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	02/18/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that resident with pressure ulcers receives treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1(Resident #1) of 5 resident's reviewed for pressure ulcers. -LVN A failed to follow physician orders while changing Resident #1's dressing to right hip. LVN A failed to apply skin prep to peri wound edge and apply Santyl (ointment used to remove dead tissue from skin ulcer) to resident wound bed. This failure could place residents with wounds at risk for delayed healing and tissue damage. Finding Included: Record review of Resident #1's face sheet dated 02/03/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 01/19/26. Resident #1's diagnoses included scoliosis (abnormal sideways curvature of the spine, forming an S or C shape), type 1 diabetes mellitus with hyperglycemia (blood sugar is above the normal range due to lack of insulin, causing the sugar to build up in the blood), end stage renal (kidney) disease, dependent of dialysis, and legally blind. Record review of Resident #1's admission MDS dated [DATE] reflected a BIMS of 13 indicating resident's cognition was intact. Review of section M (Skin) revealed that Resident #1 was admitted to the facility with pressure ulcer. Record review of Resident #1's Comprehensive Care Plan dated 12/29/25 and revised 01/02/26 Resident #1 care plan for skin concerns. Interventions included providing treatment as ordered. Record review of Resident #1's Physician order summary report for the month of February 2026 reflected the following wound treatment order: -Dated 01/30/26 Right hip, unstageable pressure injury: Cleanse with ns (normal saline) or house wound cleanser, pat dry with gauze, apply skin prep to peri wound edge (the skin immediately surrounding a wound), apply Santyl (, apply alginate calcium (absorbent dressing), cover with border gauze, everyday shift. Record review of Resident #1's MAR/ TAR for the month of February 2026 revealed that the facility was following the above prescribed order. Observation on 02/18/26 at 12:04 PM of wound care for Resident #1 by LVN A. Resident #1 said it was okay for surveyor to observe dressing change to her right hip. LVN A sanitize Resident #1's bedside table with disinfectant sani-wipes, washed her hands with soap and water, donned her PPE that consisted of disposable gown and gloves, and mask. LVN A then took wound supplies in resident's room including a small red biohazard bag and placed on top of parchment paper on top of bedside table. LVN A removed old dressing to resident's right hip, removed her gloves, sanitized her hands, and placed on a new set of clean gloves. LVN A cleaned Resident #1's wound bed with wound cleanser one wipe at a time. Resident #1's wound bed was dry and pink with tiny specs of black dots. LVN A changed her gloves again, sanitized her hands, and placed on a new set of clean gloves. LVN A did not apply skin prep to peri wound edge instead or applied Santyl to wound bed. LVN A applied to the wound bed calcium alginate covering with a border dressing. Resident #1 tolerated the procedure without complaints of discomfort. During an interview on 02/18/26 at 1:48PM, the DON said after reviewing Resident #1's orders, LVN A should have followed the physician (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound care orders to apply skin prep to wound edges and applied the Santyl. The DON was asked for the facility policy on wound care, following physician orders, and quality of care. During an interview on 02/18/26PM at 1:57PM with wound care nurse LVN A said when she made rounds with the Wound Specialist NP earlier in the day, the NP said not to apply the Santyl to Resident #1's wound on the right hip. LVN A said she had not transcribed the order in the system because she had not gotten around to it. LVN A said she had not worked at the facility in months and when she did work at the facility, it was usually on the weekend. LVN A said until the new order is put in the system, one would have to follow the present order. Interview on 02/18/26 at 2:26PM with the DON when asked what order the nurse would follow if a new wound care order had not been updated in the system and the wound dressing became soiled and the dressing needed to be changed? The DON said that would not happen because herself or the ADON would have transcribed the new wound treatment. During an interview on 02/18/26 at 2:40PM, RN B (charge nurse) said she worked at the facility full time on the 2pm-10pm shift. RN B said if a wound dressing became soiled and had to be changed, she would look in the system to see what was ordered and go by the order transcribed in the system. RN B said whenever the Wound Care Specialist NP came to the facility to make rounds on residents with wounds, the wound care nurse made rounds with the specialist. RN B said the Wound Care NP Specialist normally put in any new orders at the time she made her wound rounds. RN B said the Wound Care NP utilized a cart with a laptop , so she could put new orders into the system before she left the facility. Record review of the facility policy on Medication Administration dated 11/01/25 and revised 12/01/25 reflected in part: .Medications are administered by the licensed nurse, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Record review of the facility policy on Provision of Quality of Care dated 10/01/25 reflected in part: .Based on comprehensive assessments, the facility will ensure that residents receive treatment that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered, care plans, and the residents' choices.