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	04/25/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 3 of 4 residents (Resident #1 and Resident #2) reviewed for privacy in that: -The facility failed to ensure CNA B provided privacy during incontinent care for Resident #1. -The facility failed to ensure CNA C provided privacy during toilet use for Resident #2. -The facility failed to ensure CNA L provided privacy during incontinent care for Resident #3. These deficient practices could place residents at-risk of loss of dignity due to lack of privacy. Findings included: RESIDENT #1 Record review of Resident #1's face sheet dated 04/24/25 revealed a [AGE] year-old female was admitted to the on 03/26/25. Resident #1 diagnoses included: metabolic encephalopathy (a condition where brain function is disrupted), hypertension (force of blood against the walls of the arteries is consistently too high), and cognitive communication deficit (someone has difficulty communicating because their thinking processes, like memory, attention, and reasoning) Record review of Resident #1's admission assessment dated [DATE] revealed on BIMS of 02 indicating severely impaired cognition. Further review revealed Resident #1 dependent on staff for ADL care with one to two staff assist. Record review of Resident #1's undated care plan revealed Resident #1 had ADL self - care performance deficit related to dementia and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an observation on 04/22/25 at 1:30 p.m., CNA B entered Resident #1's room without knocking on the resident's room door when she went to provide incontinent care and did not close the window blind while she provided incontinent care for Resident #1. RESIDENT #2 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's face sheet dated 04/25/25 revealed a [AGE] year-old female was initial admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 diagnoses included: Parkinson's disease (a progressive neurodegenerative disorder leading to movement related to tremors, slow movement, and rigidity), hypertension (force of blood against the walls of the arteries is consistently too high), and diabetes mellitus (a condition where the body has trouble regulating blood sugar levels). Record review of Resident #2's quarterly assessment dated [DATE] revealed on BIMS of 13 indicating intact cognition. Further review revealed Resident #2 needed moderate assistance with trans fer with one staff assist. Record review of Resident #2's care plan dated 03/13/25 revealed Resident #2 had ADL self - care performance. Interventions: transfer: the resident requires 1 x2 staff assistance for transfers. During an observation on 04/22/25 at 3:26 p.m., CNA C entered Resident #2 without knocking on the resident's room door before she entered the resident's room. CNA C left the restroom door open when she pulled down Resident #2's pant and incontinent brief and placed her on the toilet while the two visitors could see the resident exposed body. During an observation on 04/22/25 at 3:26 p.m., CNA C entered Resident #2's room without knocking on the resident's room door before she entered the resident's room. CNA C left the restroom door open when she pulled down Resident #2's pants and incontinent brief and placed her on the toilet while the two visitors could see the resident's exposed body. Resident #3 Record review of Resident #3's face sheet dated 04/25/25 revealed a [AGE] year-old female was admitted to the facility on [DATE]. Resident #3 diagnoses included: urinary tract infection (an infection in any part of the urinary system), ovarian cyst (a fluid filled sac that developed on or inside an ovary), and diabetes mellitus (a condition where the body has trouble regulating blood sugar levels). Record review of Resident #3's admission assessment MDS dated [DATE] revealed on BIMS of 15 indicating intact cognition. Further review revealed Resident #3 incontinent of bowel and bladder and dependent on staff for ADL care with one to two staff assist. Record review of Resident #3's undated care plan revealed Resident #3 had ADL self - care performance deficit related to activity intolerance and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an observation on 04/24/25 at 4:06 a.m., while CNA L was providing incontinent care for Resident #3 and she ran out of wipes, she left Resident #3 uncovered from the waist down to her feet and left the room to get another wipe packet. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/25 at 1:57 p.m., CNA B said she did not knock on the door before she entered Resident #1, and it was a dignity issue because the resident's room was her home, and the resident could feel disrespected. CNA B also forgot to close the window blind while she provided incontinent care for Resident #1. CNA B said she had in-service on privacy, and dignity which included closing the door and the blind to protect resident dignity. CNA B said the nurse monitors the aides during rounds throughout the shift. During an interview on 04/22/25 at 3:42 p.m., CNA C said when she went to assist Resident #2 in using the toilet, she should have knocked on her room door before she entered because her room was her home. She also said it was a sign of respect. CNA C said she did not close the restroom door before she pulled Resident #2's pants and incontinent brief down and exposed her body while she had two visitors in the room who were able to see the resident's exposed body. CNA C said it was a dignity issue. CNA C said she had training on privacy and dignity and was educated to knock and announce herself before entering a resident room and provide complete privacy during any care. During an interview on 04/23/25 at 9:30 p.m., the DON said CNA B should have closed the door and the window blind to provide complete privacy. The DON said that since the window blind was not closed, anybody who walked past the window during the incontinent care could see the exposed body part of Resident#1. During an interview on 04/23/35 at 9:32 a.m., the DON said CNA B should have knocked on Resident #1's door before she entered Resident #1's room for privacy and dignity. He said the resident's room was the resident home. The DON said Resident #2 could become upset because CNA B violated her personal space. He said the nurse and staffing coordinator monitored the aides, the nurse managers monitored the nurses, and all the staff were trained before working on the floor according to the facility policy. During an interview on 04/23/25 at 9:38 a.m., the DON said CNA C should have knocked on the door before she entered Resident #2's room, and her bathroom door should have been closed to prevent the visitors in her room from seeing the resident exposed body because it was dignity issue. He said the nurses monitored the aides throughout the shift, and the nurse managers monitored the nurses during random rounding. The DON said the aides were trained according to the facility policy on privacy and dignity. During an interview on 04/24/25 at 4:56a.m., CNA L said she should have covered Resident #3 to provide privacy and dignity for the resident. CNA L said she had in service on privacy and was educated to cover the resident whenever a resident was left unattended. CNA L said the nurses monitored the aides throughout the shift. During an interview on 04/24/25 at 4:59 a.m., LVN M said CNA L should have covered Resident #3 before she left the resident, which would have provided privacy for Resident #3. LVN M said Resident #3 could feel bad or uncomfortable because she was exposed. LVN M said the nurses monitored the aides throughout the shift, and the nurse managers monitored the nurses during random rounds. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 4/24/2025 at 5:19am, he said staff were supposed to knock and ask for a resident's permission to enter the room. Residents could feel a little annoyed if staff did not knock. Privacy is to be maintained by closing the door at a minimum for private rooms, and for shared rooms curtains and blinds should be used. If these actions were not done, a resident's privacy could be compromised. Before assisting a resident with removing their clothes in the restroom, staff should ask residents before closing the bathroom door. Interview with the Unit manager on 4/24/2025 at 11:01am, staff should knock on the door before entering room because another aide might be in there, and also due to privacy and it would just be proper thing to do when entering someone's room. If a resident's room was barged into, it would make them feel bad because they should have privacy, in case they were doing something they didn't want others to know. When providing incontinent care, staff should make sure doors, windows and blinds were closed. If windows were open, someone could walk by and see the care being provided to the resident and that would not be considered respecting a resident's privacy. Staff have received competency training on privacy, and it would be on their skills check-off list and also it would be common sense. Nurses and aides received training and a skills check-off upon hire. A nurse would go into a room and train staff, and the skills check-off list should be completed before going on to the floor. Nurses and unit managers would monitor aides. Interview with the ADON on 4/24/2025 at 11:55am, she said staff needed to knock before entering a room. Staff must then let the resident know who they are and provide a name badge . If residents did not know who entered the room, they could feel uncomfortable or scared since they are in an unfamiliar place. During patient care, staff should close the doors, curtains and blinds for privacy. If this was not done, staff would not be providing total privacy for residents. Someone could see them in the middle of care which would be an issue with dignity. Staff should cover residents back up after leaving the room, and if not, they were not providing the resident with dignity and privacy. The facility in-serviced staff accordingly. During an interview on 04/25/25 at 12:20 p.m., the DON said CNA L did not provide dignity to Resident #3 when she left the resident uncovered and walked out of the room. The DON said the nurses monitored the aides throughout the shift. The DON said aides were trained according to the facility's policy . Record review of the facility policy on dignity dated 2001 MED - PASS, Inc, (Revised August 2009) read in part . Policy Interpretation and Implementation .1. Residents shall be treated with dignity and respect at all times .6. Residents' private space and property shall be respected at all times 6a. staff will knock and request permission before entering residents' rooms .10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 7 residents (Resident #10 and Resident #22) reviewed. -The facility failed to ensure that Resident #10's status of full code was a focus area in the resident's comprehensive care plan and no intervention was in place. -The facility failed to ensure that Resident #10's status of allergies was a focus area in the resident's comprehensive care plan and no intervention was in place. -The facility failed to ensure that Resident #10's status of impaired thought processes was a focus area in the resident's comprehensive care plan and no intervention was in place. -The facility failed to ensure that Resident #10's status of cellulitis was a focus area in the resident's comprehensive care plan and no intervention was in place. -The facility failed to ensure that Resident #10's status of nutritional problems and use of a feeding tube (also called a g-tube) were a focus area in the resident's comprehensive care plan and no intervention was in place. -The facility failed to ensure that Resident #22's status of nutritional problems and use of a feeding tube were a focus area in the resident's comprehensive care plan and no intervention was in place. These deficient practices could affect residents by not providing and meeting resident-specific care and needs and lead to a worsening of health. The findings included: Resident #10 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's facility admission record dated 4/25/25 revealed an [AGE] year-old female admitted on [DATE] with diagnoses that included cellulitis of both right and left lower limbs (Cellulitis is usually a superficial infection of the skin (left). But if severe (right) or if left untreated, it can spread into the lymph nodes and bloodstream. Cellulitis usually affects the lower legs, but it can occur on the face, arms and other areas.), bipolar disorder (bipolar disorder is a mental health condition characterized by significant mood swings.), mild protein-calorie malnutrition (Protein calorie malnutrition is a type of undernutrition. Undernutrition happens when you don't consume enough essential nutrients, or when you use/excrete the nutrients faster than they are replaced.), and cognitive communication deficit (cognitive communication deficit refers to difficulties in communication that arise from impairments in cognitive processes such as attention, memory, perception, and executive function). Record review also revealed that her advanced directive was full code. Record review of Resident #10's admission MDS dated [DATE] revealed Resident #10 had a BIMS score of 13 out of 15 indicating she was cognitively intact. Resident #10 was dependent to requiring substantial/maximal assistance with ADL's. She was always incontinent of bladder and frequently incontinent of bowel. Record review of section I (active diagnoses) diagnoses included malnutrition, bipolar disorder, cellulitis of both right and left lower limbs. Record review of Resident #10's comprehensive care plan revealed there were no care plans to address full code, allergies, impaired thought processes, cellulitis, and nutritional problems. Interview on 4/24/25 at 1:45 pm with the Corporate Nurse, she said that the care plans were important to follow a resident's plan of care and that a negative outcome could be the resident not receiving care. Interview on 4/24/25 at 1:47 pm with the DON said that the areas of full code, allergies, impaired thought processes, cellulitis, and nutrition problems should have had a comprehensive care plan, the care plan was important because it showed what the residents needed, and a negative outcome could be the resident not receiving those things. On 4/24/25 at 2:00 pm, an interview with MDS Nurse K, she said the importance of comprehensive and base line care plans were that the care plans provided a picture of the resident and how to take care of their needs. Staff that were responsible for the care plans included Circle of Excellence, IDT team which included Social Work, Nurses, Managers, and Therapy. Interview on 4/24/25 at 2:10 pm with MDS Nurse M, she said that the facility used the RAI Manual to complete assessments, that the care plans were important to provide care to the residents. Resident #22 Record review of Resident #22's face sheet revealed a [AGE] year-old female originally admitted on [DATE] and most recently readmitted on [DATE]. Her medical diagnoses included: Type 2 Diabetes Mellitus (high blood sugar), unspecified severe protein-calorie malnutrition, Metabolic Disorder (a group of diseases which can increase negative health outcomes such as high fat, high blood sugar, and high blood pressure), dysphagia (difficulty swallowing), and cognitive communication deficit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #22's care plan captured 4/22/2025, she did not have a feeding tube-specific focus area. Record review of Resident #22's Order Summary report dated 04/24/2025, she had the following: -Enteral Feed Order every night shift, open system container or gravity feeding with a start date of 03/01/2025. -Enteral Feed Order every shift, continuous feed, check every 4-6 hours prior to irrigation and PRN (Confirm with physician regarding withholding feedings) -Enteral Feed Order every shift Diabetisource AC (Advanced-Control) 70 ml/hour 18 hours per day via feeding tube with a start date of 04/13/2025. Record review of Resident #22's PPS (Prospective Payment System, an alternate form for residents) MDS dated [DATE], she had a BIMS score of 00, indicating severe cognitive impairment related to thinking and memory. She required total assistance for all her ADLs, including eating, toileting and dressing. Resident #22 was marked as receiving a feeding tube at the facility. She was marked as admitting to the facility with parenteral/IV feeding. Observation of Resident #22 on 4/22/2025 at 1:29pm, she was sleeping in an elevated bed in no visible discomfort. Her feeding was located next to her bed, with tubes kink-free and off the ground. Interview with MDS Nurse A on 4/25/2025 at 9:51am, she checked Resident #22's record on her computer and said resident should have enteral feeding on her care plan if she was on it. MDS Nurse A then said Resident #22 had care plans for being a one-person set-up and supervision, which could include feeding. She then said she could add it and confirmed that Resident #22 was admitted with g-tube to the facility. Interview with the DON on 4/25/2025 at 10:15am, he said Resident #22's g-tube should have been care-planned based off the physician's orders. A risk to not placing g-tube in the care plan would be the resident receiving the incorrect order. Record review of the facility policy and procedure entitled Care Plans, Comprehensive Person-Centered, dated revised March 2022, read in part .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission .the comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 2 of 3 residents (Resident #1and Resident #3) reviewed for ADLs. - The facility failed to ensure Resident #1 and Resident #3 were provided incontinent care in a timely manner by facility staff. These failures could place residents at risk for not receiving incontinent care needed to maintain personal hygiene which could lead to skin breakdown, pressure injuries or infection. Findings included: RESIDENT #1 Record review of Resident #1's face sheet dated 04/24/25 revealed a [AGE] year-old female was admitted to the on 03/26/25. Resident #1 diagnoses included: metabolic encephalopathy (a condition where brain function is disrupted), hypertension (force of blood against the walls of the arteries is consistently too high), and cognitive communication deficit (someone has difficulty communicating because their thinking processes, like memory, attention, and reasoning). Record review of Resident #1's admission MDS assessment dated [DATE] revealed BIMS score of 02 indicating severely impaired cognition. Further review revealed Resident #1 was dependent on staff for ADL care with one to two staff assist. Record review of Resident #1's undated care plan revealed Resident #1 had ADL self - care performance deficit related to dementia and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an interview on 04/22/25 at 1:26 p.m., CNA B said Resident #1 was assigned to her today, and she came to work at 6:10 a.m. CNA B said she provided incontinent once for Resident # 1 at 7:00 a.m. CNA B said she would change her now. During an observation on 04/22/25 at 1:30 p.m., Resident #1's incontinent brief was saturated from front to back, and the incontinent line on the brief was mashed and faded when CNA B opened the resident's incontinent brief. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/25 at 1:40 p.m., CNA B said Resident #1's incontinent brief was very wet with urine, and the wet indicator lines faded. CNA B said when she went to check on the resident the second time in the day (time unknown) she did not check to see if Resident #1 was wet because she had a lot of residents (14). CNA B said she should make rounds every two hours and change residents. CNA B said Resident #1 could have a skin breakdown because she was left in a wet incontinent brief. CNA B said she had a skills check-off on incontinent care and rounding. CNA B said she was educated to do rounding and incontinent care every two hours and to change the resident to prevent skin breakdown and infection. She stated the nurse monitors the aides during rounds throughout the shift. During an interview on 04/23/25 at 9:09 a.m., the DON said the aides should make rounds every two hours. He stated CNA B should check the resident's brief during rounding. The DON said if Resident #1 was left in a wet incontinent brief for an extended time, it could lead to skin breakdown. He stated the nurse monitored the aides and the staffing coordinator, while the nurse managers monitored the nurses during random rounding. He said the aides were trained before they started working on the floor on rounding and providing incontinent care. The DON responded that he would provide documentation of the care areas covered during CNA training. During an interview on 04/24/25 at 10:56 a.m., the Unit Manager said aides should check on residents every two hours. The Unit Manager said aides should check non-interviewable residents' incontinent briefs during rounds to make sure the resident was dry or wet and provide care. The Unit Manager said CNA B should not have left Resident #1 in a soiled brief for so long because her skin could break down. She said the aides had skill checkoffs before working with residents on the floor. The Unit Manager said the nurse monitored the aides, and the nurse managers monitored the nurses during rounding. Resident #3 Record review of Resident #3's face sheet dated 04/06/25 revealed a [AGE] year-old female was admitted to the on 03/26/25. Resident #3 diagnoses included: malignant neoplasm of bilateral ovaries (cancerous tumors are present in both ovaries), diabetes mellitus (a condition where the body has trouble regulating blood sugar levels), and cystitis (inflammation of the bladder). Record review of Resident #3's admission MDS assessment dated [DATE] revealed BIMS score of 15 indicating intact cognition. Further review revealed Resident #3 was dependent on staff for ADL care with one to two staff assist. Record review of Resident #3's care plan revision dated 04/24/25 revealed Resident #3 had ADL self - care performance deficit related to activity intolerance and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an observation on 04/24/25 at 4:06 a.m., incontinent care for Resident #3 provided by CNA L which revealed Resident #3's incontinent brief had feces from the lower back to the pubic area and the draw sheet was stained with feces. The feces was semi-dry. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/25 at 4:52 a.m., CNA L said she had not changed Resident #3 because she was working in another hall and came over to this hall around 1:30 a.m., and she had not made her way to Resident #3. CNA L said Resident #3 had a bowel movement, which was not fresh. CNA L said Resident #3's skin could break down if she did not change Resident #3 often. She stated the nurses monitored the aides throughout the shift. She said she was educated to make rounds every two hours and changed the resident to prevent skin breakdown. During an interview on 04/24/25 at 4:59 a.m., LVN M said the aide makes rounds every two hours to check the resident and change if the resident is dirty. LVN M said CNA L should have changed Resident #3 timely to prevent the resident skin from breaking down. She said the nurses monitored the aides throughout the shift. LVN M said she made rounds and saw Resident #3 but did not check the resident incontinent brief. During an interview on 04/24/25 at 11:55 a.m., the ADON said the aides round every two hours. The ADON said CNA L should change Resident #3 often to prevent her skin from breaking down. The ADON said nurses monitored the aides while the nurse managers monitored the nurse, and the staff had in serviced on incontinent care. ADL policy was requested but it was not provided. Record review of the facility in- service on staff rounding dated 10/20/25 through 01/23/25 read in part . staff (nurses and CNA's) must round every 2 hours and as needed, and charge should alternate with the CNA's .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #2) reviewed for accidents and for food trays left out in the halls after meals. -The facility failed to ensure CNA C used gait belt when she transferred Resident #2 from bed to walker and walked the resident to the bathroom. -There was a food cart with nine food trays eaten with cutlery left out in the hall observed on 4/23/2025 at 4:43am. This failure could place residents who required assistance from staff to transfer out of bed and ambulatory residents at risk for accidents and injury. The findings were: RESIDENT #2 Record review of Resident #2's face sheet dated 04/25/25 revealed a [AGE] year-old female was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 diagnoses included: Parkinson's disease (a progressive neurodegenerative disorder leading to movement related to tremors, slow movement, and rigidity), hypertension (force of blood against the walls of the arteries is consistently too high), and diabetes mellitus (a condition where the body has trouble regulating blood sugar levels). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 indicating intact cognition. Further review revealed Resident #2 needed moderate assistance with transfer with one staff assist. Record review of Resident #2's care plan dated 03/13/25 revealed Resident #2 had ADL self - care performance. Interventions: transfer: the resident requires 1 x2 staff assistance for transfers. Further review revealed the resident had Parkinson's affecting. Interventions: adaptive devices as recommended by therapy or MD. Monitor for safe use. Monitor/document to ensure appropriate use of safety/assistive devices. During an observation on 04/22/25 at 3:16 p.m., CNA C assisted Resident #2 by holding the resident's left arm with both of her hands and pulling on Resident #3 while she was still lying on the bed, but she could not get the resident out of the bed without a gait belt. CNA C then pulled the back of Resident #2's pants with one hand and one arm under Resident #3 left armpit, pulled her up from the bed, and asked her to hold onto her walker because she could walk. Resident #3 was wobbling, and she told the resident to walk, when she did not move, she moved the resident's walker forward. Resident #3 shuffled as she walked. When Resident #2 walked to the restroom door, the resident's gait became very unsteady, and she almost lost her balance while the aide was walking on the resident's right side. The surveyor alerted the aide, and CNA C walked to the resident's back and assisted the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/24/2025 at 4:43am, a food cart was observed in a resident hall directly in front of the kitchen door entrance with nine eaten food trays which were unsealed, with used cutlery on trays. During an interview on 04/22/25 at 3:35 p.m., CNA C said she did not use a gait belt to transfer Resident #3 because the resident did not have a gait belt and asked where she was expected to get a gait belt. She did not respond when asked if she had any training on using a gait belt and what could have happened to Resident#3 during transfer without a gait belt. During an interview on 04/23/25 at 9:38 a.m., the DON said CNA C should have transferred Resident # 2 with a gait belt because she was one person assist. He said if the staff did not use a gait belt, then the resident could fall and fracture her bone. The DON said if the staff was walking the resident, the staff should walk slightly behind and to the side with a hand on the gait belt to support the resident and prevent the resident from falling. Interview with LVN O on 4/24/2025 at 4:43am, they said the trays were from residents who preferred to have a later dinner. They said that a risk of leaving the trays out and not bringing them inside the Kitchen was that any resident could come and eat off the tray. They said that it was also an infection control issue. Interview with the Administrator on 4/24/2025 at 5:19am, he said staff were supposed to transfer residents with a gait belt. There could be potential for residents to fall if a gait belt was not used. He also said food trays should be placed in the dining room and placed in the kitchen after dinner and he had them moved after it was observed by surveyors. He would do education on that, and a risk to residents would be someone could go eat the food that was left out, which is the reason why food is to be taken out of resident's' rooms after they're done eating. Interview with the Unit manager on 4/24/2025 at 10:56am, she said that food trays were usually left outside on the cart after dinner but that the trays should have been taken off the hall and pushed into the closed kitchen door. If residents passed and tried to eat it. it would have caused harm as they could have been on a different diet. Staff who assist a resident to the restroom should wait outside the bathroom door and not leave the resident's room for safety reasons, in case the resident fell. Staff should use a gait belt when doing a one-person transfer with a resident, and this would be done for the staff's and resident's safety. The Unit Manager said she did in-services on transferring with gait belt, and staff were aware they need to use a gait belt. Interview with the ADON on 4/24/2025 at 12:09pm, she said staff were to use a gait belt for one-person assist. Without a gait belt that could cause staff injury during transfer or resident and staff could fall causing injury to the resident. Staff had been trained on proper transfers. Resident #2 could have fallen, hit her head or dislocated her shoulder. Interview with the DON on 4/25/2025 at 12:22pm, he said food trays should be in the kitchen after dinner. Residents with poor or impaired cognition could grab something, causing cross-contamination. Staff could get sick, and cutlery could cause injury to residents if used. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility Continuing Care Network - Nursing Policy & Procedure Mobility Section 10 - Transfers read in part . when transferring a patient even with minimal assistance) always place a belt around his waist . note: if at all unsure of transfer process, seek help or consult with PT or OT for further instruction . A policy was requested on accidents and hazards. The facility stated they did not have a specific policy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 3 residents (Resident #1 and Resident #3) reviewed for incontinent care. The facility failed to ensure CNA B properly cleaned Resident #1 during incontinent care when CNA B did not separate Resident #1's labia on 04/22/2025. The facility failed to ensure CNA L properly cleaned Resident #3 during incontinent care when CNA L did not separate Resident #3's labia during incontinent care on 04/24/2025. This failure could place residents at risk for pain, infection, injury, and hospitalization. Findings included: 1. Record review of Resident #1's face sheet dated 04/24/25 revealed a [AGE] year-old female was admitted to the on 03/26/25. Resident #1 diagnosis included: metabolic encephalopathy (a condition where brain function is disrupted), hypertension (force of blood against the walls of the arteries is consistently too high), and cognitive communication deficit (someone has difficulty communicating because their thinking processes, like memory, attention, and reasoning) Record review of Resident #1's admission assessment dated [DATE] revealed on BIMS of 02 indicating severely impaired cognition. Further review revealed Resident #1 dependent on staff for ADL care with one to two staff assist. Record review of Resident #1's undated care plan revealed Resident #1 had ADL self - care performance deficit related to dementia and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an observation on 04/22/25 at 1:30 p.m., CNA B did not separate Resident #1's labia when she cleaned the resident during incontinent care. CNA B was about to apply a clean incontinent brief when the surveyor intervened, and the aide separated Resident#1's labia and cleaned the area three times. There was a brown substance on the wipes. During an interview on 04/22/25 at 1:40 p.m., CNA B said she tried to separate Resident #1's labia, but she did not because her legs were straight. CNA B stated if she did not clean Resident #1's labia well, the skin could get irritated and infected. CNA B said she had training in providing incontinent care. She said she was educated to bend the resident's leg at the knee, open the labia clean side, side, and middle, and ensure the resident was clean. She said the nurse monitors the aides during rounds throughout the shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/25 at 9:15 a.m., the DON said staff should completely clean Resident #1's labia. He stated CNA B should open the labia and clean. The DON said if CNA B did not clean Resident #1's labia area properly, it could result in infection. He said the staff should have a skills check-off before working on the floor. The DON said he would refer to the facility protocol and policy to see what was taught to the staff and get back to the surveyor. 2. Record review of Resident #3's face sheet dated 04/06/25 revealed a [AGE] year-old female was admitted to the on 03/26/25. Resident #1 diagnosis included: malignant neoplasm of bilateral ovaries (cancerous tumors are present in both ovaries), diabetes mellitus (a condition where the body has trouble regulating blood sugar levels), and cystitis (inflammation of the bladder) Record review of Resident #3's admission assessment dated [DATE] revealed on BIMS of 15 indicating intact cognition. Further review revealed Resident #3 dependent on staff for ADL care with one to two staff assist. Record review of Resident #3's care plan revision dated 04/24/25 revealed Resident #3 had ADL self - care performance deficit related to activity intolerance and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an observation on 04/24/25 at 4:06 a.m., CNA L did not separate Resident #3's labia during incontinent care for Resident #3. The surveyor intervened when CNA L was about to apply a clean incontinent brief. CNA L separated the resident labia and cleaned three more times, and there were bowel movements on the wipes. During an interview on 04/24/25 at 4:56 a.m., CNA L did not separate Resident #3's labia when she provided incontinent care and when she was about to place clean incontinent brief, and the surveyor intervened. CNA L said she wiped the resident several times and the wipes had bowel movement. CNA L said if she did not clean Resident #3 correctly, the resident could have infection, rashes, and skin breakdown. CNL L said she had been in service for incontinent care and was educated to separate the labia and clean the labia area properly. She stated the nurses monitored the aides throughout the shift. During an interview on 04/24/25 at 4:59 a.m., LVN M said CNA L should have separated Resident #3's labia and cleaned properly to prevent the resident from getting any infection. LVN M stated the nurses monitored the aides throughout the shift, and the nurse manager monitored the nurses during random rounds. During an interview on 04/24/25 at 11:55 a.m., the ADON said CNA L should have cleaned Resident #3 genitalia from front to back, and the labia should be separated cleaned front to back, wiped side, side, and middle with a different wipe each time. The ADON said if CNA L did not appropriately clean Resident #3 labia area, Resident #3 could have a UTI, and her private area would smell bad. Interview with the Administrator on 4/24/2025 at 5:19am, he said that staff were supposed to make rounds at least every two hours. If residents were left in their soiled briefs for a prolonged period of time without being changed, they could get a UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Unit Manager on 4/24/2025 at 10:56am, she said aides should be checking on residents every two hours. Aides should check on non-interviewable residents during rounds to make sure if they're wet or dry. If they're in the soiled brief for so long, their skin would break down. Female genitalia should be wiped from front to back. Staff should raise residents' legs up and open and clean the labia to make sure every part of the area was clean. If residents were not cleaned properly, they could develop UTIs. During incontinent care, staff should come in with a bag and all the items they needed so they do not have to leave the room. Staff should change gloves before getting new wipes, and if they did not that would mean they were not being sanitary and causing an infection control issues especially if the staff's gloves were soiled. Staff should not bring soiled gloves outside a resident's room because that could spread their infection to another person. Gloves should not be carried in the back pocket because that would not be a sterile practice, and having something else in the pocket with the glove could cause infection. Staff should wash their hands before leaving a room. Nurses and aides received training and a skills check-off upon admissions. A nurse would go into a room and train staff, and the skills check-off list should be completed before going on to the floor. Nurses should be monitoring aides on the floor, and managers monitor the nurses. Interview with the ADON on 4/24/2025 at 11:58am, she said staff should put supplies in a bag and have everything they need to provide resident care before entering a room. Staff should place dirty briefs and used supplies in a bag. Staff should use wash their hands before donning PPE. During incontinent care, staff should not be using used gloves to pull wipes from the container because that would be infection control. Female genitalia should be cleaned from front to back, and the labia should be cleaned front to back with staff spreading and wiping each side and throwing away the wipe in between sides. When incontinence care is completed, staff should tie the bag with soiled items, wash their hands before leaving the room to avoid infection control issues. If incontinence care is not provided as instructed, residents could develop smells or a UTI, develop skin breakdown, pressure ulcers. Residents could develop open areas if they were in a soiled diaper for extended periods of time. Incontinent care policy was requested but was not provided prior to exit.

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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. 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 in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to ensure foods were dated as opened/prepared discarded after used date of 2 - 3 days per facility policy. These failures could place residents at risk of food borne illness and disease. Findings Included: Observation of the 1 of 1 facility kitchen freezer on 04/22/2025 at 8:56 a.m., revealed the following: 1. 1-gallon ziplocked sealed bag full of frozen premade waffles unlabeled/undated. 2. 4-single waffles sealed in saran wrap unlabeled/undated. In an observation on 04/22/2025 at 08:56 a.m., during the initial tour with Dietary Manager (DM) of 1 of 1 walk-in freezers in 1 of 1 kitchen observed 1-gallon ziplocked sealed bag full of frozen premade waffles unlabeled/undated and 4-premade waffles sealed in saran wrap unlabeled/undated. In an interview on 04/22/2025 at 08:56 a.m., Dietary Manager (DM) stated the waffles were served for breakfast on 04/20/2025. He stated Swing [NAME] (SC) served the waffles and it had been her responsibility to ensure that the waffles were labeled and dated before storing. He stated it was importance for foods to be labeled to know when it had surpassed its serve by dated and when it needed to be discarded. He stated food items were to be labeled to identify its content and dated to identify when its shelf life had expired, and the items needed to be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2025 at 03:24 p.m., SC stated that she had worked for the facility for 10-years. She stated she had not cooked or served any waffles on 04/20/2025. She stated 2-weeks ago, she cooked chicken and waffles for a dinner meal. She stated on 04/20/2025, she served toast. She stated she had not used nor left the waffles and it had been someone else who left the waffles unlabeled/undated. She stated she would normally use the waffles seal them in a bag and replace back into the box it came in within the freezer. She stated on 04/21/2025 the DM who was responsible for ordering foods, performed an inventory check to determine what food items needed to be reordered. She stated being that he had gone into the freezer he should have seen that the waffles were not labeled and ensured they were labeled. She stated that everyone in the kitchen had access to the freezer and were responsible for properly storing and labeling food items. She stated once a food item was opened for use, it was to be used within 3-days and/or thrown out. She stated that the importance of labeling and properly storing food items after opening, was to ensure that that it had not remained longer than it shelve life, avoid becoming freezer burnt, and was not served to residents after those 3-days. She stated serving resident improperly stored food could cause them to become ill. She stated that she had an in-service (training) with her staff on labeling foods a couple of months ago. In an interview on 04/23/2025 at 09:09 a.m., the Director of Nursing stated that the DM had been responsible for ensuring that the food storage policy and procedures were relied to the kitchen staff. She stated it had been her expectation that the kitchen staff followed storing and labeling procedures appropriately and according to the policies. She stated the importance of labeling food was to know what food was stored and how long it had been stored and when to discharged . She stated the negative outcomes of storing unlabeled food could be serving spoiled food that could make the residents ill. Record review of facility's in-service training report dated 04/22/2025 reflected: Topic Labeling and dating evaluation, comments, or suggestion. Presented by DM manager and signed by the dietary staff to include SC. Record review of facility's policies and procedures titled Food Storage Nutrition Services Policy & Procedures . Food Production and Food Safety POLICY: dated March 2009; Rev 3/2019. Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. 9. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food was used within 2-3 days or discarded. 16. Frozen Foods: Foods should be covered, labeled, and dated.

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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. Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 8 resident halls observed for proper garbage disposal. The facility failed to dispose of garbage when a food tray cart safely and properly with nine trays that were eaten including cutlery laying on the trays were seen outside the Kitchen entrance on 4/24/2025. This failure could place residents at risk of eating food incompatible with their prescribed diet and which could attract pests. Findings included: During an observation on 4/24/2025 at 4:43am, a food cart was observed in a resident hall directly in front of the kitchen door entrance with nine eaten food trays which were unsealed, with used cutlery on trays. Interview with LVN O on 4/24/2025 at 4:43am, they said the trays were from residents who preferred to have a later dinner. LLVN O said that a risk of leaving the trays out and not bringing them inside the Kitchen was that any resident could come and eat off the tray. LVN O said that it was also an infection control issue. Interview with the Administrator on 4/24/2025 at 5:19am, who said food trays should be placed in the dining room and placed in the kitchen after dinner and he had them moved the food cart after it was observed by surveyors. He would do education on that, and a risk to residents would be someone could go eat the food that was left out, which was the reason why food was to be taken out of resident's rooms after they're done eating. Interview with the Unit manager on 4/24/2025 at 10:56am, who said that food trays were usually left outside on the cart after dinner but that the trays should have been taken off the hall and pushed into the closed kitchen door. If residents passed by and tried to eat the food, it would have caused harm as they could have been on a different diet. Interview with the DON on 4/25/2025 at 12:22pm, who said food trays should be in the kitchen after dinner. Residents with poor or impaired cognition could grab something, causing cross-contamination. Staff could get sick, and cutlery could cause injury to residents if used. Record review of the facility's policy on food-related garbage and refuse disposal last revised October 2017, it read in part that, 1. All food waste shall be kept in containers . 5. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. Record review of the facility's policy on food-related garbage and refuse disposal last revised October 2017, it read in part that, 1.All food waste shall be kept in containers . 5. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 3 of 4 residents (Resident #1, Resident #2, and Resident #3) and 4 of 5 staff (CNA B, CNA C, CNA L, CNA F) observed for infection control. 1-The facility failed to ensure CNA B followed appropriate infection control and hand hygiene procedure during incontinent care for Resident #1 on 04/22/2025. 2-The facility failed to ensure CNA C followed appropriate infection control and hand hygiene procedure while assisting resident to the bathroom for Resident #2 on 04/22/2025. 3-The facility failed to ensure CNA L followed appropriate infection control and hand hygiene procedure during and after incontinent care for Resident #3 when she was seen leaving a resident's room with gloves on 04/24/2025. 4-The facility failed to ensure CNA F followed appropriate infection control when two plastic bags with soiled items were left opened and on the floor outside a resident's room observed on 04/24/2025. These failures could place the residents at risk for infection. Findings included: 1-Record review of Resident #1's face sheet dated 04/24/25 revealed a [AGE] year-old female was admitted to the on 03/26/25. Resident #1 diagnosis included: metabolic encephalopathy (a condition where brain function is disrupted), hypertension (force of blood against the walls of the arteries is consistently too high), and cognitive communication deficit (someone has difficulty communicating because their thinking processes, like memory, attention, and reasoning) Record review of Resident #1's admission assessment dated [DATE] revealed on BIMS of 02 indicating severely impaired cognition. Further review revealed Resident #1 dependent on staff for ADL care with one to two staff assist. Record review of Resident #1's comprehensive care plan revealed Resident #1 had ADL self - care performance deficit related to dementia and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an observation on 04/22/24 at 1:30 p.m., CNA B walked into Resident #1's room and donned (put on) gloves without sanitizing or washing her hands. CNA B provided incontinent care to Resident #1 with the same gloves throughout, pulled wipes from the container with the same dirty gloves she used to clean the resident, and did not change gloves when she went from dirty to clean. She used the same gloves, applied barrier cream, and applied a clean incontinent brief on Resident #1. CNA B removed her gloves and left Resident #1's room after she provided care and did not wash or sanitize her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2-Record review of Resident #2's face sheet dated 04/25/25 revealed a [AGE] year-old female was initial admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 diagnosis included: Parkinson's disease (a progressive neurodegenerative disorder leading to movement related to tremors, slow movement, and rigidity), hypertension (force of blood against the walls of the arteries is consistently too high), and diabetes mellitus (a condition where the body has trouble regulating blood sugar levels) Record review of Resident #2's quarterly assessment dated [DATE] revealed on BIMS of 13 indicating intact cognition. Further review revealed Resident #2 needed moderate assistance with transfer with one staff assist. Record review of Resident #2's care plan dated 03/13/25 revealed Resident #2 had ADL self - care performance. Interventions: transfer: the resident requires 1 x2 staff assistance for transfers. During an observation on 04/22/25 at 3:16 p.m., CNA C did not wash her hands before she put on gloves when assisting Resident #2 in the restroom. She removed her gloves when she finished attending to Resident #2 in the restroom and left the resident's room without washing her hands. 3-Record review of Resident #3's face sheet dated 04/25/25 revealed a [AGE] year-old female was initial admitted to the facility on [DATE]. Resident #3 diagnosis included: urinary tract infection (an infection in any part of the urinary system), ovarian cyst (a fluid filled sac that developed on or inside an ovary), and diabetes mellitus (a condition where the body has trouble regulating blood sugar levels) Record review of Resident #3's admission assessment MDS dated [DATE] revealed on BIMS of 15 indicating intact cognition. Further review revealed Resident #3 incontinent of bowel and bladder and dependent on staff for ADL care with one to two staff assist. Record review of Resident #3's comprehensive care plan revealed Resident #3 had ADL self - care performance deficit related to activity intolerance and impaired balance. Interventions: The resident requires assistance with 1 or x2 staff for toileting. This may fluctuate with weakness, fatigue, or weight bearing status. During an observation on 04/24/25 at 4:06 a.m., CNA L did not wash or sanitize her, took gloves from her uniform pocket, and put on the gloves. CNA L used the same gloves she was wiping the bowel movement and pulled wipes from the wipe packet. When she ran out of wipes, she removed her gloves and left Resident #3's room without washing her hands. When CNA L returned, she did not wash her hands, took gloves from her uniform pocket again, and continued to clean Resident #3's bowel movement. She still pulled wipes from the container and her gloves, which had bowel movements. CNA L removed her gloves after providing incontinent care for Resident #3 and left the room without washing her hands. 4-Observation on 4/24/2025 at 4:00am, there were briefs in original bags and about 8 white bedsheets stacked on top of a wheelchair. There were also two untied plastic bags with used briefs and gloves inside them, with gloves partly outside the bag on the floor. A later observation on 4:43am, CNA L was observed walking out of a resident's rooms with gloves on. At the same time, a food tray cart with approximately nine trays were seen eaten with cutlery outside the Kitchen entrance. (continued on next page)

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solera at West Houston	2101 Greenhouse Road Houston, TX 77084

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/25 at 1:48 p.m., CNA B said she was supposed to wash or sanitize her hands before she donned (put on) gloves and wash her hands before going from dirty to clean and after providing incontinent care for Resident #1. CNA B said she did not wash her hands or change gloves while she provided incontinent care for Resident #1. CNA B said she used the same gloves she wiped the resident to take wipes from the packet and it could have contaminated the wipes in the packet because you do not go from dirty to clean. CNA B said she had a skill check off on infection control and was educated not to use dirty gloves to take wipes from the clean packet and to wash her hands before and after providing care for residents. She said the nurse monitors the aides throughout the shift. During an interview on 04/22/25 at 3:42 p.m., CNA C said she did not wash her hands before and after attending to Resident #2 in the restroom. CNA C said she should have washed her hands to prevent cross-contamination. CNA B said the nurse monitored the aide throughout the shift. CNA C said she was in serviced on infection control and was educated to wash or sanitize her hands before and after providing care for the resident. During an interview on 04/23/25 at 9:23 a.m., the DON said CNA C should wash her hands before she donned gloves and after doffing (took off) when she finished assisting residents in the bathroom. The DON said hand washing would prevent the spread of germs. The DON also said CNA B should have pulled enough wipes from the wipe container and should not go back into the wipe container because there was a risk of cross-contamination. The DON said CNA B should change gloves when going from dirty to clean while providing incontinent care for Resident #1 because of cross-contamination. He said the aides were provided skills check-off and had been in-serviced (an in-service is a training for staff typically as a periodic refresher on a topic related to their duties)on infection control and ADL care, which included incontinent care. The DON said the staff were educated according to the facility policy. During an interview on 04/24/25 at 4:59 a.m., LVN M said CNA L should wash her hands before and after providing incontinent Care for Resident #3. LVN M said CNA L should not have used the gloves from her uniform pockets or the same dirty gloves and pulled wipes from the wipe container because it was cross-contamination. LVN M said she had in service on hand washing and PPE (Personal Protective Equipment). LVN M said the nurses monitored the aides throughout the shift, and the nurse managers monitored the nurses during rounding. During an interview on 04/24/25 at 5:54 a.m., CNA L said she did not wash her hands, and she donned the gloves she took from her uniform pockets, and it was infection control (cross-contamination). She said she used the same gloves to wipe bowel movements and pull out the wipes from the wipe packets. CNA L said she left the room without washing or sanitizing her hands when she took off her gloves and left the room when she went to get another packet of wipes. CNA L said that when she came back, she did not wash or sanitize her hands, donned other gloves taken from her uniform pocket, and continued to provide incontinent care for Resident #3. She said she continued pulling wipes from the new packet with the same dirty gloves she used to wipe her bowel movements. CNA L stated that was an infection control issue (cross-contamination). She said she had an in-service on hand washing and PPE. She stated the nurses monitored the aides throughout the shift. She said she was educated to wash hands before and after taking care of a resident and to change gloves when going from dirty to clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/25 at 11:55 a.m., the ADON said CNA C should have washed her hands before and after providing care for Resident #2. She said the aides had in-service on infection control, including hand washing and PPE. The ADON said the nurses monitored the aides during rounds, and the nurse managers monitored nurses during random rounds. In a later interview on 4/24/2025 at 11:58am, she said staff should put supplies in a bag and have everything they need to provide resident care before entering a room. Staff should place dirty briefs and used supplies in a bag. Staff should use wash their hands before donning PPE. During incontinent care, staff should not be using used gloves to pull wipes from the container because that would be infection control. Female genitalia should be cleaned from front to back, and the labia should be cleaned front to back with staff spreading and wiping each side and throwing away the wipe in between sides. When incontinence care is completed, staff should tie the bag with soiled items, wash their hands before leaving the room to avoid infection control issues. If incontinence care is not provided as instructed, residents could develop smells or a UTI, develop skin breakdown, pressure ulcers. Residents could develop open areas if they were in a soiled diaper for extended periods of time. The ADON said staff were not supposed to use gloves from their pocket as that is an infection control issue. Staff were not supposed to come out of a resident's room with opened soiled bags and should not have left them sitting on the floor but be taken immediately to the dirty linen room. Confused residents could grab it or fall over it. Staff should be using trash bags to bring in clean items to resident rooms. If items were transported on the wheelchair without bags, that would be infection control. She said staff were in-serviced on infection control. Interview with CNA F on 4/24/2025 at 4:43am, who said she was using the wheelchair observed by the surveyor was not how items were usually transported down the hall, she usually used carts. CNA F said the bedsheets were clean. Interview with CNA L on 4/24/2025 at 4:43am, who said she wore her gloves outside the room because she was carrying a dirty bag and used the gloves to carry the bag to the soiled linen room and didn't want to touch it. She said she forgot about it and shouldn't have done it because it was an infection control issue. Interview with LVN O on 4/24/2025 at 4:43am, who said that any resident could come and eat the used trays that were left outside the kitchen, which was a potential for infection control. LVN O also said aides usually used wheelchairs to transport items, and that was clean linen on the wheelchair that CNA F was using. Interview with the Administrator on 4/24/2025 at 5:19am, he said clean linens should not be stored on the wheelchair without being transported in plastic bags, because that could cause an infection control issue. Gloves should not be in a staff's pocket and pulled out for use, as that would also be an infection control concern. Regarding CNA F leaving bags with soiled items on the floor after changing residents, the Administrator said items should have been taken to the dirty room. He also said food trays should be placed in the dining room and placed in the kitchen after dinner and he had them moved the left cart after it was observed by surveyors. He would do education on that, and a risk to residents would be someone could go eat the food that was left out, which was the reason why food was to be taken out of resident's rooms after they're done eating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 4/25/25 at 12:17 p.m., the DON said staff are not supposed to carry gloves in the uniform pocket and use the gloves on the resident because of cross-contamination. The DON said all staff should wash or sanitize their hands before and after providing care for the residents. The DON said CNA L should have pulled out enough wipes before she started to give incontinent care to Resident #3 to prevent cross-contamination. He said the aides were in service on infection control, which covered hand washing and PPE. He said the nurses monitored the aides throughout the shift, and the nurse managers monitored the nurses during random rounds. In a later interview with the DON on 4/25/2025 at 12:22pm, he said clean linen should be transported in bags on supply carts. If that, that could cause cross-contamination. Before leaving a room, staff should tie up bags with dirty items inside to prevent any escape of things in the bag into the atmosphere to avoid cross-contamination. Food trays should be in the kitchen after dinner. Residents with poor or impaired cognition could grab something, causing cross-contamination. Staff could get sick, and cutlery could cause injury to residents if used. Interview with the Unit Manager on 4/24/25 at 11:04am, female genitalia should be wiped from front to back. Staff should raise residents' legs up and open and clean the labia to make sure every part of the area was clean. If residents were not cleaned properly, they could develop UTIs. During incontinent care, staff should come in with a bag and all the items they needed so they do not have to leave the room. Staff should change gloves before getting new wipes, and if they did not that would mean they were not being sanitary and causing an infection control issues especially if the staff's gloves were soiled. Staff should not place bags containing soiled items on the floor but should take bags directly to the dirty linen room for disposal. Staff should not place linens on wheelchairs around the facility without placing them in plastic bags, and that was not how linen was supposed to be stored and could cause infection control issues to be passed on. Record review of the facility policy on Infection Control dated 2001 (Revised October 2018)) read in part . 1. The facility must establish an infection prevention and control program (IPCP) that must include . A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. This applies to all Patients, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment .Policy Interpretation and Implementation . Personnel who perform tasks that may involve exposure to blood/body fluids are provided appropriate personal protective equipment (PPE) at no charge . 2. Personal protective equipment provided to our personnel includes but is not necessarily limited to: 2b. gloves (sterile, non-sterile, heavy- duty and/or puncture-resistant) . Record review of the facility policy on hand washing dated 2001 (Revised August 2019) read in part . policy statement . This facility considers hand hygiene the primary means to prevent the spread of infections . Policy interpretation and implementation . #2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . #8. Hand hygiene is the final step after removing and disposing of personal protective equipment . #9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . applying and removing gloves .#1. Perform hand hygiene before applying non-sterile gloves . #5. Perform hand hygiene .