 30 minutes.</p> <p>In a phone interview with LVN B on 12/27/2024 at 5:16 p.m., she stated she worked on last night (12/26/2024) on hall 200 from 2:00 p.m.- 10:00 p.m. She stated trained on abuse and neglect. She stated she was knowledge on types of abuse to include sexual, and they report it immediately to the ED. She stated she was trained when there is resident to resident abuse to separate them immediately, assess, head to toe assessment, and report. She stated she was at the nursing station charting at about 9:30 p.m. and the DON called and informed to check on Resident #1, and she went to room with CNA C and Nurse assigned LVN A. She stated when they approached the room the door was close. She stated upon entering the room the female resident was in bed, her shirt was over her head, breast was exposed, and her brief was open. She stated the male resident was standing over the female resident fully clothes, he was touching her breast with one hand, and other the other hand was near her brief. She stated he was asked what he was doing, and he jumped and pulled the cover over her. She stated she immediately got him in his wheelchair and took him to his room. She stated the aide was asked to stay 1:1 with male resident. She stated she did not know that the resident could ambulate out wheelchair without help. She stated she and the assigned nurse went to assess the female resident, she had no visible injuries, and she was not interview-able. She stated they then assessed the male resident, and he did not have any injuries. She reported the DON said that they should call RP's, MD's and 911. She stated the family of the female resident was enroute and came to the facility. She stated she called the RP of the male resident and left a message. She stated the assigned nurse called the MD. She stated law enforcement came to the facility, did an interview with them and she left. She stated she was not sure what happened to the male resident because her shift ended. She stated that at 8:30 p.m. the male resident was at the bistro near nursing station drinking coffee in his wheelchair, but she did not see him leave but assumed he went back to the room. She stated she did not see the male resident go into the room of the female resident. She stated the male resident said that the female resident called him into the room and told him to do it. She stated the male resident is alert and oriented x4. She stated the female resident is alert and oriented x1.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with DON on 12/27/2024 at 5:39 p.m., he stated he has been employed at the facility for 4 months. He stated he was off duty at home on 12/26/2024 and at about 9:30 p.m., he was contact by RP of Resident #1. He stated RP informed that there was male in the room standing over Resident #1 from what she could see from electronic monitoring in the room. He stated RP informed that the male was touching the resident. The DON stated RP described the resident as a black male, and stated he was touching Resident #1's legs. The DON stated he called the assigned nurse and had her go to the room of Resident #1, and he remained on the phone. DON stated the nurse informed that the male resident, CR #2, was in the room. DON stated the nurse reported that CR #2's hands were touching Resident #1 near her brief and her breast were exposed. The DON stated he instructed the nurse, to separate the residents, 1:1 supervision for CR #2, head to assessment for both residents, call police, call MD, and RP to CR #2. He stated he called the RP back for Resident #1, who was in route to the facility. He stated he called the ED. He stated that Resident #1's room was changed closer to the nurse's station. The DON reported CR #2 was arrested by the Sheriff's Department, because he admitted to being in the room uninvited. He reported that CR#2 was alert and oriented x 3-4, so the DA picked up charges. He stated that initially the plan was to transfer CR #2 to a behavioral hospital because he does have a Dementia diagnosis, but law enforcement refused. He stated that the electronic monitoring was live stream, and RP said she was unable to provide a copy. The DON stated they tried to send Resident #1 to the hospital, but RP refused because she could see that there was not a sexual assault that warranted hospital transfer; she stated it would upset the resident even more. The DON stated CR #2 did not have behaviors of inappropriate sexual contact or behaviors of wandering into other resident's rooms. DON stated CR #2 was admitted as a skill resident, and then moved to long term care. He stated he was not aware of CR #2 to have criminal history of sexually inappropriate behaviors prior to admission. The DON reported CR #2 would not have been admitted to the facility if he had a history of sexual assault. He stated the facility has taken the following steps since the incident has occurred: Changed the female resident room close to nurse station, Male resident placed on 1;1 until police arrested, Head to toe assessment for both resident, Safety surveys with residents on the hall, and adjoining hall and In-servicing.</p> <p>In an interview with SW on 12/27/2024 at 6:30 p.m., she stated she had been employed at the facility since April 2023. She stated she had been trained on abuse and neglect; she was knowledgeable about different types of abuse to include sexual. She stated abuse should be reported immediately to the ED. She stated residents should be separated immediately if resident/resident abuse occurs. She stated she is unable to touch residents so she would notify nursing staff to get involved immediately. She stated on last night (12/26/2024) there was resident/resident incidents involving, Resident #1 and CR #2. She stated she did not witness the incident but she was informed of what occurred. She stated she spoke the RP of Resident #1, and she was informed that the RP observed on camera that Resident #1's shirt was up above her head. She stated Resident #1 was assessed and her room was changed for more supervision. She stated CR#2 was arrested after being interviewed by police. She stated she completed a well-being assessment with the Resident #1 and safety check surveys with other residents throughout the building ongoing. She stated CR #2 was alert and oriented, and she was unsure if he had a diagnosis of Dementia. She stated CR #2 did not have behavior of inappropriate touching or wandering into residents. She stated he did not have any criminal history in lined with behaviors of sexual inappropriate behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with Executive Director (ED) on 12/27/2024 at 6:38 p.m., he stated he had been employed at the facility since March of 2022 and he was the Abuse Coordinator. He stated he was contacted by the DON at 9:36 p.m. informing that CR #2 was seen on camera in a resident's room from RP. He stated he gave the following instructions: Nurses to assess both residents, Nurses were to call 911, Nurses were to call MD. He stated RP of Resident #1 was aware and in route to the facility, so he informed staff to contact RP of CR #2. He stated CR #2 was to be placed on 1:1 supervision until LE came and he left out the facility. He stated they made efforts to get electronic monitoring from RP but was unsuccessful due to the video being live feed only. He stated he started his investigations and Law enforcement was notified, he made a self-report last night, safe surveys with residents were initiated by the social worker and on-going, abuse and neglect in-services initiated and on-going, the social worker completed assessment for emotional issues with Resident #1, Resident #1's room was changed and she was moved closer to the nursing station, witness statements have been initiated and ongoing, efforts to send Resident #1 to the hospital was unsuccessful because RP refused. He stated Law enforcement arrested CR #2 because he admitted to going into Resident #1's room when he should not have. He stated it was initially planned to send CR #2 to the behavioral hospital due to his Dementia diagnosis, but Law enforcement did not agree. He stated the Medical Director was contacted. He stated he will continue with safe surveys, frequent rounding, and in-services. He stated CR #2 did not have behaviors of wandering into resident's rooms or inappropriate touching. He stated CR#2 did not have criminal history upon admission of any sexual behaviors, and if he had he would not have been admitted .</p> <p>In an interview with LVN I on 12/30/2024 at 5:27 p.m., she stated she has been employed at the facility for 6 months. She stated she is assigned to 800 hall. She stated she works 2-10 shift Monday through Friday. She stated she did not witness the resident-on-resident incident and she was not familiar with the residents. She stated she was trained on abuse and neglect daily. LVN I was knowledgeable about the different types of abuse and who to report abuse to. She stated if she suspected abuse or neglect, she would inform the ED who is also the abuse coordinator know and if he is not available, she would let another administrator know. She stated staff checks on the residents every 2 hours.</p> <p>In an interview with CNA J on 12/30/2024 at 5:31 p.m., she stated she had been employed at the facility for 2.5 years. She stated she was assigned to the 300 hall today. She stated she works all over but mostly hall 300. She stated she was familiar with CR #2 and she had worked with him in the past. She stated she had never observed the resident being inappropriate with other residents. She stated she has never observed the resident wandering into other residents' rooms. She stated she was trained on abuse and neglect 2 days ago as well as today. She stated they were trained on what to do if they see a resident abusing another resident (separate), then who they would report it to (ED; Abuse Coordinator). She stated she checks on the resident every 30 minutes.</p> <p>In an interview with CNA K on 12/30/2024 at 5:36 p.m., she stated she has been employed at the facility for one year. She stated she was assigned to hall 700 and 800 today but she typically works all over. She stated they always get training for abuse and neglect. She stated if abuse or neglect is suspected she would report it to the ED, ED assistant or the DON. She stated if she observed resident to resident abuse, she would separate the residents and report it. She stated she checks on the residents any time their light is on and they are to position the residents every 2 hours.</p> <p>(continued on next page)</p>		

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  12/30/2024
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.			
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's document titled, Abuse Protocol dated April 2019 revealed, 1. The Patient has the right from Abuse, neglect, mistreatment of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the Patients symptoms 2. Our Facility will not condone Patient abuse, neglect, mistreatment or misappropriation of Patient property and exploitation (collectively. Patient Abuse) by anyone, including staff members, other Patient, family members, legal guardians, sponsors, friends, and other individuals.</p> <p>Record review of the facility's policy entitled, Resident Rights revised February 2021 revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . c. be free from abuse, neglect, misappropriation of property and exploitation .</p> <p>Record review of the facility's Emergency QAPI plan dated, 12/26/2024 revealed; On Thursday 12/26/2024 facility self-reported allegation of reside to resident inappropriate touching. Male resident was found in female resident room. Facility held an emergency QAPI meeting with the Medical Director on 12/27/2024 regarding steps to ensure the safety of all residents.</p> <p>Steps Taken regarding incident:</p> <ul style="list-style-type: none"> <li>*RPs, Police, Ombudsman, Physician, Medical Director immediately notified</li> <li>*Facility immediately assessed female resident, no negative findings. RP refused to have patient sent to ER.</li> <li>*Facility conducted psychosocial mental evaluation, no negative findings.</li> <li>*Facility immediately placed male resident 1:1 until discharged from facility.</li> <li>*Facility to initiate safe surveys at random to ensure facility residents feel safe.</li> <li>*Facility to initiate immediate discharge notice to male patient to ensure he does not return.</li> <li>*DON/Designee initiated abuse/neglect in-service with all staff with continue weekly x 4 weeks.</li> <li>*The leadership team will monitor safe surveys weekly to ensure patients feel safe and secure in the facility and are free from abuse.</li> <li>*The leadership team will monitor through daily rounds to ensure patients feel safe and secure. Will report any negative findings to the administrator immediately.</li> </ul> <p>Record review of In-Service Training Report dated 12/27/2024- on going revealed all staff all were educated by the ED and Assistant ED regarding recognizing and reporting abuse and neglect.</p> <p>Record review of the facilities document titled, Patient Abuse Investigation Questionnaire dated 12/28/2024 revealed, Questionnaires with residents were completed by the activity director.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interviews were conducted with staff on 12/27/2024 between 2:15 p.m. until 8:30 p.m. and on 12/30/2024, between 3:30p.m.-6:00 p.m. including LVN A, LVN B, CNA C, RN D, LVN E, CNA F, CNA G, CNA H, SW, LVN I, CNA J, and CNA K to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding understanding of requirements, training material, and expectations. LVN A, LVN B, CNA C, RN D, LVN E, CNA F, CNA G, CNA H, SW, LVN I, CNA J, and CNA K were able to explain the importance of recognizing abuse and neglect and reporting as well as immediately reporting abuse to the abuse coordinator.</p> <p>The noncompliance was identified as Past Non-Compliance. The IJ began on 12/26/2024 and ended on 12/27/2024. The facility corrected the noncompliance before the survey began.</p> <p>On 12/27/2024 at 8:20 p.m., the facility's Administrator and Regional Director of Clinical Services were notified of the past noncompliance IJ. A plan of removal was not requested. An IJ template was provided to the Administrator on 12/30/2024 at 8:20 p.m.</p>		