Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIE Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 N Logan St Texas City, TX 77590	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG		UMMARY STATEMENT OF DEFICIENCIES Each deficiency must be preceded by full regulatory or LSC identifying information)	
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	and neglect by anybody.  **NOTE- TERMS IN BRACKETS H  Based on observation, interviews, from abuse and neglect for 1 (CR #  1. The facility failed to ensure CR # combative behaviors, was free fror into his bed by CNA A and CNA E burst blood vessels in both eyes.  2. The facility failed to ensure staff prevention and providing care to re  3. CNA A and CNA E failed to followhen CR #1 exhibited combative/a  These failures resulted in two Imm 10/08/22 at 12:31 p.m. While the Is the severity level of actual harm will effectiveness of the corrective systems.	ediate Jeopardy (IJ) situations identified Js were removed on 10/17/2022, the fact that a scope identified as isolated due to sems.	ensure each resident was free and neglect.  ad a history of dementia and ed, kicked, punched, and thrown ve, bruising around both eyes and ed and competent in abuse/neglect behaviors.  urse for guidance and assistance d on 10/06/2022 at 4:00 p.m. and cility remained out of compliance at the facility's need to evaluate the

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  675214  (X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP	(X3) DATE SURVEY COMPLETED 10/18/2022 CODE
4700 111	CODE
4700 111	CODE
1 Decidence 11 - 10 and Decidence 20 - 20 - 20 - 20 - 20 - 20 - 20 - 20	
Solidago Health and Rehabilitation 1720 N Logan St Texas City, TX 77590	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey ag	ency.
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information	n)
Record review of CR#1's face sheet revealed he was an [AGE] year-old ma facility on [DATE]. He was diagnosed with Alzheimer's Disease (a progressi and other important mental functions), anxiety disorder (intense, excessive, about everyday situations), protein-calorie malnutrition (inadequate instake of shortening and hardening of muscles, tendons, or other tissue, often lead insomnia (persistent problems falling asleep), polysebacentrinitis (damage of shortening and hardening of muscles, tendons, or other tissue, often lead insomnia (persistent problems falling asleep), polysebacentrinitis (damage of shortening and hardening of muscles, tendons, or other tissue, often lead insomnia (persistent problems falling asleep), polysebacentrinitis (damage of shortening and hardening of persistently) depressed mood or loss of indementia (a chronic disorder marked by memory disorders, personality chapsychotic disturbance (disorder in which one loses contact with reality and edusions), muscle wasting and atrophy, and right leg above knee amputatic Record review of CR #1's MDS dated [DATE] revealed he was usually under and wants and he was usually able to understand others; he had a BIMS so impairment); he did not have hallucinations or delusions; he rejected care an extensive physical assistance from at least two staff for transfers; he was to staff for personal hygiene and bathing; he was wheelchair bound; he was all bladder; and he was prescribed antidepressant medication.  Record review of CR #1's care plan, updated on 09/26/2022 revealed the for "Alzheimer's Disease (Goal: Resident will have positive experiences in the of demanding tasks and without becoming overly stressed; Approach: Allow arrespond; Maintain a calin environment and approach to the resident; Use not techniques to encourage resident for respond;)  *he had a history of refusing care at times due to confusion, agitation, and dooperate with care; Approach: Allow resident to make decisions about trea of control; Educate resident and responsible party of po	le who was admitted to the ve disease that destroys memory and persistent worry and fear f food), contracture (a condition ling to deformity) of left lower leg, cartilage, resulting in joint pain neterest in activities), pain, nges, and impaired reasoning), experience hallucinations, and on.  Perstood when expressing ideas core of 3 (severe cognitive nd wandered; he required otion, and dressing; he required tally dependent on at least one ways incontinent of bowel and allowing care areas:  Idaily routine without having overly dequate time for resident to on-verbal communication  Idementia (Goal: Resident will the tregime to provide a sense not complying with treatment of le during care activities; Give a refuses care, reassure resident,

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			NO. 0936-0391
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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
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F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	(Goal: Resident will have a reduction evidenced by documentation in the and document on behavior monitor [reducing disruptive stimuli], Redirecaregivers; Ensure his physical necommunication is understood [prior directions for tasks, Maintain a caln to communicate their needs]; Give aggressive, remove from other resist to stop current behavior and if need to calm sufficiently to allow care sa reason, assure them of their safety [talking about family, favorite music resident status or of new escalated the was at risk for falls due to impain medications. The resident has a cast the floor when he wants to get up (Ensure fall mats are at bedside. Cobed and fall mats in place; Anticipa frequently, if resident hollering out or reach and use call light; Monitor for shorts or pants on at all times);  *he has impaired communication at to understand others, impaired dail and meet all needs that resident is digest information - do not rush; Apneeded; Praise resident for communication are the has dementia as evidenced by daily decisions at times (Goal: Resitasks and responses; Explain all prais to maintain or increase level of ineeded).  Record review of CR #1's medical embass on 10/02/2022 at 6:02 p.m. C spine, head/brain, and maxillofacia were found, but there were no acut hip/pelvis, and chest. No fractures of the communication in the properties of t	y aggressive, verbally aggressive, and on in unwanted mood or behaviors, for medical record; Approach: Attempt no ing flow record, such as music therapy action/Reassurance, Increased observateds are met [toileting, pain, hunger, thire to beginning task inform resident of in slow approach, do not argue with the medications as ordered; If resident bedents to a safe, less stimulating envirous ded, tell him you will return to complete fely for all, Notify nursing; If resident is and notify nursing; Resident specific indications, and in the lobby area, family behaviors; Rule out environmental causified cognition, impaired mobility, inconfigured in his room where is responsible Goal: Resident will not experience majoratione all interventions, Patient is not attended to be a serviced by reduced ability to be united an intervention of the all needs; Encourage resident to asterior put to be dor get up; Encourage incontinence per routine rounds and a service of the providence of the provided because	an increased quality of life as n-pharmacological interventions, exercise, outdoor time, quiet time tition, Validation, and Consistent st, hot, cold]; Ensure tent, offer verbal one step resident, allow extra time for them comes physically agitated or nment, Set firm limits by telling him care/task when he has had a time hallucinating, do not argue or try to interventions include: Redirect by visit]; Notify family of changes in uses);  tinence and use of psychotropic party has witnessed him crawl on or injuries due to falls. Approach: alling but scooting out of bed. Low a staff for assistance. Staff to check isocialization; Ensure call light is in its needed. Ensure resident has inderstood by other, reduced ability spanish (Goal: Staff will anticipate pproach: Allow time for resident to be; Attempt to find an interpreter as interfering environmental stimuli; and other and impaired ability to make a antained. Approach: Allow time for it can understand; Involve in care deded; Repeat information as of a local acute care hospital via 10/02/2022. CT scans of his cervical inpleted. Degenerative changes are taken of CR #1's right knee, right injuries were not described in the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
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F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	was found on floor by CNA. I was to let me know that CR #1 was four ground and placed in his bed. I too Resident was conscious upon arriv vitals I assisted CNA J in changing and was also trying to kick the CNA to the nurse's station. I notified emersident was sent to ER.  Record review of CR #1's SBAR C read in part . Situation, The change head injury, This started on 10/02/2 Resident/Patient Evaluation . 3. Be 9. Pain Evaluation . Does this resideyes . Does the resident show non pain . Review and Notify: Primary CM. Recommendations of Primary CM. Recommendations of Primary CM. Recommendations of Primary CM. Review and interview on 10/06 had a laceration to the corner of his eyelids and underneath both eyelid covered with a dressing (CR #1 pu was some light purple bruising to h with CR #1 via Spanish-speaking F #1 stated his injuries were caused lived at home with his mother befor CR #1 said nobody ever mistreated.  In a telephone interview on 10/06/2 yelling, Help me! in his sleep since observation). The RP said CR #1 to the incident on 10/02/2022, CR #1 history of getting himself out of bed and sometimes, his wheelchair was frustrated because they would put family put the camera in his room to #1's former roommate (who was not the property of the camera in his room to #1's former roommate (who was not the property of the camera in his room to #1's former roommate (who was not the property of the camera in his room to #1's former roommate (who was not the property of the camera in his room to #1's former roommate (who was not the property of the camera in his room to #1's former roommate (who was not the property of getting himself out of bed and sometimes, his wheelchair was frustrated because they would put family put the camera in his room to #1's former roommate (who was not the property of getting himself out of bed and sometimes, his wheelchair was frustrated because they would put family put the camera in his room to #1's former roommate (who was not the property of getting himself out of bed and someti	2022 at 9:40 a.m., CR #1's RP said he he was admitted to the hospital (he coold his other family members some girl was in a low bed, and he got himself of and scooting around on the floor. He is placed too far away from his bed. He CR #1 in the bed, and he would get ou hree years ago when he (CR #1) was cool longer at the facility) told him the facil eatment to the Administrator and DON	lications when CNA A came to me ad already been lifted off the 7, O2: 95, Temp: 97.3, A&O x2. towards the CNAs. After taking his kicked CNA A in the abdomen area I him in his wheelchair and took him physician. 911 was called and written by LVN K. The document erved and evaluated is/are: Fall with dent observed on floor by staff. on . 8. Skin Evaluation: Laceration . Mion/location of pain: head/bilateral dementia)? Yes, Complains of an, Date: 10/02/2022, Time: 5:25 p. d treatment .  Cal acute care hospital, revealed he county purple bruising to his bilateral earts of eyes). CR #1's left wrist was ected by the dressing) and there are the knee amputation. Interview eared. Through the interpreter, CR every upset with him. CR #1 said he did not recall living at the facility).  Dobserved CR #1 kicking and uld not give the date of this shit him. He said in the video from ut of the bed. He said CR #1 had a said CR #1 wanted to be in pants said the facility's staff would get to over and over. He said CR #1's on a different hallway. He said CR ity's staff were mistreating CR #1.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	time stamped. The video did not hat he identified CR #1 as the resident revealed a male (the faces of the in leg, slowly lowered himself off the sin contact with any structure while he the room. CNA E (CNA E identified in a telephone interview on 10/05/2 talking to CR #1 and she pointed to pants out of a closet and threw their the room and closed the door, CR#CNA E returned to the room with Cnear CR #1, moved back the sheet approached CR #1. CNA E attempi #1's left leg and right arm but let his stump with one hand and his right a wheelchair and pulled it towards hir and forcefully threw CR #1's left leg left side buttocks area. CNA E was several feet towards the bed. CNA side of his shirt while CNA E grabb bed, then both staff flipped his botto standing in front of CR #1's head arms and his left leg and right stum CR #1's left foot (He only had a foo was against the wall) could be seen.  In an interview with LVN K on 10/05/10/02/2022. She said CR #1 had do wandering, refusing care, crawling Spanish speaking, but he could spet 10/02/2022 when she passed morn.	ave audio. CR #1's RP stated the video in the video) revealed it was recorded in the video) revealed it was recorded in the video were not complesside of a bed which was in a low position was alone in the video. The male so the herself as the CNA who had on a pink 2022 at 3:47 p.m.) entered the room an owards the bed twice during the convert on on the arm of a wheelchair which was alone the blue pants and put then NA A. CNA E walked inside the room, and blanket on the bed, and handed the determinant of the determinant of the determinant of the properties of the pr	in CR #1's room. The video itely clear) with an amputated right on. The resident's face did not composed himself towards the door of a shirt and the other CNA as CNA in a closed the door. CNA E was see sation. CNA E took a pair of blue as near CR #1. When CNA E left no while he was still on the floor. The footh of the did closed the door in the floor. The condition of the condi

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the family member arrived.

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started to assist with getting CR #1's paperwork ready to transfer him to the hospital. She said at that time, she did not know anything other than CR #1 had a fall. She said she called the Administrator to inform her of the fall. She said LVN V was fluent in Spanish and when CR #1 was on the stretcher to leave with EMS, he told LVN V one of the aides hit him. She said she stopped and called the Administrator to notify her. She said CR #1's fall was not a surprise because he frequently crawled out of bed, but the head injury was a surprise (because he had never hit his head before). She said when she saw CR #1 at the nurse's station before he left with EMS, he had a laceration at the corner of one of his eyes the other eye was red. LVN K said CR #1 pointed at one of the aides (CNA A or CNA E) and told LVN V she was the one who hit him. She said CR #1's family member arrived at the facility on 10/02/2022 at 6:45p.m. and showed her the video of CR #1's assault before she posted it on social media. She said CNA A and CNA E were both out of the facility when

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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 0600  Level of Harm - Immediate jeopardy to resident health or	In a telephone interview with LVN V on 10/05/2022 at 4:00 p.m., she stated she worked PRN on weekends but 10/02/2022 was not the first day she worked with CR #1. She said CR #1 had dementia and tended to go in and out with memory. She said CR #1 could be combative when he was upset, but she never had issues with him trying to hit or kick her. She said redirecting CR #1 with coffee helped to calm him down. She stated		

Residents Affected - Few

safety

she spoke Spanish. She said CR #1 had one leg, but he could self-propel in his wheelchair. She said staff put CR #1 in bed and he tried to get himself out. She said whenever there was a fall, CNAs were supposed to call a nurse to assess each resident for injuries. She said if the resident hit their head, neuro checks would be initiated. She said on 10/02/2022, she was down 400 hall passing medication when CNA A came and said CR #1 fell out of bed. She said she was confused because she thought CR #1 was already out of bed and in the dining room. She said earlier on 10/02/2022, she was doing medication rounds and CNA E came and said CR #1 was trying to get out of his bed. She said typically, staff put CR #1 in his wheelchair and take him to the nurse's station if he was trying to get up out of bed. She said she asked CNA E to put CR #1's pants on and put him in his wheelchair and take him to the dining room. She said she grabbed the medication cart and went down to CR #1's hall. She said she thought it was strange when she walked into CR #1's room and saw the privacy curtain was closed. She said she pulled open the curtain and saw CR #1 on the bed. She said CR #1's face shocked her. She said CR #1's injuries did not look they were caused by a fall. She said the area under CR #1's left eye was already puffy, liked he got socked (hit) in the face. She said the area above CR #1's eye was swollen and red. She said the blood vessels in both of CR #1's eyes had burst. She said CR #1 had a laceration in the corner of one eye. She said it looked like CR #1's whole eye burst. She said CR #1 kept cursing and yelling at CNA A and CNA E like he did not want them by him. CR #1 was angry. She said she told the CNAs CR #1's injuries were not consistent with a fall. She said one of the CNAs (she could not recall which one) said the laceration was from when CR #1 hit himself on the side rail. She said CR #1 was already in bed, so there was no way for her to tell how he fell or where. She said CNA J was in CR #1's room with her, so she (CNA J) assisted with incontinent care, and they changed his clothes. She said they put CR #1 in his wheelchair and took him to the nurse's station to get ready for transport. She said when LVN K saw CR #1 at the nurse's station, she said, Oh God! She said she told LVN K this (CR #1's injuries) did not look like a fall. LVN V said once EMS arrived, CR #1 was looking at CNA A while he cursed and said that was the fucking black bitch that hit him. She said she told LVN K, CR #1 said he was hit. She said CNA E went down the hall, but CNA A stayed close to the nurse's station watching the nurses and EMS prepare CR #1 for transport. She said when CR #1 saw CNA E walk down the hall, he said that's the fucking black lady that hit him. LVN V said she asked CR #1 who hit him, but he would not initially repeat what he said. She said CR #1 again said that is the other black bitch that hit him. She said after CR #1 left for the hospital, she called his responsible party and told him CR #1 fell but she did not know how he landed on the floor. She said she explained CR #1's injuries and told the responsible party they sent the resident to ER. She said the responsible party was very short and quickly said goodbye. She said within maybe 20-30 minutes, another one of CR #1's family members called and said they reviewed the video from the camera inside CR #1's room. She said the family member said both of the women (CNA A and CNA E) were fighting CR #1. LVN V said as soon as they got the information from CR #1's family member, LVN K walked towards the CNAs (CNA A and CNA E) and she saw one of them clock out. She said both CNAs were out of the building, but CNA A had to wait outside waiting for her ride. She said CNA A asked her who was going around saying CR #1 was assaulted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	members posted a video of CR #1 said on Sunday, 10/02/2022, she waid LVN K initially told her CR #1 head as a result of the fall. She said to HHSC, she received a text mess her the video of CR #1's assault by the conference room to question the asked the CNA's about abuse and a the CNA's said nothing happened. immediately and she notified the proboth CNAs and asked about the abboth CNAs were terminated by phoreacted and said she wanted to preasked CNA A if she used proper praid proper protocol would have be resident when he got aggressive. The Administrator said an electronic placed in his room by his family for The Administrator said CR #1 had was in the lowest position at the tin aggressive/combative behaviors. Step weeks. She said CNA A and C	for on 10/05/2022 at 10:30 a.m., she stored being assaulted by CNA A and CNA Evas called by LVN K, who was the wee fell out of bed and was being sent out to diver the week of the was in the process of reposition of the was in the process of reposition of the was on the was o	to social media. The Administrator kend supervisor at that time. She to a local hospital because he hit his rting the unwitnessed fall with injury CR #1's RP. She said the RP sent LVN K bring CNA A and CNA E to speaker phone. She said when she ning the specific resident's name, NAs to leave the building norning, 10/03/2022, she called aid nothing happened. She said as calm and said okay, but CNA A her. The Administrator said she and she said no. The Administrator tance or walk away from the did not kick CR #1, but she tripped. Its door and the camera had been he camera was in CR #1's room). But of bed. She said CR #1's bed said CR #1 also had a history of ame halls, but they rotated every a while (she could not say how

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F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	fought staff every day. She said whout when she came back, he was a she heard CR #1 screaming and ye floor around 5:00 p.m. She said sho off the floor, he had a laceration on the bed, but she did not know becalaceration until they put CR #1 in the laceration did not appear until they floor, he fought them like normal. Sourse. She said the nurse assesse hospital. She said normal procedur floor, but because he did that (place put him in bed. She said CR #1 onleto him. She said normally, she wound to all for that this time. She said is She said in reference to the video of said she never had to drag CR #1 she did not usually work on CR #1' received abuse/neglect training, but and other aggressive residents like.  In a telephone interview with CNA her certification as a result of the in injuries were caused by CNA A hitt off the floor.  Unsuccessful attempts were made 11:00 a.m., and 10/19/2022 at 3:42. Unsuccessful attempts were made 11:37, 10/10/2022 at 3:15 p.m., and In an interview with the Administrat training records and stated the recontrainings on dementia/aggressive be Management and, Caring for the Proceedings of the said she page said stated the recontrainings on dementia/aggressive be Management and, Caring for the Proceedings and stated the recontraining for the Proceedings and stated the recontrainings on dementia/aggressive be Management and, Caring for the Proceedings and stated the recontraining for the Proceedings and stated the recontraining son dementia/aggressive be Management and, Caring for the Proceedings and stated the recontraining son dementia/aggressive be Management and, Caring for the Proceedings and stated the recontraining son dementia/aggressive be Management and, Caring for the Proceedings and stated the recontraining son dementia/aggressive be Management and, Caring for the Proceedings and stated the recontraining son dementia/aggressive be Management and, Caring for the Proceedings and stated the recontraining son dementia/aggressive be succeeding and stated the recontraining son	E on 10/06/2022 at 11:06 a.m., she standard with CR #1 on 10/02/2022. She ing him. CNA E said she only held CR to contact CNA E by phone for addition p.m. Voicemail messages and texts what to contact CNA A by phone on 10/04/2 d 10/19/2022 at 3:45 p.m. Voicemail meters or on 10/06/2022 at 12:13 p.m., she product indicated neither of the CNAs complete indicated neither	left him alone for a period of time, day of the incident (10/02/2022), to CR #1's room and saw him on the said when they picked CR #1 up bly happened when he fell out of sell. She said she did not see the his eye when he fell but the y proceeded to get CR #1 off the ack in his bed, they went to get a sheelchair to send him out to the re they picked CR #1 up off the ey just usually picked him up and sessed him (LVN V) spoke Spanish before she put them in bed, but did happened all the time with CR #1. as the woman in the pink shirt. She lways wanted to fight. CNA E said often. She said she had recently ficiently trained to care for CR #1 and his #1's arm when she tried to get him the line with the said she did not hit CR#1 and his #1's arm when she tried to get him the line with the said she did not hit CR#1 and his #1's arm when she tried to get him the line with the line with the said she did not hit CR#1 and his #1's arm when she tried to get him the line with the li

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	STATEMENT OF DEFICIENCIES acy must be preceded by full regulatory or LSC identifying information)	
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Alzheimer's Disease and Related Decompleted (the Administrator said to Caring for the Person with Demention Administrator said the training was about Caregiver Conduct, and Prevention of Caring for Alzheimer's Disease/of Record review of CNA E's employed 10/03/2022. All background checks Record review of CNA E's training Caring for a Guest with Dementia - Alzheimer's Disease and Related Decompleted (the Administrator said to Caring for the Person with Dementia Administrator said the training was About Caregiver Conduct, and Prevention of CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for the Person with the Ad A and CNA E failed to complete (Al Management and, Caring for t	Disorders, Behavior and ADL Management training was not completed because the training was not completed because the training was not completed because there was not completed because there was not completed because there was not giventing, Recognizing, and Reporting Alled no other trainings/in-services related the training was hired on 01 as were completed upon hire.  The records revealed:  Completed 01/19/2018.  Disorders, Behavior and ADL Management training was not completed because the training was not completed because there was not completed because there was not completed because there was not completed no other trainings/in-services related the training was not completed because there was not completed to other trainings/in-services related the training was not completed because there was not completed to other trainings/in-services related the training was not completed because there was not completed to other trainings/in-services related the training was not completed to other trainings that were not different with dementia were mention to other trainings that were not different with dementia) were mention to other trainings that were not different with dementia were mention to other trainings that were not different with dementia were mention to other trainings that were not different with dementia were mention to other trainings that were not different with dementia were mention to other trainings that were not different with dementia were mention to other trainings that were not different with dementia were mention to other trainings that were not different with dementia were mention to other trainings that were not different with dementia were not different with dementia were not different were not different were not different were not different with dementia were not different were not dif	nent - dated 04/14/2022: Not ethere was no grade).  ed 04/14/2022: Not completed (the grade).  buse - Completed on 09/16/22.  ed to residents with aggressive  //19/2018 and was terminated on  nent - dated 06/21/2022: Not ethere was no grade).  ed 06/21/2022: Not completed (the grade).  buse - Completed on 09/16/22.  ed to residents with aggressive , she stated the two trainings CNA lers, Behavior and ADL ommunication) were not mandatory mandatory. She said those uned in other mandatory trainings CNA A's and CNA E's  d not received any training at the h Alzheimer's Disease and  and not been trained regarding ase or dementia.  d not received any training from the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIE Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 1720 N Logan St Texas City, TX 77590	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	the facility regarding providing care and dementia.  In an interview with CNA B on 10/1 residents with Alzheimer's Disease previously. She said she had not responsible for ensuring staff were electronic training system every two the report was distributed to each of the interview with the Administrate head were responsible for ensuring review a report from their electronic by each staff. She said the reports complete training. The Administrate Administrator said she did not know training records.  Record review of the facility's docured not give up any rights when you exercise your rights. Any violation of facility employee to threaten, coerci	0/2022 at 2:12 p.m., she stated she had to residents with aggressive behaviors of the cereived those trainings at her current factor on 10/11/2022 at 12:21 p.m., she said current with all training/in-services. She weeks which listed each employee's department head to ensure their staff where training system which indicated which were distributed to each department head to reach department head to ensure their staff where distributed to each department head which were distributed to each department had she also frequently spoke to start why CNA A and CNA E had not complement Statement of Resident Rights under the analysis of these rights is against the law. It is a e, intimidate or retaliate against you for glects your care, takes your property, or ave the righ [TRUNCATED]	ceived training on how to care for at a different facility she worked at icility.  If she and the Administrator were a said they ran a report from their training to be completed. She said ere trained.  In the HR Director run and a trainings needed to be completed and to make sure their staff ff about their training needs. The oleted trainings listed on their dated revealed, You, the resident st encourage and assist you to fully gainst the law for any nursing rexercising your rights. If anyone

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED	
	675214	B. Wing	10/18/2022	
NAME OF PROVIDER OR SUPPLIE	I ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Solidago Health and Rehabilitation		1720 N Logan St Texas City, TX 77590		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0684	Provide appropriate treatment and	care according to orders, resident's pre	eferences and goals.	
Level of Harm - Actual harm	**NOTE- TERMS IN BRACKETS F	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 44241	
Residents Affected - Few	treatment and care in accordance	nd record review, the facility failed to en with professional standards of practice, e residents' choices for 1 of 12 residents	the comprehensive	
	The facility failed to ensure CNA A and CNA E followed facility protocol and called for a nurse to assist and assess CR #1 before attempting to pick him up off the floor after an assumed fall.			
	CNA A and CNA E failed to seek assistance from a nurse when CR #1 became combative/aggressive and resulted in CR #1 sustaining facial injuries.			
	These failures placed residents at risk of injury and pain.			
	Findings include:			
	facility on [DATE]. He was diagnos and other important mental function about everyday situations), , contra other tissue, often leading to deform polyosteoarthritis (repetitive use of with at least five joints), major depressonality changes, and impaired	face sheet revealed he was an [AGE] year-old male who was admitted to the soliagnosed with Alzheimer's Disease (a progressive disease that destroys memory all functions), anxiety disorder (intense, excessive, and persistent worry and fear a), contracture (a condition of shortening and hardening of muscles, tendons, or a to deformity) of left lower leg, insomnia (persistent problems falling asleep), we use of joints causes damage to cartilage, resulting in joint pain and swelling agior depression (a mental health disorder characterized by persistently depressed a activities), pain, dementia (a chronic disorder marked by memory disorders, impaired reasoning), psychotic disturbance (disorder in which one loses contact to hallucinations, and delusions), muscle wasting and atrophy, and right leg above		
	Record review of CR #1's MDS dated [DATE] revealed he was usually understood when expressing ideas and wants and he was usually able to understand other; he had a BIMS score of 3 (severe cognitive impairment); he did not have hallucinations or delusions; he rejected care and wandered; he required extensive physical assistance from at least one staff for bed mobility, locomotion, and dressing; he required extensive physical assistance from at least two staff for transfers; he was totally dependent on at least one staff for personal hygiene and bathing; he was wheelchair bound; he was always incontinent of bowel and bladder; and he was prescribed antidepressant medication.			
	Record review of CR #1's care plan, updated on 09/26/2022 revealed the following care areas:			
	demanding tasks and without beco	ent will have positive experiences in the ming overly stressed; Approach: Allow ent and approach to the resident; Use o respond);	adequate time for resident to	
	(continued on next page)			

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NAME OF PROVIDER OR SUPPLIER Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 1720 N Logan St Texas City, TX 77590	P CODE
For information on the nursing home's pla	an to correct this deficiency, please conf	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	EIENCIES full regulatory or LSC identifying information	on)
F 0684 Level of Harm - Actual harm Residents Affected - Few	cooperate with care; Approach: Allo of control; Educate resident and rescare; Encourage as much participal clear explanation of all care activitie leave and return 5-10 minutes later Praise resident when behavior is ap *he had a history of being physicall! (Goal: Resident will have a reductive evidenced by documentation in the and document on behavior monitor [reducing disruptive stimuli], Redire caregivers; Ensure his physical necommunication is understood [prior directions for tasks, Maintain a caln to communicate their needs]; Give aggressive, remove from other resito stop current behavior and if need to calm sufficiently to allow care saft reason, assure them of their safety [talking about family, favorite music resident status or of new escalated *he was at risk for falls due to impa medications. The resident has a cathe floor when he wants to get up (Ensure fall mats are at bedside. Cobed and fall mats in place; Anticipal frequently, if resident hollering out creach and use call light; Monitor for shorts or pants on at all times);  *he has impaired communication as to understand others, impaired daily and meet all needs that resident is digest information - do not rush; Apneeded; Praise resident for commu Use terms, gestures that resident of the has dementia as evidenced by daily decisions at times (Goal: Resitasks and responses; Explain all processors.)	It times due to confusion, agitation, and ow resident to make decisions about the sponsible party of possible outcomes of tion/interaction by the resident as possible party of and as they occur; If resident and try again; Involve responsible participation; and they again; Involve responsible participation; and they again; Involve responsible participation; and in unwanted mood or behaviors, for medical record; Approach: Attempt no ing flow record, such as music therapy ction/Reassurance, Increased observateds are met [toileting, pain, hunger, thire to beginning task inform resident of information as ordered; If resident of information approach, do not argue with the medications as ordered; If resident bedients to a safe, less stimulating environted, tell him you will return to complete felly for all, Notify nursing; If resident is and notify nursing; Resident specific information, and interventions, Resident specific information in the lobby area, family behaviors; Rule out environmental causified cognition, impaired mobility, incommera in his room where is responsible Goal: Resident will not experience magnitude all interventions, Patient is not fit all needs; Encourage resident to asker all needs; Enc	eatment regime to provide a sense of not complying with treatment of ible during care activities; Give a trefuses care, reassure resident, by when resident refuses care;  refusing care related to dementia an increased quality of life as n-pharmacological interventions, exercise, outdoor time, quiet time tion, Validation, and Consistent st, hot, cold]; Ensure tent, offer verbal one step resident, allow extra time for them comes physically agitated or nament, Set firm limits by telling him care/task when he has had a time hallucinating, do not argue or try to interventions include: Redirect by visit]; Notify family of changes in uses);  tinence and use of psychotropic party has witnessed him crawl on or injuries due to falls. Approach: alling but scooting out of bed. Low a staff for assistance. Staff to check socialization; Ensure call light is in a needed. Ensure resident has  derstood by other, reduced ability panish (Goal: Staff will anticipate oppoach: Allow time for resident to be; Attempt to find an interpreter as interfering environmental stimuli; and  lems and impaired ability to make aintained. Approach: Allow time for it can understand; Involve in care

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. Building	(X3) DATE SURVEY COMPLETED
	675214	B. Wing	10/18/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Solidago Health and Rehabilitation 1720 N Logan St Texas City, TX 77590			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0684 Level of Harm - Actual harm Residents Affected - Few			
	threw CR #1 into the bed, his left side was against the wall) could be seen moving around on the floor underneath the privacy curtain.  (continued on next page)		

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		B. Wing	10/18/2022
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(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0684 Level of Harm - Actual harm Residents Affected - Few	was found on floor by CNA. I was do to let me know that CR #1 was four ground and placed in his bed. I tool Resident was conscious upon arrive vitals I assisted CNA J in changing and was also trying to kick the CNA to the nurse's station. I notified emeresident was sent to ER.  Record review of, SBAR Communic document read in part . Situation, T is/are: Fall with head injury, This stafloor by staff . Resident/Patient Eva Evaluation: Laceration . 9. Pain Eva Description/location of pain: head/b residents with dementia)? Yes, Cor #1's Physician, Date: 10/02/2022, T evaluation and treatment .  Record review of CNA A's employe 10/03/2022. All background checks	e record revealed she was hired on 01	ications when CNA A came to me ad already been lifted off the , O2: 95, Temp: 97.3, A&O x2. towards the CNAs. After taking his icked CNA A in the abdomen area him in his wheelchair and took him obysician. 911 was called and di ti was completed by LVN K. The signs observed and evaluated formation: Resident observed on sical Aggression . 8. Skin Yes, New Pain, non-verbal signs of pain (for mary Care Clinician Notified: CR trimary Clinicians: send to ER for //30/2020 and was terminated on

			10. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIER Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, Z 1720 N Logan St Texas City, TX 77590	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	Lact 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)		ion)
F 0684 Level of Harm - Actual harm Residents Affected - Few	members posted a video of CR #1 said on Sunday, 10/02/2022, she waid LVN K initially told her CR #1 head as a result of the fall. She said to HHSC, she received a text mess her the video of CR #1's assault by the conference room to question the asked the CNA's about abuse and a the CNA's said nothing happened. immediately and she notified the proboth CNAs and asked about the abboth CNAs were terminated by phoreacted and said she wanted to preasted CNA A if she used proper praid proper protocol would have be resident when he got aggressive. The Administrator said an electroni placed in his room by his family for The Administrator said CR #1 had was in the lowest position at the tin aggressive/combative behaviors. Stewoweeks. She said CNA A and C	for on 10/05/2022 at 10:30 a.m., she sibeing assaulted by CNA A and CNA Evas called by LVN K, who was the wee fell out of bed and was being sent out if dwhen she was in the process of reposage (on 10/02/2022 at 6:03 p.m.) from text. The Administrator said she had learn about the video while she was on an unusual occurrence, without mention the Administrator said she told both Colice. The Administrator said both CNAs some on 10/03/2022. She said CNA E was charges against CR #1 for kicking for tocol during the incident with CR #1 are for the staff to get a nurse for assist the Administrator said CNA A said she is committed to give a nurse for assist the Administrator said CNA A said she is monitoring sign was posted on CR #1 a while (she could not say how long the a history of falls and scooting himself one of the incident on 10/02/2022. She said the aides usually worked the sNA E stayed (worked) on CR #1's hall or R #1's hall). She said according to the large of the said the aides usually worked the sNA E stayed (worked) on CR #1's hall or R #1's hall). She said according to the large of the said the aides usually worked the sNA E stayed (worked) on CR #1's hall or R #1's hall). She said according to the large of the said the aides usually worked the sNA E stayed (worked) on CR #1's hall or R #1's hall). She said according to the large of the said the aides usually worked the solution of the large of the said the aides usually worked the solution of the large of the said the aides usually worked the solution of the large of the said the aides usually worked the solution of the large of the said the aides usually worked the solution of the large of the said the aides usually worked the solution of the large of the said the aides usually worked the solution of the said the aides usually worked the solution of the said the aides usually worked the solution of the said the aides usually worked the solution of the said the aides usually worked the said the said the aides usually worked the said the said the said the	to social media. The Administrator kend supervisor at that time. She to a local hospital because he hit his orting the unwitnessed fall with injury a CR #1's RP. She said the RP sent LVN K bring CNA A and CNA E to speaker phone. She said when she ming the specific resident's name, that to leave the building morning, 10/03/2022, she called aid nothing happened. She said as calm and said OK, but CNA A her. The Administrator said she and she said no. The Administrator trance or walk away from the did not kick CR #1, but she tripped. 1's door and the camera had been he camera was in CR #1's room). But of bed. She said CR #1's bed said CR #1 also had a history of tame halls, but they rotated every a while (she could not say how

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0684 Level of Harm - Actual harm Residents Affected - Few	10/02/2022. She said CR #1 had d wandering, refusing care, crawling Spanish speaking, but he could spend 10/02/2022 when she passed morr lunch. She said that evening, LVN started to assist with getting CR #1 she did not know anything other that the fall. She said LVN V was fluent told LVN V one of the aides hit him CR #1's fall was not a surprise become (because he had never hit his head left with EMS, he had a laceration apointed at one of the aides (CNA A #1's family member arrived at the form the said that found a resident on the floor of the resident for injuries. She said if a reare assessed by a nurse. She said entered the room and that was not In a telephone interview with CNA fought staff every day. She said whout when she came back, he was a she heard CR #1 screaming and will floor around 5:00 p.m. She said shoff the floor, he had a laceration on the bed, but she did not know becall aceration did not appear until they floor, he fought them like normal. Sonurse. She said the nurse assesses hospital. She said normal procedur floor, but because he did that (place put him in bed. She said CR #1 on to him. She said normally, she would did not call for that this time. She sid She said she never had to drag CR said she did not usually work on Cl	E on 10/05/2022 at 3:47 p.m., she state nen CR #1 was combative, she usually always still combative. She said on the elling from the hall. She said she went to get CNA A for assistance. She his eye. She said the laceration probatuse she was not in the room when he had been said the said when the put him in the bed. She said when the put him in the bed. She said when the bad CR #1 and told them put him in his ewe would have been to get a nurse befored himself on the floor) all the time, the ly spoke Spanish but the nurse who assuld call for a nurse to assess a resident aid this (CR #1 being aggressive with stee of the incident from 10/02/2022, she will be she had set the still and she did not work with Calining, but she still did not feel she had	It to person, and had a history of She said CR #1 was mostly a said she interacted with CR #1 on id CR #1 went back to bed after out of bed and hit his head, so she he hospital. She said at that time, did the Administrator to inform her of the stretcher to leave with EMS, he Administrator to notify her. She said but the head injury was a surprise at at the nurse's station before he had the head injury was a surprise at at the nurse's station before he had the head injury was a surprise at at the nurse's station before he had the head of CR #1's assault of the out of facility when the family found the resident. She said if a rese to assist and assess for the bould be left on the floor until they was already in bed when she came and left him alone for a period of time, day of the incident (10/02/2022), to CR #1's room and saw him on the said when they picked CR #1 up bly happened when he fell out of fell. She said she did not see the hais eye when he fell but the ay proceeded to get CR #1 off the ack in his bed, they went to get a sheelchair to send him out to the rethey picked CR #1 up off the had the help in the head of the picked him up and sessed him (LVN V) spoke Spanish before she put them in bed, but it staff) happened all the time with CR was the woman in the pink shirt. The always wanted to fight. CNA ER #1 often. She said she had

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NAME OF PROVIDER OR SUPPLIER Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 1720 N Logan St Texas City, TX 77590	P CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	Unsuccessful attempts were made 11:06 a.m., 10/17/2022 at 11:00 a Unsuccessful attempts were made	to contact CNA E by phone for additionm., and 10/19/2022 at 3:42 p.m. Voicel to contact CNA A by phone on 10/04/2 d 10/19/2022 at 3:45 p.m. Voicemail m	nal information on 10/04/2022 at mail messages and texts were left.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
		and she worked PRN on weekends at #1 had dementia and tended to go supset, but she never had issues elped to calm him down. She stated in his wheelchair. She said staff a was a fall, CNAs were supposed thit their head, neuro checks would dication when CNA A came and ght CR #1 was already out of bed edication rounds and LVN E came at CR #1 in his wheelchair and take ne asked CNA E to put CR #1's he said she grabbed the as strange when she walked into dopen the curtain and saw CR #1 adid not look they were caused by got socked (hit) in the face. She at vessels in both of CR #1's eyes said it looked like CR #1's whole like he did not want them by him. consistent with a fall. She said one when CR #1 hit himself on the side ell how he fell or where. She said inent care, and they changed his rise's station to get ready for id, Oh God! She said she told LVN red, CR #1 was looking at CNA A esaid she told LVN K CR #1 said to the nurse's station watching the CNA E walk down the hall, he said on the nurse's station watching the CNA E walk down the hall, he said on the nurse's station watching the CNA E walk down the hall, he said on the nurse's station watching the CNA E walk down the hall, he said on the him, but he would not initially the that hit him. She said after CR 1 fell but she did not know how he responsible party they sent the said goodbye. She said within a said they reviewed the video from the women (CNA A and CNA E) CR #1's family member, LVN K clock out. She said both CNAs	

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For information on the nursing home's plan to correct this deficiency, please co			agency
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulators)		CIENCIES	-
F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of undated facility dive up any rights when you enter a exercise your rights. Any violation of facility employee to threaten, coerchurts you, threatens to hurt you, nether right to file a complaint. You had courtesy, consideration, and respect Record review of Abuse, Neglect, and facility's Leadership prohibits negles chemical restraint not required to the misappropriation of a patient's/resident property, and are reported unreasonable confinement, intimidation, and resident property, and are reported unreasonable confinement, intimidation, and residents pain or mental anguish. Willful, as Neglect is the failure of the facility, resident that are necessary to avoid a Component II: Training. 1. All new education, training and reinforcement materials include: B. Education or care for its residents. D. Dementia Adequate supervision of staff is maderials include: B. Condouring assess special needs that may lead to negother patient/resident requiring excess resident-to-resident altercation.  Record review of Combative Residents procedures in place to protect proximity of a combative resident. Behavior or an escalation of behavilicensed nurse. 2. A licensed profee evaluates the resident and may include but environment. B. Conducting freque continuous observation and intervede-escalation. 4. Notification of chalicensed independent practitioner.	cocument Statement of Resident Rights a nursing facility. The facility must encore of these rights is against the law. It is agree, intimidate or retaliate against you for eglects your care, takes your property, cave the right to: . 3. Be free from abuse oct .  Exploitation, Or Mistreatment, revised 1 oct, mental, physical and/or verbal abuse eat a medical condition, involuntary sedent's property and/or funds and ensurreatment, including injuries of unknown immediately . 1. Abuse. Abuse is the vation, or punishment with resulting physical used in this individual must have intensits employees or service providers to ple diphysical harm, pain, mental anguish, and current employees including voluent that identify all aspects of abuse provint that identify all aspects of abuse provintained in order to identify and prevent planguage; B. Rough handling; and C. sments, care planning, and monitoring lect, for example: A. History of aggress story of self-injury; D. Communication of sive nursing care or staff attention. F. Rent, Care And Safety revised on 03/02/2 the health and safety of residents, staff Procedures: 1. Any person who identification which may lead to physical combating sistency of the service of the excellation testion. B. Relocating individuant checks on the individual. C. Providing and condition and escalation of behalts. Family or responsible party. C. Law as any or appropriate to ensure the safety or appropriate to ensure the safety.	revealed, You, the resident do not burage and assist you to fully gainst the law for any nursing rexercising your rights. If anyone or violates your dignity, you have and exploitation; 4. Be treated with 0/23/2019 revealed, Policy: 1. The e, use of a physical and/or clusion, corporal punishment and es that alleged violations involving a source and misappropriation of willful infliction of injury, sical harm, pain, or mental anguish I condition, cause physical harm, ded to inflict injury or harm . 6. rovide goods and services to a or emotional distress . Procedures: Interes receive continuous oblibition . 2. Education/training onsibilities of a facility to properly ention . III: Prevention . 4. It inappropriate behaviors, such as: Ignoring the patient's/resident's of those patients/residents with sive behavior; B. History of entering disorder; and/or, E. esidents with history of  //2018 revealed, Policy: The Facility is, visitors and other in the care or es a resident with a change in veness, reports observation to a used independent practitioner indiques, if appropriate . 3. er may be placed on close all to a less stimulating and one-on-one staff member for a other therapeutic techniques for aviors is made to: A. Physician or enforcement, emergency medical

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIER Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI	P CODE
Solidago Fleatiff and Renabilitation		Texas City, TX 77590	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0684 Level of Harm - Actual harm Residents Affected - Few	patient/resident who is at risk for far patient/resident fall management p strategies while recognizing patient function. Definitions: fall refers to the but not because of an overwhelmin suggesting otherwise, when a residencedures: . 5. If a fall occurs, quadetermines what may have caused trying to do before he or she fell, a	trevised 03/29/2019 revealed, Policy: Ils and will plan care and implement introgram will be implemented that educates/resident's rights and their need to make unintentional coming to rest on the greaternal force. A fall without injury is lent is found on the floor, a fall is considified staff evaluates patient/resident for contributed to the fall, including asciddresses the risk factors for the fall survestigation Worksheet.	terventions to manage falls . 3. A tes staff in creative, functional aintain the highest practical level of ground, floor, or other lower level, a still a fall. Unless there is evidence dered to have occurred . Or injury from the fall and certaining what the resident was ch as the resident's medical

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Solidago Health and Rehabilitation 1720 N Logan St Texas City, TX 77590				
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0741	Ensure that the facility has sufficier behavioral health needs of residen	nt staff members who possess the conts.	npetencies and skills to meet the	
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 44241	
Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure staff who provide direct services to residents had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population, including knowledge of and appropriate training and supervision for 2 of 8 (CNA A and CNA E) staff reviewed for scompetency.  The facility failed to ensure CNA A and CNA E, who were observed on video dragging, kicking, and thro CR #1 into bed, had adequate, updated, and effective training specifically related to providing care to residents with dementia and aggressive/combative behaviors.  An Immediate Jeopardy (IJ) situation was identified on 10/08/2022 at 12:32 p.m. While the IJ was remove on 10/17/2022, the facility remained out of compliance at severity level of actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems.			
	This failure placed cognitively impaired residents with aggressive behaviors at risk of being physical abuse, neglect, hospitalization, or death.			
	Findings include:			
	Record review of CR#1's face sheet revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), protein-calorie malnutrition (inadequate intake of food), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity) of left lower leg, insomnia (persistent problems falling asleep), polyosteoarthritis (damage to cartilage, resulting in joint pain and swelling), major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), pain, dementia (a chronic disorder marked by memory disorders, personality changes, and impaired reasoning), psychotic disturbance (disorder in which one loses contact with reality and experience hallucinations, and delusions), muscle wasting and atrophy, and right leg above knee amputation.			
	Record review of CR #1's MDS dated [DATE] revealed he was usually understood when expressing ideas and wants and he was usually able to understand others; he had a BIMS score of 3 (severe cognitive impairment); he did not have hallucinations or delusions; he rejected care and wandered; he required extensive physical assistance from at least one staff for bed mobility, locomotion, and dressing; he required extensive physical assistance from at least two staff for transfers; he was totally dependent on at least one staff for personal hygiene and bathing; he was wheelchair bound; he was always incontinent of bowel and bladder; and he was prescribed antidepressant medication.			
	·	n, updated on 09/26/2022 revealed the	tollowing care areas:	
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZI	D CODE
NAME OF PROVIDER OR SUPPLIER		1720 N Logan St	PCODE
Solidago Health and Rehabilitation		Texas City, TX 77590	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0741  Level of Harm - Immediate jeopardy to resident health or safety	*Alzheimer's Disease (Goal: Resident will have positive experiences in the daily routine without having overly demanding tasks and without becoming overly stressed; Approach: Allow adequate time for resident to respond; Maintain a calm environment and approach to the resident; Use non-verbal communication techniques to encourage resident to respond);		
Residents Affected - Few	*he had a history of refusing care at times due to confusion, agitation, and dementia (Goal: Resident will cooperate with care; Approach: Allow resident to make decisions about treatment regime to provide a sense of control; Educate resident and responsible party of possible outcomes of not complying with treatment of care; Encourage as much participation/interaction by the resident as possible during care activities; Give a clear explanation of all care activities prior to and as they occur; If resident refuses care, reassure resident, leave and return 5-10 minutes later and try again; Involve responsible party when resident refuses care; Praise resident when behavior is appropriate);		
*he had a history of being physically aggressive, verbally aggressive, and refusing care related to (Goal: Resident will have a reduction in unwanted mood or behaviors, for an increased quality of li evidenced by documentation in the medical record; Approach: Attempt non-pharmacological inten and document on behavior monitoring flow record, such as music therapy, exercise, outdoor time, [reducing disruptive stimuli], Redirection/Reassurance, Increased observation, Validation, and Cor caregivers; Ensure his physical needs are met [toileting, pain, hunger, thirst, hot, cold]; Ensure communication is understood [prior to beginning task inform resident of intent, offer verbal one ste directions for tasks, Maintain a calm slow approach, do not argue with the resident, allow extra tim to communicate their needs]; Give medications as ordered; I resident becomes physically agitate aggressive, remove from other residents to a safe, less stimulating environment, Set firm limits by to stop current behavior and if needed, tell him you will return to complete care/task when he has to calm sufficiently to allow care safely for all, Notify nursing; If resident becomes physically agreason, assure them of their safety and notify nursing; Resident specific interventions include: Rec [talking about family, favorite music, hanging out in the lobby area, family visit]; Notify family of charesident status or of new escalated behaviors; Rule out environmental causes);  *he was at risk for falls due to impaired cognition, impaired mobility, incontinence and use of psycl medications. The resident has a camera in his room where is responsible party has witnessed him the floor when he wants to get up (Goal: Resident will not experience major injuries due to falls. All Ensure fall mats are at bedside. Continue all interventions, Patient is not falling but scooting out of bed and fall mats in place; Anticipate all needs; Encourage resident to ask staff for assistance. Staff requently, if resident bollering out either put to bed or get up;		an increased quality of life as n-pharmacological interventions, exercise, outdoor time, quiet time tition, Validation, and Consistent st, hot, cold]; Ensure tent, offer verbal one step resident, allow extra time for them comes physically agitated or nment, Set firm limits by telling him care/task when he has had a time hallucinating, do not argue or try to interventions include: Redirect by visit]; Notify family of changes in uses); tinence and use of psychotropic party has witnessed him crawl on or injuries due to falls. Approach: alling but scooting out of bed. Low a staff for assistance. Staff to check socialization; Ensure call light is in its needed. Ensure resident has inderstood by other, reduced ability spanish (Goal: Staff will anticipate pproach: Allow time for resident to e; Attempt to find an interpreter as interfering environmental stimuli;	
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022	
NAME OF DROVIDED OR SUDDIUS	NAME OF PROVIDER OR SUPPLIER		P CODE	
Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 1720 N Logan St Texas City, TX 77590	FCODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0741  Level of Harm - Immediate jeopardy to resident health or safety	*he has dementia as evidenced by short term and long term memory problems and impaired ability to make daily decisions at times (Goal: Resident's needs will be met and dignity maintained. Approach: Allow time for tasks and responses; Explain all procedures using terms/gestures resident can understand; Involve in care as to maintain or increase level of independence; Reorient resident as needed; Repeat information as needed).			
Residents Affected - Few	Record review of CR #1's medical records revealed he arrived at the ER of a local acute care hospital via EMS on 10/02/2022 at 6:02 p.m. CR #1 was admitted to the hospital on 10/02/2022. CT scans of his cervical spine, head/brain, and maxillofacial area (face, jaw, and mouth) were completed. Degenerative changes were found, but there were no acute intracranial abnormalities. X-rays were taken of CR #1's right knee, right hip/pelvis, and chest. No fractures or acute changes were found. CR #1's injuries were not described in the medical records (the complete medical record could not be provided because CR #1 was still a admitted in the hospital at that time).			
	Record review of Resident Progress Note dated 10/02/2022 revealed LVN V wrote, At 5:10 p.m. resident was found on floor by CNA. I was down hall 400 giving a resident his medications when CNA A came to me to let me know that CR #1 was found on the floor. Upon arriving, CR #1 had already been lifted off the ground and placed in his bed. I took his vitals: BP 120/77, P: 66, Resp: 17, O2: 95, Temp: 97.3, A&O x2. Resident was conscious upon arrival to his room and was very combative towards the CNAs. After taking his vitals I assisted CNA J in changing the resident because he had already kicked CNA A in the abdomen area and was also trying to kick the CNA E. After changing resident, we placed him in his wheelchair and took him to the nurse's station. I notified emergency contact on file and notified his physician. 911 was called and resident was sent to ER.			
	Record review of, SBAR Communication Form, dated 10/02/2022 revealed it was completed by LVN K. The document read in part . Situation, The change in condition, symptoms, or signs observed and evaluated is/are: Fall with head injury, This started on 10/02/2022 . Other relevant information: Resident observed on floor by staff . Resident/Patient Evaluation . 3. Behavioral Evaluation: Physical Aggression . 8. Skin Evaluation: Laceration . 9. Pain Evaluation . Does this resident have pain: Yes, New Pain, Description/location of pain: head/bilateral eyes . Does the resident show non-verbal signs of pain (for residents with dementia)? Yes, Complains of pain . Review and Notify: Primary Care Clinician Notified: CR #1's Physician, Date: 10/02/2022, Time: 5:25 p.m. Recommendations of Primary Clinicians: send to ER for evaluation and treatment .			
	(continued on next page)			

Facility ID:

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIER  Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 1720 N Logan St Texas City, TX 77590	P CODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state s		tact 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 0741  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	time stamped. The video did not have identified CR #1 as the resident revealed a male (the faces of the ir leg, slowly lowered himself off the sin contact with any structure while the room. CNA E (CNA E identified in a telephone interview on 10/05/2 seen talking to CR #1 and she poir blue pants out of a closet and threveleft the room and closed the door, of floor. CNA E returned to the room was near CR #1, moved back the sapproached CR #1. CNA E attemp #1's left leg and right arm but let his stump with one hand and his right wheelchair and pulled it towards hi and forcefully threw CR #1's left leg left side buttocks area. CNA E was several feet towards the bed. CNA side of his shirt while CNA E grabb bed, then both staff flipped his bott standing in front of CR #1's head a arms and his left leg and right stum CR #1's left foot (He only had a foowas against the wall) could be seen Observation and interview with CR had a laceration to the left corner of eyelids and underneath both eyelic covered with a dressing (CR #1 pu was some light purple bruising to h with CR #1 at that via Spanish-spe interpreter, CR #1 stated his injuried.	CR #1's RP on 10/06/2022 at 10:30 a ave audio. CR #1's RP stated the video in the video) revealed it was recorded individuals in the video were not compleside of a bed which was in a low position was alone in the video. The male so the was alone in the video. The male so the was alone in the video. The male so the was alone in the video. The male so the was alone in the video. The male so the was alone in the video. The male so the was alone in the video. The male so the was alone in the video. The male so the was alone in the video. The male so the was alone in the video during the control was alone with the company of a wheelchair which can be alone with the same of a wheelchair which with CNA A. CNA E walked inside the restrict of the was alone with the start of the was kicking. Charm with her other hand but let him go m. CNA E grabbed CR #1's left wrist and she was alone of the wheelchair but when he kick still holding CR #1's left wrist and she A approached CR #1 and grabbed the ed his left arm. The staff lifted CR #1's om half in the air and onto the bed whill not on half and appeared to be struggling appeared to be kicking in the air. Cho to on the left side. When the staff threw in moving around on the floor undernear #1 at a local acute care hospital on 10 of his left eye that was healing. He had also be some of the was admitted to the was were caused by five women at his how is mother before he was admitted to the mistreated him.	in CR #1's room. The video itely clear) with an amputated right on. The resident's face did not come cooted himself towards the door of a shirt and the other CNA as CNA A diclosed the door. CNA E could be conversation. CNA E took a pair of the was near CR #1. When CNA E hem on while he was still on the room, moved a bedside table that did CNA A some gloves. Both staff ted kicking. CNA A grabbed CR in A A then grabbed CR #1's right because his left leg kicked the NA A pulled the wheelchair back and her, she kicked him around his dragged him across the floor right side of his pants and right body. CR #1's head was on the le he was kicking. CNA A was ing with him while he flailed his la E pulled the privacy curtain but CR #1 into the bed, his left side the privacy curtain.  1/06/2022 at 9:45 a.m. revealed he dark purple bruising to bilateral larts of eyes). CR #1's left wrist was ected by the dressing) and there is the knee amputation. Interview they impaired. Through the larts of who were very upset with him.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Solidago Health and Rehabilitation		1720 N Logan St Texas City, TX 77590	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG			on)
F 0741  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	SUMMARY STATEMENT OF DEFICIENCIES  [Each deficiency must be preceded by full regulatory or LSC identifying information)  In a telephone interview with CR #1's RP on 10/06/2022 at 9:40 a.m., he said he observed CR #1 kicking and yelling, Help mel in his sieep since he was admitted to the hospital (he could not give the date of this observation). The RP said CR #1 told his other family members some girls hit him. He said in the video from the incident on 10/02/2022, CR #1 was in a low bed, and he got himself out of the bed. He said CR #1 had a history of getting himself out of bed and scooting around on the floor. He said CR #4 wanted to be in pants and sometimes, his wheelchair was placed to far away from his bed. He said the facility's staff would get frustrated because they would put CR #1 in the bed, and he would get out over and over. He said CR #1's family put the camera in his room three years ago when he (CR #1) was on a different hallway. He said CR #1's former roommate (who was no longer at the facility) told him the facility's staff were mistreating CR #1. He said when he brought the mistreatment to the Administrator and DON at that time (neither the Administrator nor DON were still employed at the facility) the staff involved was terminated.  In an interview with the Administrator on 10/05/2022 at 10:30 a.m., she stated one of CR #1's family members posted a video of CR #1's leng assaulted by CNA A and CNA E to social media. The Administrator said on Sunday, 10/02/2022, she was called by LVN K, who was the weekend supervisor at that time. She said LVN K initially told her CR #1 fell out of bed and was being sent out to a local hospital because he in this head as a result of the fall. She said when she was in the process of reporting the unwitnessed fall with injun to HHSC, she received a text message (on 10/02/2022 at 6:03 p.m.) from CR #1's R-She said when she asked the CNAs about abuse and an unusual occurrence, without mentioning the specific resident's name, the CNAs said nothing happened. The Adm		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022
NAME OF PROVIDER OR SUPPLIE	:R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Solidago Health and Rehabilitation		1720 N Logan St Texas City, TX 77590	
For information on the nursing home's	plan to correct this deficiency, please conf	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG			on)
F 0741  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	SUMMARY STATEMENT OF DEFICIENCIES ([Cach deficiency must be preceded by full regulatory or LSC identifying information)  In an interview with LVN K on 10/05/2022 at 11:30 a.m., she stated she was the weekend supervisor on 10/02/2022. She said CR #1 had dementia, was usually alert and oriented to person, and had a history of wandering, refusing care, crawling out of bed, and combative behaviors. She said CR #1 was mostly Spanish speaking, but he could speak and understand some English. She said she interacted with CR #1 or 10/02/2022 when she passed morning medication and he was ok. She said CR #1 went back to bed after lunch. She said that evening, LVN V approached her and said CR #1 fell out of bed and hit his head, so she started to assist with getting CR #1's paperwork ready to transfer him to the hospital. She said at that time, she did not know anything other than CR #1 had a fall. She said she called the Administrator to inform her or the fall. She said that very was fluent in Spanish and when CR #1 was on the stretcher to leave with EMS, he told LVN V one of the aides hit him. She said she stopped and called the Administrator to notify her. She sas CR #1's fall was not a surprise because he frequently crawled out of bed, but the head injury was a surprise (because he had never hit his head before). She said when she saw CR #1 at the nurse's station before he left with EMS, he had a laceration at the corner of one of his eyes the other eye was red. LVN K said CR #1 pointed at one of the aides (CNA A or CNA E) and told LVN V she was the one who hit him. She said CR #3 transity member arrived.  In a telephone interview with CNA E on 10/05/2022 at 3:47 p.m., she stated CR #1 was combative and fought staff every day. She said when CR #1 was combative, she usually left him alone for a period of time, but when she came back, he was always still combative. She said on the day of the incident (10/02/2022), she heard CR #1 streaming and yelling from the hall. She said on the day of the incident (10/02/2022) she he		

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NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Solidago Health and Rehabilitation	1	1720 N Logan St Texas City, TX 77590	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0741  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	In a telephone interview with LVN Not to 10/02/2022 was not the first dain in and out with memory. She said Cwith him trying to hit or kick her. She spoke Spanish. She said CR # put CR #1 in bed and he tried to ge to call a nurse to assess each resic be initiated. She said on 10/02/202 said CR #1 fell out of bed. She said and in the dining room. She said eand said CR #1 was trying to get on him to the nurse's station if he was pants on and put him in his wheeld medication cart and went down to CR #1's room and saw the privacy on the bed. She said CR #1's face a fall. She said the area under CR said the area above CR #1's eye whad burst. She said CR #1 kept cur CR #1 was angry. She said she tolof the CNAs (she could not recall wrail. She said CR #1 was already in CNA J was in CR #1's room with he	to contact CNA A by phone on 10/04/2d 10/19/2022 at 3:45 p.m. Voicemail m V on 10/05/2022 at 4:00 p.m., she state y she worked with CR #1. She said CR CR #1 could be combative when he was the said redirecting CR #1 with coffee he said redirecting CR #1 with coffee he thinself out. She said whenever there dent for injuries. She said if the resident 2, she was down 400 hall passing med a she was confused because she thougarlier on 10/02/2022, she was doing ment of his bed. She said typically, staff put trying to get up out of bed. She said shair and take him to the dining room. SCR #1's hall. She said she thought it was curtain was closed. She said the pulle shocked her. She said CR #1's injuries #1's left eye was already puffy, liked he was swollen and red. She said the blood accration in the corner of one eye. She sing and yelling at CNA A and CNA Ed the CNAs CR #1's injuries were not of the chair and the corner was from a bed, so there was no way for her to be the cr. so she (CNA J) assisted with incont in his wheelchair and took him to the nu	essages and texts were left.  In the desired she worked PRN on weekends at #1 had dementia and tended to go supset, but she never had issues alped to calm him down. She state in his wheelchair. She said staff a was a fall, CNAs were supposed the hit their head, neuro checks wou lication when CNA A came and and the CR #1 was already out of bed edication rounds and LVN E came at CR #1 in his wheelchair and take asked CNA E to put CR #1's he said she grabbed the as strange when she walked into dopen the curtain and saw CR #1's did not look they were caused by a got socked (hit) in the face. She at vessels in both of CR #1's whole like he did not want them by him. consistent with a fall. She said one when CR #1 hit himself on the sidl how he fell or where. She said inent care, and they changed his

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going around saying CR #1 was assaulted.

transport. She said when LVN K saw CR #1 at the nurse's station, she said, Oh God! She said she told LVN K this (CR #1's injuries) did not look like a fall. LVN A said once EMS arrived, CR #1 was looking at CNA A while he cursed and said that was the fucking black bitch that hit him. She said she told LVN K CR #1 said he was hit. She said CNA E went down the hall, but CNA A stayed close to the nurse's station watching the nurses and EMS prepare CR #1 for transport. She said when CR #1 saw CNA E walk down the hall, he said that's the fucking black lady that hit him. LVN V said she asked CR #1 who hit him, but he would not initially repeat what he said. She said CR #1 again said that is the other black bitch that hit him. She said after CR #1 left for the hospital, she called his responsible party and told him CR #1 fell but she did not know how he landed on the floor. She said she explained CR #1's injuries and told the responsible party they sent the resident to ER. She said the responsible party was very short and quickly said goodbye. She said within maybe 20-30 minutes, another one of CR #1's family members called and said they reviewed the video from the camera inside CR #1's room. She said the family member said both of the women (CNA A and CNA E) were fighting CR #1. LVN V said as soon as they got the information from CR #1's family member, LVN K walked towards the CNAs (CNA A and CNA E) and she saw one of them clock out. She said both CNAs were out o the building, but CNA had to wait outside waiting for her ride. She said CNA asked her who was

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022	
NAME OF PROVIDED OR CURRU		CTREET ADDRESS CITY STATE 71	D CODE	
NAME OF PROVIDER OR SUPPLIER  Solidago Health and Rehabilitation  STREET ADDRESS, CITY, STATE, ZIP CO  1720 N Logan St  Texas City, TX 77590		PCODE		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG		MMARY STATEMENT OF DEFICIENCIES  h deficiency must be preceded by full regulatory or LSC identifying information)		
F 0741  Level of Harm - Immediate jeopardy to resident health or safety	In an interview with the Administrator on 10/06/2022 at 12:13 p.m., she provided CNA A and CNA E's training records and stated the records indicated neither of the CNAs completed two computer-generated trainings on dementia/aggressive behaviors, Alzheimer's Disease and Related Disorders, Behavior and ADL Management and, Caring for the Person with Dementia Behaviors and Communication.			
Residents Affected - Few	Record review of CNA A's employee record revealed she was hired on 06/30/2020 and was terminated on 10/03/2022. All background checks were completed upon hire.  Record review of CNA A's training records revealed:  Caring for a Guest with Dementia - Completed 06/30/2020.  Alzheimer's Disease and Related Disorders, Behavior and ADL Management - dated 04/14/2022: Not completed (the Administrator said the training was not completed because there was no grade).  Caring for the Person with Dementia Behaviors and Communication - dated 04/14/2022: Not completed (the Administrator said the training was not completed because there was no grade).  About Caregiver Conduct, and Preventing, Recognizing, and Reporting Abuse - Completed on 09/16/22.			
	Further review of the records reveal behaviors or Alzheimer's Disease/o	iew of the records revealed no other trainings/in-services related to residents with aggressive or Alzheimer's Disease/dementia.  iew of CNA E's employee record revealed she was hired on 01/19/2018 and was terminated on . All background checks were completed upon hire.		
	Record review of CNA E's training			
	Caring for a Guest with Dementia -			
		ntia Behaviors and Communication - dated 06/21/2022: Not completed (the s not completed because there was no grade).		
	About Caregiver Conduct, and Preventing, Recognizing, and Reporting Abuse - Completed on 09/16/22.			
	Further review of the records revealed no other trainings/in-services related to residents with aggressive behaviors or Alzheimer's Disease/dementia.			
	A and CNA E failed to complete (A Management and, Caring for the P trainings and she could not force st subjects (aggressive behaviors and	ministrator on 10/18/2022 at 11:53 a.m. Izheimer's Disease and Related Disord erson with Dementia Behaviors and Cotaff to complete trainings that were not d residents with dementia) were mentio d upon hire. She said she did not think with them abusing the residents.	ers, Behavior and ADL ommunication) were not mandatory mandatory. She said those oned in other mandatory trainings	
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			NO. 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675214	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2022	
NAME OF PROVIDER OR SUPPLIER Solidago Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1720 N Logan St Texas City, TX 77590		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)	
F 0741  Level of Harm - Immediate jeopardy to resident health or safety	her certification as a result of the ir	E on 10/06/2022 at 11:06 a.m., she stancident with CR #1 on 10/02/2022. She ing him. CNA E said she only held CR	said she did not hit CR#1 and his	
Residents Affected - Few	In an interview with CNA L on 10/09/2022 at 9:43 a.m., she stated she had not received any training at the facility regarding aggressive resident behaviors or caring for residents with Alzheimer's Disease and dementia.  In an interview with CNA O on 10/09/2022 at 10:00 a.m., she stated she had not been trained regarding aggressive residents or providing care to residents with Alzheimer's Disease or dementia.  In an interview with CNA T on 10/10/2022 at 2:02 p.m., she stated she had not received any training from the facility on how to care for residents with aggressive behaviors or residents with Alzheimer's Disease and dementia.  In an interview with CNA N on 10/10/2022 at 2:12 p.m., she stated she had not received any training from the facility regarding providing care to residents with aggressive behaviors or residents Alzheimer's Disease and dementia.  In an interview with CNA B on 10/10/2022 at 2:40 p.m., she stated she received training on how to care for residents with Alzheimer's Disease, dementia, and aggressive behaviors at a different facility she worked at previously. She said she had not received those trainings at her current facility.  In an interview with the HR Director on 10/11/2022 at 12:21 p.m., she said she and the Administrator were responsible for ensuring staff were current with all training/in-services. She said they ran a report from their electronic training system every two weeks which listed each employee's training to be completed. She said the report was distributed to each department head to ensure their staff were trained.			
	In an interview with the Administrator on 10/11/2022 at 12:42 p.m., she stated she and each department head were responsible for ensuring each staff were trained. She said she and the HR Director run and review a report from their electronic training system which indicated which trainings needed to be completed by each staff. She said the reports were distributed to each department head to make sure their staff complete training. The Administrator said she also frequently spoke to staff about their training needs. The Administrator said she did not know why CNA A and CNA E had not completed trainings listed on their training records.			
	facility's Leadership prohibits negle chemical restraint not required to tr misappropriation of a patient's/resi	Exploitation, Or Mistreatment, revised 1 ct, mental, physical and/or verbal abusteat a medical condition, involuntary sedent's property and/or funds and ensurteatment, including injuries of unknown	se, use of a physical and/or clusion, corporal punishment and es that alleged violations involving	