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	07/25/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility must develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and include the minimum healthcare information necessary to properly care for residents for 3 (Residents #139,#140, and #143) of 5 residents reviewed for baseline care plans -Resident #139 had a tracheostomy and an enteral feeding tube that were not baseline care planned. -Residents 139, #140, and #143's baseline care plans did not designate the code status of the residents. The failures could place the residents at risk for not receiving the care and services needed and placed them at risk for deteriorating health. Findings included: Resident #139 Record review of the admission Record for Resident #139 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, tracheostomy status, and dysphagia (inability to swallow). His code status was reflected as Full Code. Record review of the Physician's Orders for Resident #139, dated 07/25/25, revealed the resident had an indwelling urinary catheter. The Orders reflected the resident was to have blood glucose monitoring four times daily. The Orders reflected the resident had an enteral feeding tube. Review of the electronic medical record for Resident #139 revealed there was an entry MDS assessment, but no admission MDS. Record review of the Care Plan initiated 07/18/25 revealed Resident #139 was on EBP because he had a tracheostomy. However, the Care Plan did not reflect any care instructions or precautions related to the tracheostomy. The Care Plan did not mention Resident #139 had an enteral feeding tube. The Care Plan did not mention the resident required blood glucose monitoring. The Care Plan did not reflect the code status of the resident. Observation on 07/22/25 at 8:05 a.m. revealed Resident #139 was lying in his bed in his room. He was awake and alert. He had a tracheostomy, a catheter, and an enteral feeding tube. Resident #140 Record review of the admission Record for Resident #140 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes mellitus, and hypertension (high blood pressure). His code status was reflected as Full Code. The baseline care plan dated 07/17/25 for Resident #140 read, in part, Resident request Code Status of [Specify]: Full Code/DNR. Date initiated 07/17/25. The baseline care plan did not reflect the resident's code status. The baseline care plan dated 07/17/25 for Resident #140 read, in part, The resident expresses (SPECIFY) desire for/little or no activity involvement r/t Date initiated 07/17/25. The baseline care plan did not specify the possible reason for the decreased desire to participate in activities. The baseline care plan dated 07/17/25 for Resident #140 read, in part, The resident has an ADL self-care performance deficit r/t Date initiated 07/17/25. The baseline care plan did not specify a possible reason for the deficit. The baseline care plan dated 07/17/25 for Resident #140 read, in part, The resident has altered cardiovascular status r/t Date initiated 07/17/25. The baseline care plan did not provide what contributed to the altered cardiovascular status. Resident #143 Record review of the admission Record for Resident #143 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, severe sepsis with septic shock, and pneumonia. His code status was reflected as Full Code. The baseline care plan dated 07/17/25 for Resident #143 read, in part, Resident request Code Status of [Specify]: Full Code/DNR. Date initiated 07/17/25. The baseline care plan did not reflect the resident's code status. The baseline care plan dated 07/17/25 for Resident #143 read, in part, The resident expresses (SPECIFY) desire for/little or no activity involvement r/t Date initiated 07/17/25 The baseline care plan did not specify the possible reason for the decreased desire to participate in activities. The baseline care plan dated 07/17/25 for Resident #143 read, in part, The resident has an ADL self-care performance deficit r/t Date initiated 07/17/25. The baseline care plan did not specify a possible reason for the deficit. The baseline care plan dated 07/17/25 for Resident #143 read, in part, The resident wishes to (SPECIFY return/be discharged) to (SPECIFY home, another facility) Date initiated: 07/17/25 The baseline care plan did not specify where the resident wished to be discharged to. The baseline care plan dated 07/17/25 for Resident #143 read, in part, The resident has impaired cognitive function/dementia or impaired thought processes r/t Date initiated 07/17/25 The baseline care plan did not reveal the possible cause of the impaired thought processes. The baseline care plan dated 07/17/25 for Resident #143 read, in part, .The resident has a communication problem r/t Date initiated: 07/17/25 The baseline care plan did not provide a possible reason or description of the communication problem. The baseline care plan dated

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #9 and #47) of 21 residents reviewed for comprehensive care plans. The facility failed to ensure that Resident #47 has a comprehensive care plan that included all care areas triggered on her assessment. The facility failed to ensure that Resident #9 comprehensive care plan included her hospice service and oxygen. These failures could place residents at risk of not receiving proper care and service to develop and improve their mental, physical and psychosocial well-being. Findings Included Resident#47 Record review of Resident#47 admission face sheet dated 7/25/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included urinary tract infection(infection of the urinary tract), hypertension (high blood pressure), osteoporosis(a disease of the bone) , gastro esophageal reflux disease (heart burn), chronic obstructive pulmonary disease (a lung disease that blocks air flow making it difficult to breath), chronic kidney disease (the inability to filter from the blood), atrial fibrillation (irregular/rapid heart rate that causes poor blood flow. , protein calorie malnutrition (insufficient intake of both protein and calories), muscle weakness(decrease strength in the muscle) and lack of coordination (impaired balance due to damage nerves, brain of muscles). Record review of Resident #47's admission MDS dated [DATE] revealed she coded as having a BIMS score of 14 indicating she was cognitively aware, was occasionally incontinent of bladder and bowel and had a fall with fracture in the last 6 months. Further record review revealed Resident #47 was triggered for incontinence, pressure sore, nutrition, activities of daily living, falls and dehydration. Record review of the care plan initiated 6/18/2025 revealed it did not address falls dehydration and incontinent care. Further record review revealed the care plan was updated on 7/25/2025 to address dehydration and falls but did not address incontinent care. Observation on 7/22/2025 at 10:00am Resident #47 was observed in her room she was alert and oriented and good make her needs known. She was clean and without any offensive odor. Call light was observed to be reached. In an interview on 7/22/2025 at 10:00am, Resident #47 said they answer her call light. She said she had to ask for help because she did not want to fall again. She said she fell at home and that was why she was in the facility for rehabilitation. She said she rehab was working with her, and she was able to move around much better. In an interview on 7/25/2025 at 10:15 am with the MDS Coordinator she said all triggered areas should be captured on the care plan. She said if the area were not captured on the care plan, they would not have a full picture on how to take care of the residents and they would not know what resident's daily needs were. She said moving forward they going to ensure that all triggered area were captured on the care plan and completed by day 21. Resident #9Record review of Resident #9's face sheet dated July 25th, 2025, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included malignant neoplasm of the lungs(cancer that begins in the lungs), chronic obstructive pulmonary disease(lung disease that blocks air flow), hypertension(high blood pressure), acute metabolic acidosis (too much acid accumulates in the body), lack of coordination(impaired balance due to brain or muscle damage), chronic respiratory failure with hypoxia (lungs cannot adequately exchange oxygen and carbon dioxide leading to insufficient carbon dioxide and oxygen in the body), muscle weakness(decreased strength in the muscles)weak, lack coordination (impaired balance or coordination due to damage brain, nerves or muscle) hyperlipidemia (high levels of fat in the blood), acute kidney failure, metastatic breast cancer with brain tumor(where the cancer cells spread from the original cancer cell to the brain, and atrial fibrillation (irregular/rapid heartbeat causing poor blood flow). Record review of Resident #9's admission MDS dated [DATE] revealed the resident was coded as having a BIMS score of 5 indicating she was severely impaired for cognition, For ADL's the resident was code as dependent of staff for eating, oral hygiene, toileting, shower, upper body dressing, putting/on taking off footwear, and personal hygiene. For Special Care she was coded as being on hospice care. For incontinence she was coded as always incontinent of bowel and bladder. Record review of Resident #9's admission nurses notes dated 6/26/2025 revealed the resident was admitted on respite care with hospice. Her primary diagnosis was metastatic breast cancer with brain tumor. Record review of physician order dated 6/26/2025 revealed order for 02 via nasal canula at 2LPM. Record review of the Resident #9's care plan initiated 7/1/2025 revealed the care plan did not address hospice care

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and permit only authorized personnel for three of five medication carts observed in common areas accessible to staff and residents. -Three unlocked and unattended medication carts were observed in areas accessible to residents, staff, and visitors. This failure could place residents at risk of ingesting medications not prescribed to them and placed the facility at risk for drug diversion. Findings included:Observation on 07/22/25 at 10:55 a.m. revealed an unlocked/unattended medication cart in front of room [ROOM NUMBER]. The cart was facing the door, which was closed. There was no staff visible from the cart. At 10:56 a.m. revealed MA A opened the door of room [ROOM NUMBER] and exited the room. MA A said the medication cart should have been locked. She said she thought she had locked it. MA A open the top drawer of the medication cart without using keys. Observation revealed the top drawer of the cart contained multiple plastic containers of various over the counter medications. Observation and interview on 07/22/25 at 11:33 a.m. revealed an unlocked/unattended medication cart in front of room [ROOM NUMBER]. The medication cart was facing the door, which was closed. There was no staff visible in the area. At 11:38 a.m. revealed the DON was walking in the hallway approaching the cart. At that time LVN G exited room [ROOM NUMBER]. She said she did not have a key to the medication cart, and that the keypad lock was inoperable. She said a MA had the key. She said this was the second room she went to where she had to leave the cart unlocked. The DON was present, and told LVN G that she could not leave the medication cart unlocked and unattended.Observation and interview on 07/23/25 at 11:20 a.m. revealed an unlocked and unattended medication cart in front of room [ROOM NUMBER]. The medication cart was facing the door, which was closed. At 11:21 a.m. LVN H walked up to the medication cart. She stated it was unlocked. She said I stopped what I was doing because another resident needed me. In an interview on 07/24/25 at 12:12 p.m. the DON said the medication carts should have been secured. He said a resident could get into the medications and ingest medications that were not meant for them. The facility policy Security of Medication Cart (revised April 2007) read, in part, The medication cart shall be secured during medication passes.Policy Interpretation and Implementation1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry.1.4.Medication carts must be securely locked at all times when out of the nurse's view.

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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 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 observation, interview and record review, the facility failed to ensure that foods are store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen in that:1.Foods were not sealed, labeled, and dated.2.Plates with dried food particles were stored with clean plates.3. Food items on the steam table was not maintained at 135 degrees F and above.4. Equipment were clean.5. Dry storage room free of dented cans. These failures could place residents who ate food prepared by the kitchen at risk for food borne disease and illness. Findings included: Observation of the kitchen on 07/22/2025 at 9:10 AM revealed the following:1.The coffee machine had an accumulation of brown stains on the coffee machine. At the time the DM immediately started to clean the coffee machine.2. Plates and bowls with stains and food particles in them were stock with clean plates and bowls. Observation on 7/22/2025 at 9:30 am revealed the deep fat fryer had very dark oil and burnt food particles in it. Observation on 7/22/2025 at 9:35 am of the dry storage room revealed the following:1. 1- 6lbs. dented can of beans.2. 1 single serving plastic container of cheerios was open not sealed. Observation on 7/22/2025 at 9:40 am of the walk-in-freezer revealed the following:1. 1 plastic bag with chicken tenders that was open not sealed.2. 1 plastic bag with mixed vegetables open not sealed3. 1 box with French toast open not sealed. 4. Instant vanilla pudding and chocolate pudding mix not dated. Observation on 7/23/2025 at 12:15pm of the steam table revealed two menu items not at the correct holding temperature:1. Baked fish at 76 degrees 2. Cream pie was at 42 degrees.The fish was reheated to 160 and above and the cream pie was chilled to 41 degrees and below. In an interview on 7/22/2025 at 9:20 AM the Dietary Manager said the coffee machine was clean daily. The Dietary Manager said when cleaning the dishes they should pre rinse ensuring that there was no food in the plates and bowls, and then put in the machine to wash rinse and sanitized. He said after the washing procedure they should check to ensure there were no food particles in the plates and bowls and then they would pack them away. In an interview with the DM on 7/22/2025 at 10:00am he said all food particles should clean from the plates, and they should wash rinse and sanitized allow to air dry and then check to ensure they were clean with no food particles before they were packed away. The DM he said the deep fat fryer was cleaned on Fridays and the coffee machine was cleaned daily. He said he had used the fryer cooked the previous day to cook and that was why the oil was black. Interview with the DM on 7/22/2025 at 10:45 am he said he was going to in-service the staff ensuring that when foods were open, they should be sealed, labeled and dated. In an interview on 7/23/2024 at 12:45 PM Dietary Staff A said food not served at the correct food temperature could get resident sick. He said he was going to ensure that food was always at the correct temperature during meal service. Record review of the policy on Food Temperatures dated May 2008 read in part.Policy:The Dietary Services Manager shall check food temperature routinely. Procedures.1. All hot and cold food items must be served to the resident at a palatable temperature. All hot food must be held at a minimum of 145 degrees Fahrenheit.2. All cold foods must hold at 40 degrees F or below.6. Temperatures should be taken periodically to ensure hot foods stay above 145 degrees F and cold foods stay below 40 degrees F during the tray line period. Record review of the policy on Food Storage dated read in part. Policy: 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. Refrigeration:a. Temperatures for refrigerators should be between 40 degrees Fahrenheit or lower. Thermometers should be checked at least twice daily. (See Freezer and Refrigerator Temperature Form).b. Every refrigerator must be equipped with an internal thermometer. e. All foods should be covered, labeled and dated.f. All foods should be stored to allow air circulation.g. Refrigerated foods should be stored upon delivery and careful rotation procedures should be followed