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	11/17/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 (CR#1) of 3 residents reviewed for accuracy of assessments. The WCN failed to accurately document the presence of an existing wound on CR#1's weekly skin assessment after a new skin issue occurred on 10/15/25. CR#1's initial MDS Assessment failed to document the presence of a skin issue. These failures could place residents at risk for delayed treatment, worsening of condition, and hospitalization Findings include:Record review of CR #1's facesheet revealed a seventy-six-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses was a pulmonary embolism without acute pulmonale (blood clot in the lung), secondary malignant neoplasm of bone (cancer that has spread throughout the body), hyperlipidemia, difficulty walking, and the presence of a pacemaker. Record review of CR#1's admitting hospital records dated 09/15/25 documented that CR#1 had Type 2 Diabetes, a pressure injury to the right heel that was present upon admission, and a right arthroplasty of the and hip (hip replacement) on 8/18/25. Record review of CR #1's care plan initiated 09/18/25 documented pain management and interventions stated that if pain was present, LVN should assess and document the pain assessment including location, nature, intensity, and duration of pain. Pressure ulcer interventions included floating heels as tolerated and using a pressure redistribution mattress. Record review of CR#1's MDS dated [DATE] revealed a BIMS score of 11 (moderate cognitive impairment). Section GG titled Functional Abilities upon admission noted that CR#1 was dependent to sit to stand, transfer from chair to bed, toilet transfer, and walking 10, 50, and 150 feet. Section M titled Skin conditions documented that CR#1 was at risk at developing a pressure ulcer based off a formal and clinical assessment. In the subsection unhealed pressure ulcers/injuries, it was documented that CR#1 had no present skin conditions. Record review of CR#1's admission assessment completed by RN A documented that no wound was present upon admission. She was marked as bed bound due to prior hip replacement surgery. Record review of CR#1's weekly head to toe assessment located on the TAR for September 2025 reflected on the following:* 09/22/25, WCN marked E that identified an existing wound alteration. *09/29/25, WCN marked 0, which was not listed as an abbreviation on the assessment key. Review of the weekly skin assessments for October 2025 documented the following:*10/6/25, WCN marked 0*10/13/25, WCN marked 0*10/21/25, WCN marked E*10/27/25, WCN marked 0 Record review of CR#1's active orders as of 9/18/25 were as follows:*09/22/15: ordered weekly head to toe assessments every Monday where N=new, E= existing skin altercation, and C= clear. *10/16/25: Wound Treatment - Xeroform every day shift every other day for open blister. Cleanse open blister right heel with saline, pat dry, apply skin prep to skin of surrounding area, apply xeroform to bruised open wound, cover with ABD. Secure with kerlix wrap. Elevate and off load. Monitor for discomfort. This order was discharged on 10/22/25. *10/17/25: Doxycycline ordered.*10/23/25: Wound Treatment - Dry Dressing every day shift every other day for wound healing. Cleanse right heel eschar wound with saline, pat dry, apply iodosorb gel to wound bed then cover with ABD, secure with kerlix wrap as directed and PRN. *10/31/25: Wound Treatment - Dry Dressing everyday shift for Wound healing. Cleanse right heel eschar with betadine, then apply moist to dry betadine gauze followed by ABD, Secure w/ kerlix wrap qd. Record review of CR#1's progress notes documented by WCN on 09/24/25 stated that her skin was assessed with no open areas and the heels were clear. Record review of CR#1's progress notes documented by the NP on 10/2/25, the NP identified calluses during examination (location unspecified) and CR#1 was started on Tylenol after complaints of pain during her PT sessions. Record review of CR#1's progress notes documented on 10/7/25, the NP documented complaints of worsening foot pain contributed to bilateral lower extremity edema with marked swelling and multiple large, thick calluses present on both feet, particularly prominent on pressure-bearing areas. The calluses appeared dry, hyperkeratotic, and well-established, causing discomfort and contributing to her pain. Skin was noted as noticeably discolored and had chronic venous changes consistent with chronic venous insufficiency. Record review of CR#1's progress notes documented on 10/9/25 by the NP indicated the chronic venous skin changes was consistent with pressure related changes, with difficulty lifting lower right extremity. Record review of CR#1's progress notes documented on 10/15/25, the NP identified the wound on the right heel as a Stage 2 pressure ulcer with drainage and partial thickness skin loss involving the epidermal. Wound management initiated. Record review of CR#1's progress notes documented by the WCN on 10/15/25, that on 10/14/25, a skin issue identified as a blister had appeared on

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents with pressure ulcers receive necessary treatments and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (CR #1) of 5 residents reviewed for wound care. The facility failed to properly identify the pressure ulcer and provide immediate oversight by a wound care specialist when the wound was first identified as a Stage 2 Pressure Ulcer on 10/15/25. CR#1 was admitted to the hospital on [DATE] with a necrotic pressure ulcer to the right heel and the need for possible amputation of the lower right extremity. On 11/17/25, CR#1's family member stated that CR#1's right leg was amputated above the knee due to an infected pressure ulcer of her heel. An Immediate Jeopardy (IJ) was identified on 11/14/25. The IJ template was provided to the facility on [DATE] at 3:31 pm. While the IJ was removed on 11/15/25, the facility remained out of compliance at a scope of pattern and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action. These failures could place residents at risk for delayed treatment, worsening of condition, hospitalization, and death.Findings Include:Record review of CR #1's facesheet revealed a seventy-six-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses was a pulmonary embolism without acute pulmonale (blood clot in the lung), secondary malignant neoplasm of bone (cancer that has spread throughout the body), hyperlipidemia, difficulty walking, and the presence of a pacemaker. Record review of CR#1's admitting hospital records dated 09/15/25 documented that CR#1 had Type 2 Diabetes, a pressure injury to the right heel that was present upon admission, and a right arthroplasty of the and hip (hip replacement) on 8/18/25. Record review of CR #1's care plan initiated 09/18/25 documented pain management and interventions stated that if pain was present, LVN should assess and document the pain assessment including location, nature, intensity, and duration of pain. Pressure ulcer interventions included floating heels as tolerated and using a pressure redistribution mattress. Record review of CR#1's MDS dated [DATE] revealed a BIMS score of 11 (moderate cognitive impairment). Section GG titled Functional Abilities upon admission noted that CR#1 was dependent to sit to stand, transfer from chair to bed, toilet transfer, and walking 10, 50, and 150 feet. Section M titled Skin conditions documented that CR#1 was at risk at developing a pressure ulcer based off a formal and clinical assessment. In the subsection unhealed pressure ulcers/injuries, it was documented that CR#1 had no present skin conditions. Record review of CR#1's admission assessment completed on 9/18/25 by RN A, documented that no wound was present upon admission. She was marked as bed bound due to prior hip replacement surgery. Record review of CR#1's weekly head to toe assessment located on the TAR for September 2025 reflected on the following:* 09/22/25, WCN marked E that identified an existing wound alteration (location not specified). *09/29/25, WCN marked 0, which was not listed as an abbreviation on the assessment key. Review of the weekly skin assessments for October 2025 documented the following:*10/6/25, WCN marked 0*10/13/25, WCN marked 0*10/21/25, WCN marked E*10/27/25, WCN marked 0 Record review of CR#1's active orders as of 9/18/25 were as follows:*09/22/15: ordered weekly head to toe assessments every Monday where N=new, E= existing skin altercation, and C= clear. *10/16/25: Wound Treatment - Xeroform every day shift every other day for open blister. Cleanse open blister right heel with saline, pat dry, apply skin prep to skin of surrounding area, apply xeroform to bruised open wound, cover with ABD. Secure with kerlix wrap. Elevate and off load. Monitor for discomfort. This order was discharged on 10/22/25. *10/17/25: Doxycycline ordered.*10/23/25: Wound Treatment - Dry Dressing every day shift every other day for wound healing. 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