STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP 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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on record review and interview, the facility failed to consult with resident physician and notify, consistent with his or her authority, the resident representative when there is a need to alter treatment significantly for 1 out of 8 residents (Resident #3) reviewed for notification of changes. -The facility failed to notify the physician when resident was refusing insulin Lantus on dialysis days Tuesday, Thursday, and Saturdays. This failure could place residents at risk for hyperglycemia (increase blood sugar levels) and hospitalization . Findings included: Record review of Resident #3 face sheet revealed an 63year old admitted to the NF on 01/21/2022 with the following diagnoses that included Type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage from pain and numbness in feet to issues with the functions of internal organs such as the heart and bladder), end stage renal disease (kidney disease), dependence on renal dialysis, absence of left leg below knee, hypertension (elevated blood pressure), and heart failure. Record review of Resident #3's MDS dated [DATE] revealed that resident had a BIMS score of 14 indicating that resident cognition was intact. Record review of Resident #3's Care Plan dated 02/15/2023 revealed that resident was being care planned for risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diagnosis of diabetes mellitus. Resident interventions included administer medications as ordered per MD, evaluate/record/report effectiveness/adverse side effects. Further review did not reveal that resident was being care planned for refusing his insulin. Record review of Resident #3's Physician Orders revealed the following orders: -dated 12/06/2022 dialysis Tuesday, Thursday, and Saturday -dated 02/08/2023 Lantus 20 units subcutaneous (beneath the skin) for diabetes mellitus once a day at 7:00am (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-dated 02/07/2023 Blood glucose checks twice a day at 7:00am and 8:00pm Record review of Resident #3's Nursing Progress Notes dated 04/10/2023 documented by LPN T revealed in part: .Resident refused scheduled long actin insulin. PA notified. Blood sugar was 130 at breakfast time. Checked resident's blood sugar at lunch 179. Resident is in stable condition resting in bed eyes closed call light in reach. Will continue to monitor . Further review of Resident #3's Nursing Progress Notes dated 04/11/2023 documented by LPN T revealed in part: .Resident refused insulin due to no appetite and his scheduled dialysis day. Blood sugar 137 resident is resting eyes closed stable condition shows no s/s (signs or symptoms) of pain or discomfort will continue to monitor. Family and PA (Physician Assistant) notified . Record review of Resident #3's MAR for January 2023 revealed on dialysis days the insulin Lantus was not administered on 8 dialysis days. Resident blood sugars were being done at 7:00am and 8:00pm with blood sugars ranging from 97-230. Record review of Resident #3's MAR revealed for the month of February 2023 the insulin Lantus was held 4 times on dialysis days with blood sugar ranging from 93-238. Record review of Resident #3's MAR for the month of March 2023 revealed that the insulin Lantus was held on 8 dialysis days with resident blood sugars ranging from 82-289. Record review of Resident #3's MAR for the month of April 2023 revealed that resident did not receive insulin on 6 dialysis days with blood sugars ranging from 120-254. Interview on 04/10/2023 at 12:50pm, LPN T said she was Resident #3's nurse. LPN T said Resident #3's blood sugar was 130 at 7:00am and anytime it was below 150 she would hold resident morning insulin Lantus because she was familiar with resident food consumption. LPN T said there was not an order to hold resident insulin Lantus she just done it that way. LPN T said she did not notify the physician about holding Resident #3's insulin and that Resident #3 and herself agreed to hold the insulin when resident blood sugar was below 130. Interview on 04/11/2023 at 1:49pm LPN T said on the days that Resident #3 did not receive his insulin for the month of April was because resident had refused and that she had documented. Interview on 04/11/2023 at 2:13pm the mobile DON said that if a resident was refusing their insulin as ordered by the physician, the physician should be notified so that interventions could be put in place to better care for the resident. Interview on 04/11/2023 at 3:05pm via phone the NP for Resident #3 said no one from the NF had called him regarding Resident #3 refusing his insulin on 04/10/2023 or any other day. The NP said if Resident #3 had been refusing his insulin, he would first talk to the resident educating resident on the benefits of taking his insulin before making any changes to his medications. Further interview with the NP said Resident #3 did not have PA (Physician Assistance) just himself and the doctor. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/12/2023 at 9:00am the mobile DON and the ADON stated that Resident #3 had a NP that came to see him and not a Physician Assistant. Interview on 04/12/2023 at 9:20am RP for Resident #3 stated that they had never received a call from the NF on 04/10/23 or any other day that resident was refusing his insulin, or that resident insulin was being held or certain days. Observation on 04/12/2023 at 9:46am Resident #3 sitting in wheelchair at the front entrance of the NF wearing street clothing. Resident #3 had a left below the knee amputation (removal of a limb). Interview on 04/12/2023 at 9:46am Resident #3 said he went to dialysis on Tuesday, Thursday, and Saturday. Resident #3 said he sometime refused his insulin on these days because he sometimes did not feel good but did not refuse his insulin on Monday 04/10/2023. Interview on 04/12/2023 at 10:05am LVN X said if a resident refused their insulin, she would notify the doctor/NP and document the happenings. Interview on 04/12/2023 at 10:42 via phone RN U said the reason she did not administer Resident #3 morning insulin Lantus on 04/04/2023 was because resident was scheduled to go to dialysis. RN U said she was afraid resident might become hypoglycemic (low blood sugar) and therefore held resident insulin. RN U said she did not inform the doctor/NP of her holding the insulin and that it was nursing judgement. Interview on 04/12/2023 at 11:30am the mobile DON said she had reviewed Resident #3's MAR for 04/09/2023 and saw where resident insulin Lantus was not being administered as order by the physician. The mobile DON said she had begun to in-service the nurses on administration of insulin. The mobile DON said when insulin is not administered as order by the physician, resident blood sugar readings would not be consistent but up and down. The mobile DON said nurse LPN T could not come back to the NF to work and that the NF had suspended LPN T pending further investigation. The mobile DON said LPN T could not be trusted to work at the NF. Further interview on 04/12/2023 at 11:48am the NP said he learned from the surveyor and speaking with Resident #3 on 04/12/2023 that the insulin Lantus was not being administered as ordered. The NP said by not administering resident insulin as ordered placed resident at risk for becoming hyperglycemic (increase in blood sugar) or go into diabetic ketoacidosis (when the body does not have enough sugar to meet its energy needs, it will break down fat instead) which was not good. The NP said he would look at possibly making changes to resident insulin on dialysis days but first had to draw labs to see what resident Hemoglobin A-1 C level was. Further interview on 04/12/2023 at 12:38pm the mobile DON said it was herself and the ADON that monitored the resident MARs to ensure that the physician orders were being followed. The mobile DON said she had been working at the NF for 4 weeks. The mobile DON said how herself and the ADON was checking the MARS by reviewing the facility report that showed if all medications had been administered or not given. The mobile DON said she discovered that Resident #3 insulin was not being administered as ordered by the physician on 04/09/2023. The mobile DON said she began to in-service the staff regarding following physician orders and notifying the doctor when a resident (s) insulin is held or if the resident refuse a medication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 04/12/2023 of in-service done with the NF staff on insulin medication administration documentation, 5 rights of medication administration, and when a resident refuses to take insulin the doctor and RP must always be notified, dated 04/10/2023. Record review of physician orders for residents on dialysis revealed that Resident #3 was the only resident that received insulin. Interview on 04/19/2023 at 10:48am Doctor for Resident #3 said he and his NP were the only medical health care providers that gave orders on Resident #3 at the NF. The doctor said he learned from his NP that the Nursing staff at the NF was not administering resident insulin Lantus as order. The doctor said a conversation needed to be had with him and the NF regarding resident refusing medication Lantus so that he could look at other alternatives involving resident medication. Record review of the NF policy regarding Physician and Other Communication/Change in Condition revised 2017 revealed in part: .To improve communication between physician and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsibility regarding changes in condition .Notify the physician of change in medical condition .The nurse will document all assessments and changes in the patient's/resident's condition in the medical record .The patient's/resident family member/legal representative will be notified of any change in medical condition or treatment plan .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 44333 Based on observation, interview and record review the facility failed to have evidence that all alleged violations are thoroughly investigated and measures are taken to prevent further potential abuse, neglect, exploitation or mistreatment in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate, corrective action must have been taken for 1 of 2 residents (Resident #12) reviewed for abuse and neglect - The facility failed to thoroughly investigate alleged incident of abuse and neglect by waiting 10 days after the incident to interview residents with memory concerns, not interviewing other resident that had contact with the alleged perpetrator and not completing the investigation within 5 days as required by the state for allegations of abuse and neglect. - The facility failed to take action to protect Resident #12. These failures could place residents at risk of further abuse and neglect. Findings included: Record review of Resident #12 face sheet, revealed, a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: Alzheimer's disease, muscle wasting and atrophy, unspecified dementia, psychotic disturbance, mood disturbance, anxiety, cognitive communication deficit, unspecified osteoarthritis, and major depressive disorder. Record review of Resident #12's Brief Interview for Mental Status dated 3/28/23 revealed a score of 3 out of 15. Recall section revealed scores of 0. Temporal Orientation revealed a score of 0. Repetition of three words revealed a score of 3. Summary score revealed a score of 3. Record review of Resident #12's Care plan dated 4/5/2023 revealed Resident #12 has impaired communication evidenced by: reduced ability to be understood by others, reduced ability to understand others, impaired daily decision-making ability, speaks a foreign language (English was her 2nd language). Observation on 4/8/23 at 1:24pm revealed CNA Q was in a room for Resident #11 and Resident #12 when a surveyor overheard CNA Q speaking loudly stating Shut up using obscenities for example You will end up on the floor, I am not your friend anymore. Resident #12 was heard speaking loudly in Spanish. Laundry aid B entered the room and said something to CNA Q, and both exited the room. In an interview on 4/8/23 at 1:28pm with CNA Q she stated she was just playing with Resident #12 and that she always joked with her in that way. She stated she did not mean anything by her words and that she respects the residents. She stated she plays with many of them in that way. CNA Q stated she understands what abuse and neglect was and reported that she had received in service training on abuse and neglect. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with administrator on 4/8/23 at 1:35pm she stated that CNA Q was in-service on abuse and neglect and that she would investigate the allegation of abuse. In an interview with Resident #12 on 4/8/23 at 2:43pm utilizing a Spanish phone translator service the resident was determined to be not interview able. Resident #12 was unable to answer questions or stay on subject. Record review of Resident #11 undated face sheet, revealed, an [AGE] year-old female admitted to the facility on [DATE] with the latest return of 3/14/23. Diagnosis includes cerebral infraction, muscle weakness, cognitive communication deficit. Major depressive disorder, and vascular dementia. Interview with MDS nurse on 4/27/2023 at 10:08am, she stated that the BIMS goes through the resident's cognition. She stated that Resident's #11 BIMS revealed she could not be interviewed. She is severely impaired no temporal orientation (orientation to year, month, and day), long term and short-term memory problem, classified as unscorable. Record review of Brief Interview for Mental Status for Resident #11 revealed a score of 0 which stated interview was not conducted (resident was rarely/ never understood). Record review of Resident #11 care plan dated 2/15/2023 revealed Resident #11 has an impaired ability to be understood by others, reduced ability to understand others, impaired daily decision-making ability. Record review of the Incident Intake Investigation Worksheet dated 04/17/23 revealed, on 04/08/23 the facility reported an allegation of abuse made by Surveyor at 2:00pm. The Description of the allegation stated, Surveyor was making rounds in the building when she overheard someone in a resident's room calling a resident ugly, and saying shut up using obscenities, don't fall or you'll end up on the floor and we are not going to be best friends. Provider response stated, Residents were assessed with no injuries noted. Administrator talked with residents to ensure they felt safe. Investigation summary revealed CNA Q was suspended pending investigation upon administrator notification of the verbal abuse. Reeducation was initiated including verbal abuse. Investigation findings revealed a status of confirmed. Provider investigation taken post investigation revealed reeducation completed on abuse and neglect. CNA Q remained suspended and then was terminated on 4/17/23. Record review of email dated 4/17/23 from Human resources to RVP revealed CNA Q was interviewed. The email stated, I was doing my rounds and when I entered the room, the patient's legs were kind of hanging out of the bed, so I repositioned her. I also tried to explain to her that if she fell , she was going to hurt herself. When I was done repositioning the patient [NAME] me Callete. When I asked the patient what that meant she told me it meant shut up. I will admit to laughing and repeating but I was not talking to the resident directly. The email also revealed that laundry aide B was in the room delivering clothes and she denied witnessing any type of abuse or neglect. Record review of resident questionnaire dated 4/18/23 given by Social worker revealed Resident #12 responded Yes to the question do you feel safe at this facility, responded no to the question has any staff member ever abused you verbally or physically, responded yes to the question do you feel that you can talk to your guardian angel about any concerns/grievances and responded by thanking the Social worker for asking or checking if there was anything else she would like to report. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of resident questionnaire dated 4/18/23 given by Social worker revealed Resident #11 responded Yes to the question do you feel safe at this facility, responded no to the question has any staff member ever abused you verbally or physically, responded yes to the question do you feel that you can talk to your guardian angel about any concerns/grievances and responded by thanking the Social worker for being her friend when she was asked if there was anything else she would like to report. Record review of document titled Record of in service dated 4/8/23 revealed in service on abuse, neglect, abuse coordinator and when abuse should have been reported. In service was signed by employees from all departments. Interview on 4/26/2023 at 1:36pm with social worker, stated that he was named the abuse and neglect coordinator on 4/24/2023. He stated he has been working at the facility for approaching 2 months. He stated he was told to inform the administrator and director of nursing of allegations of abuse and neglect. He stated he was informed by the administrator of the incident and instructed to complete the questionnaire for Resident #12 and Resident #11 on 4/18/23. He stated he did not interview any other residents that CNA Q may have interacted with. He stated he did not interview any other residents on the hall where the incident occurred or within the facility. He stated he believes the investigation was not thoroughly investigated because of this. He stated the administrator made it seem like it was not a big deal and like stuff like this happen. He stated that he is familiar with Resident #12 and her diagnosis. He stated that Resident #12 has a diagnosis that prohibits long term memory. He stated he was able to interview the resident but not sure about the validity of the interview due to her diagnosis and the interview being conducted on 4/18/23 10 days after the incident which occurred on 4/8/23. He stated he was still reviewing the packet that discusses his role as the abuse coordinator. He stated that as the abuse coordinator residents, staff and visitors would report allegations or incidents of abuse and neglect to him. He stated his protocol when investigating would be to go to each room, talk to all the residents in the immediate vicinity as well as the alleged perpetrator. He stated he is still learning the position of the abuse coordinator. In an interview on 4/26/2023 at 2:23pm with Laundry Aide B she stated that she has worked at the facility for two months. She stated that she has been trained on abuse and neglect upon hire. She stated that abuse can be how you talk to and treat a resident. She stated that she heard the resident from the first bed as you walk into the room closest to the door taking loud and it surprised her. She stated she overheard the resident saying, I'm going to call the police and CNA Q saying, I am going to give you the phone. She stated she didn't hear or witness any abuse or neglect. She stated that Human resources interviewed her on 4/17/23 and she stated she did not witness abuse or neglect. In an interview with RVP on 4/27/23 at 5:13pm she stated that it normally takes 5 days to do an investigation of abuse or neglect. She stated that she forgot and lost track of time. She stated that she reviewed the investigation and asked the social worker to go back and ask Resident #11 and Resident #12 about the incident. She stated that she knows that it was a little late after the incident. She stated that when there is an allegation of abuse or neglect and an employee was named as the perpetrator, the protocol would be to suspend the employee until the investigation was completed. She stated that she considers the Brief Mental Status of the residents when investigating abuse or neglect. She stated that the normal procedure would be to interview other residents that the employee would have had contact with. She stated that there was no documentation of any other residents being interviewed other than Resident #11 and Resident #12. She stated that she instructed the social worker to interview the two residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Termination form dated 4/18/23 revealed CNA Q was terminated effective 4/18/23. Termination was involuntary. Record review of Policy titled Organizational ethics subject: abuse, neglect, exploitation, or mistreatment dated 11/1/2017 revealed: The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment, and misappropriation of a patient's/resident's property and/ or funds and ensures that alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately. The facility's Leadership will designate a staff member to oversee the abuse prohibition policy (Facility Abuse Coordinator). Verbal abuse includes any use of Oral language, Written language, Gestured language including, but not limited to, disparaging or derogatory terms directed to or within the patient's/resident's hearing distance. The facility maintains that all allegations of abuse, neglect, misappropriation of property etc. are thoroughly investigated and appropriate actions are taken. Investigations are prompt, comprehensive and responsive to the situation and contain founded conclusions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 1 (Resident #4) of 8 residents reviewed for incontinent care. -The facility failed to ensure Resident #4 was provided incontinent care in a timely manner. This failure could place residents at risk for urinary tract infections, further decrease in skin integrity, and unwanted hospitalization . Findings included: Record review of Resident #4's Face sheet revealed an 80year old male admitted to the NF originally on 01/28/2021 and again on 04/13/2022. Resident #4's diagnoses included Parkinson's Disease (A chronic disease that effects muscle movement and coordination) , dementia (decline in mental function), bilateral (both sides) primary osteoarthritis (wearing down of tissue around the bone joints) of knee, pain, and peripheral vascular disease (circulation disorder involving the arteries or veins narrowing and restricting blood flow). Record review of Resident #4's Physician orders dated 11/26/2022 had an order to apply barrier cream to sacrum every shift after each incontinent episode. Further review revealed an order dated 04/11/2023 to clean left buttock wound with NS (normal saline), pat dry, cover with calcium alginate and apply dry dressing daily. Record review of Resident #4's MDS dated [DATE] revealed that resident BIM's score was 3 indicating that resident cognition was severely impaired. Further review revealed that resident required extensive assistance with bed mobility, eating, and was total dependence with transfer, dressing, toilet use, and personal hygiene. Further review revealed that resident was always incontinent of bowel and bladder Record review of Resident #4's Care Plan dated 04/18/2022 and updated 03/13/2023 revealed that resident required assistance to complete ADL task due to impaired cognition, impaired mobility and incontinence, personal hygiene, toileting with 1-2 person assist by CNA, license nurse, nursing, Registered Nurse (RN). Observation on 4/21/23 at 9:50 a.m., Resident #4's room smelled of urine. Interview on 4/21/23 at 10:00am with CNA R, she stated residents were to be repositioned and provided incontinent care every two hours. She stated today she didn't change Resident #4 because she wasn't working the front of the hall where his room was. Her shift today was 6am to 2pm. She had not changed him today. Observation on 04/21/2023 at 10:30am, Resident #4 was in his bed resting on his back on an air mattress. Resident was not inter-viewable. Resident's room had a strong urine odor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/21/2023 at 10:35am, CNA S said she was the CNA for Resident #4. CNA S said she worked full time on the 2pm-10pm but was called in to work for the 6am-2pm shift because a CNA had to leave on the 6am to 2pm shift. CNA S said she had made it to the NF around 9am or a little after. CNA S said when she arrived to the NF, the CNA that was caring for Resident #4 had already left the NF, therefore she did not receive a report from the CNA or the nurse caring for Resident #4. CNA S said when she arrived at the facility, she made rounds making sure all the residents were breathing and not in any distress but did not check to see if any residents were incontinent of bowel or bladder instead, started passing the breakfast trays. Observation on 04/21/2023 at 10:45am revealed incontinent care for Resident #4 done by CNA S with the assistance of the Unit Manager. Resident #4 was wearing a brief that was heavily soiled with urine and had a bowel movement. Interview on 04/21/2023 at 12:42pm CNA S said the last time she had received in-service on incontinent care she believed was last year of 2022. CNA S said the residents should be checked for incontinent care at least every 2 hours. Interview on 04/27/2023 at 4:00pm, the ADON said the CNAs should be providing or checking the residents for incontinent care at least every 2 hours and as needed. The ADON said for those residents that were heavy wetter's, the CNAs should be checking more frequently than every 2 hours for incontinent care. Further interview with the ADON said herself and the DON done in-service with the staff regarding resident care. The ADON said she had not provided any in-service to the CNA's regarding incontinent care. The ADON was unable to find in-service done with the CNA's regarding incontinent care. The ADON said the NF had just hired a new DON. Record review of the NF Policy on Quality-of-Life revised 2017 revealed in part: .The facility will promote a quality of life for patient's/residents .The facility staff will assist patient/resident in activities of daily living .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure a resident with pressure ulcer receives necessary treatment services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers from developing for 1 of 8 residents (Resident #4) reviewed for pressure ulcers in that: -The facility failed to do weekly skin assessments on Resident #4. -The facility delayed in getting wound care orders for Resident #4 when resident's skin to the sacrum went from redness to stage II. -The facility failed to place an air mattress on Resident #4's bed when it was documented that Resident #4's Braden scale revealed High Risk for pressure ulcers. This failure placed resident at risk for further skin breakdown, infections, and pain. Findings: Record review of Resident #4's face sheet revealed an 80yearold resident admitted to the NF initially on 01/28/2021 and again on 04/13/2023. Resident's diagnoses included the following: Parkinson's Disease (brain disorder that leads to tremors, stiffness, and difficulty with balance and coordination, dementia (impairment of memory and loss of judgement), type 2 diabetes mellitus, hypertension (elevated blood pressure), peripheral vascular disease (narrowing of the blood vessels reducing blood flow to the limbs), and osteoarthritis of knee (tissue around the bone joints begin to wear down causing pain and loss of movement). Record review of Resident #4's physician orders included the following: -dated 05/03/2022 consult hospice of patient/family choice -dated 05/19/2022 admit to hospice diagnosis Parkinson's Disease -dated 11/26/2022 apply barrier cream to sacrum every shift after each incontinent episode every shift -dated 04/11/2023 clean left buttock wound with NS (normal saline), pat dry, apply, cover with calcium alginate (cream substance to promote wound healing) and apply dry dressing daily (this order documented was given by Resident #4's doctor at the NF). -dated 10/04/2022 ST (Speech Therapist) to evaluate and treat as indicated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	05/01/2023

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's MDS dated [DATE] revealed that resident's BIMS score was a 3 indicating resident's cognition was severely impaired. Further review revealed that Resident #4's functional status section G of the MDS revealed that resident required extensive assistance with mobility and eating. Resident was totally dependent upon staff with transfer, dressing, toilet use, and personal hygiene. Further review of skin conditions section M of the MDS revealed that resident was at risk for developing pressure ulcers and did not have any pressure ulcer. Record review of Resident #4's Care Plan dated 04/18/2022 and revised on 03/13/2023 revealed that the NF was only care planning resident for risk for skin breakdown with the intervention to report any skin breakdown (sore, tender, red, or broken areas). Record review of Resident #4's Nursing Progress Notes from January 2023 to April 20th, 2023, did not mention any assessment of resident having skin breakdown. Further review revealed that on 04/07/2023 documented by RN ZZ revealed in part: Hospice nurse is here to see resident, assessment completed . Record review of the NF 24-hour report sheet for the month of April 2023 did not reveal any skin breakdown for Resident #4, just that resident was stable and being seen by hospice services. Record review of Resident #4's Braden Scale (for predicting sore risk) dated 01/23/2023 revealed a score of 12 (HIGH RISK) for predicting pressure sore risk. Further review of Resident #4's Braden Scale dated 03/22/2023 revealed an 11. The interpretation of score as follows: -19 or higher, no risk -15-18 at risk-if other major risk factors are present e.g. advanced age, fever, poor dietary intake of protein, diastolic less than 60 -13-14 moderate risk-if other major risk factors are present -10-12 HIGH RISK -9 VERY HIGH RISK Record review of the FACILITY and HOSPICE DECLINEATION of DUTIES signed 05/10/2022 revealed in part: .Durable Medical Equipment required/Provided (hospice list included suction, nebulizer, and oxygen concentrator) . Nrsing list included bed and OBT (overbed table) . Further review of the delineation of duties revealed that both hospice and the NF checked the yes box to perform wound care as follows: per facility protocol. Record review of Resident #4's weekly skin assessments revealed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/11/23 completed by RN ZZ revealed, new wound to sacrum, new orders given, assessed by hospice nurse, today area is approx. 4cm long, 3.5 cm wide, no drainage, surrounding area is ashen in color with a beefy red center, per hospice RN wound is unstageable There was not a weekly skin assessment completed for the week of 4/2/23 through 4/8/23 3/28/23 completed by former wound care nurse- no skin issues noted. Record review of Resident #4's MAR for April 2023 revealed a weekly skin assessment was completed on 4/4/23 by LVN U. Observation on 04/21/2023 at 10:30am, Resident #4 was in bed resting on his back. Resident had an air mattress on his bed. Resident was not inter-viewable. Interview on 04/21/2023 at 10:32am, the mobile DON said the NF did not have a wound care nurse and that the Unit Manager was doing the wound dressing changes at the NF. Interview on 04/21/2023 at 10:40am, the Unit Manager said she had changed Resident #4's dressing to his sacral wound earlier in the am. The Unit Manager said she did not know when Resident #4 acquired the pressure ulcer to the sacral area and that today was her first time seeing the wound to resident sacral area. The Unit Manager said an air mattress was placed on resident's bed approximately 3 days ago and that hospice was overseeing resident wound to his sacrum. Further interview on 04/21/2923 at 10:50am, the Unit Manager said she was Resident #4's primary care nurse in the past when she worked the 200-Hall. The Unit Manager said she could not remember when the last time she cared for Resident #4 and had never done a skin assessment on the resident. The Unit Manager said skin assessments were done weekly by the unit nurses. The Unit Manager said she mainly worked hall 300 but had to float sometimes to other halls to work. The Unit Manager said she was just promoted from a staff nurse to Unit Manager on 04/21/2023 and wound care nurse. The Unit Manager said skin assessments were done on Hall 300 on Wednesdays and Hall 200 skin assessments were done on Tuesdays. The Unit Manager said if a CNA saw a change in a resident skin or change in resident condition, the CNA should report the change to unit nurse working that specific hall. The Manager said the nurse would document the change on the 24-hour report sheet as well as notifying the physician to get treatment for the wound. The Unit Manager said the ADON reviewed the 24-hours report each morning. Observation on 04/21/2023 at 12:20pm, lunch tray was delivered to Resident #4's room. Resident was served a pureed diet that consisted of the following foods: chicken, potato's, green beans, and pudding for dessert with tea as a beverage. Resident #4's family members were present at the bedside. Further observation was made of the family assisting resident with food to eat bought in to the facility. Interview on 4/21/23 at 12:27 p.m. with CNA Y, she stated Resident #4 had a sore on the behind area. She said the last time she worked the hall was over a week ago when she worked that hall. She said when she provided incontinent care he didn't' have a bandage on it. She said she knew the nurse was aware of it because she had reported to the nurse. She said it was a circular wound, and guessed the diameter was about 2 inches, and it was open. She stated she believed everyone knew about the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Point of Care History revealed CNA Y documented an open area to buttock on 4/1/23. Interview on 04/21/2023 at 12:30pm, Resident #4's family member said she brought resident plant-based protein shakes, coconut water, puree oatmeal, beans, and sugar free pudding that resident would eat. The family member said Resident #4 sometimes did not like the puree food served at the NF but the food at the NF had improved. The family member said she came to the NF about three times a week and that there were other family members that came to the NF as well. The family member said when resident was admitted to the NF, he did not have any skin break down. The family member said the concerns she had with the NF was that the NF was not keeping resident clean and dry and not repositioning resident every 2 hours or as needed. The family member said over the past 2 years the family had to continuously stay on staff about assisting residents with his feeding. The family member said Resident #4 had suffered multiple strokes and could not turn himself, and therefore required total assistance with care. The family member said she was not aware of resident having any skin breakdown until 04/16/2023 around noon time. The family member said when they were assisting the CNA (name unknown) with incontinent care and had to turn resident, they observed skin breakdown to resident sacral area. The family member said she spoke with the nurse on duty who was an agency nurse. The family member said the agency nurse said she was not aware that Resident #4 had a wound to the sacral area because it was not mentioned in the shift change report. The family member said Resident #4 did not have an air mattress on his bed on 04/16/2023 and that the air mattress was just placed on resident bed a few days ago. The family member said she placed a call to the hospice nurse A who told her that the NF notice some redness. The family member said she asked the Hospice nurse how did the resident's skin breakdown go undiscovered between the Hospice company and the NF? The family member said when she observed the resident's sacrum on 04/16/2023, resident's skin was not intact and skin tissue was exposed not just redness but with bruising around the wound area. The family member said she asked the Hospice nurse why the resident was not already on an air mattress. The family member said the hospice nurse tried to say that it was the resident disease process as the reason why resident skin had break down. The family member said she told the hospice nurse that she could not accept that reason for resident skin breakdown to the sacral area. Interview on 04/21/2023 at 12:42pm, CNA S said the first time she noticed Resident #4's skin breakdown was about 2 weeks ago or more. CNA S said at that time, resident's skin to his sacral area was a bruised purple color. CNA S said she told the nurse on duty which was an agency nurse. CNA S said it had been a lot of agency nurses working at the NF. CNA S said she was applying barrier cream to resident perineal area after administering incontinent care. CNA S said it was also about 2 weeks ago that resident's sacral area was being covered with a dressing by the nurse. Interview on 4/21/23 at 1:00pm with CNA NN, she stated that she noticed the sacral wound and it looked like it got really bad. She said about a week ago it got bad. CNA NN was unable to provide an exact date when she noticed resident wound. CNA NN said it wasn't too deep, not like a hole, but it was open skin and red and white. CNA NN said it wasn't deep yet, the size was about a nickel size. CNA NN said she did not report it to anyone. CNA NN said, the girl (hospice aid) came to the NF and because Resident #4 was on hospice so she thought hospice would take care of it because they bathe him. CNA NN said she doesn't document it on the POC either, but she should, and she just doesn't. CNA NN said she should have reported it to the nurse. CNA NN said she would put barrier cream on it. CNA NN doesn't know the date specifically. CNA NN said she would take bandages off or they would fall off, and she didn't report it to anyone to replace the bandage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/21/2023 at 1:00pm, the ADON said she started working at the NF in January of 2023. The ADON said the wound care nurse stopped working at the NF she believed April 6th, 2023. The ADON said it was the unit nurses responsibility for each hall to do the weekly skin assessments and document on the EMAR. The ADON said she just reviewed the 24-hour sheets but did not use it as a tool to communicate the resident care. Observation and interview on 04/21/2023 at 1:50pm revealed Resident #4 resting in bed on his right side with family member at the bedside. The family member said 2 CNAs had just repositioned resident to his right side. The family member said resident refused his puree diet that the NF gave him but tolerated 30% of the chicken stock broth and almost 100% of a 32 ounce of [NAME] made with rice, milk, and cinnamon with no sediments just the juice. The family member said she tried to be creative with the resident's diet. The family member said resident now liked sweets where as before, he liked salty foods. Observation on 04/21/2023 at 2:00pm revealed dressing change of Resident #4's sacral wound by the Unit Manager with the assistance of CNA S. Observation of the sacral wound revealed bruising (black bluish in color) surrounding the wound bed. The wound bed was a pale pink reddish in color with some sloughing (shedding of skin tissue) yellowish tissue in different sections of the wound bed. The Unit Manager cleaned the sacral wound bed with normal saline patting dry with a 4x4. The Unit Manager then applied calcium alginate followed with a dry border adhesive dressing. There was no odor detected from the wound. The nurse did not measure the wound. The wound surface area appeared to be the size of 2 silver dollar coins. There was no skin breakdown to the buttocks area. The Unit Manager said the wound appeared to be a stage II. Interview on 04/24/2023 at 9:52am, the Hospice nurse said she started working for the Hospice Company in July of 2022. The Hospice Nurse said Resident #4 was already on hospice service and believed at one time went off and then came back on hospice services. The hospice nurse said she came to the NF once a week and as needed checking resident vital signs, doing skin assessment, assessing pain level, etc. The Hospice nurse said the NF was monitoring resident food intake. The hospice nurse said several weeks ago, the NF CNA who's name she could not remember had informed RN ZZ about Resident #4 having some skin breakdown. The hospice nurse said she could not remember the day this was reported and was driving at present time therefore could not review her documentation. The hospice nurse said Resident #4 wound was staged at a 2 and that she got an order from the NP to start treating Resident #4's wound. The hospice nurse said she also got an air mattress for Resident #4 but could not remember what day. The hospice nurse said Resident #4's intake had started to decline 3-4 months ago. The hospice nurse said about a month ago Resident #4 had begun to pocket his food. The Hospice nurse said Resident #4 had always been total care. The hospice nurse said she would not request for an air mattress unless resident had developed a wound and not before. The hospice nurse said the NF were supposed to care plan resident, keep resident turned, clean, and dry. The hospice nurse said it was expected for Resident #4 to have skin breakdown due to his health declining. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/2023 at 10:42am with the Regional Nurse and VP of Clinical Operations said the 24-hour report was used as a communication tool about the care of the resident (s) or any changes in condition. Both said the 24-hour report sheets should be used when the nurses were giving shift to shift report. Both said the DON and ADON should be reviewing the 24-hour reports daily to help guide them in their morning meeting. The VP of Clinical Operations said QAPI (Quality Assurance Performance Improvement) meetings were held once a month and as needed. The VP of Clinical Operations said topics discussed in the QAPI meetings consisted of wounds, infection control, falls, PIPS (Performance Improvement Project), etc. The Regional Nurse said typically the hospice manages the care of a resident (s) who were on their hospice services including ordering any necessary equipment that the resident may need. The Regional Nurse said she was not certain how the process worked at the NF. The Regional Nurse said the hospice nurse came to the NF once a week and the hospice CNA came to the NF 3 times a week. Interview on 04/24/2023 at 1:48pm, the ADON said she was not aware Resident #4's total Braden Scale being a 12 with the last one at 11 signifying high risk for skin breakdown. The ADON said Resident #4 should have been placed on an air mattress. The ADON said it was herself, DON, and the wound care nurse that reviewed the residents Braden scale. The ADON said the unit nurse was the one that does the Braden scale on the residents. The ADON said had she known about resident Braden scale score, she would have ordered an air mattress. The ADON said Resident #4 could not feed himself, turn himself, and required total assistance with incontinent care. The ADON said because of resident total dependence with ADL's, on hospice care, and could not feed himself, placed resident at high risk for skin breakdown. The ADON said the previous wound care nurse should have ordered Resident #4 an air mattress. The ADON said she was new to the facility and was learning something new every day. Attempted interview via phone on 04/24/2023 at 1:56pm and on 04/25/2023 at 1:48pm with the previous wound care nurse was unsuccessful. There was no answer and voicemail had not been set-up. Interview on 4/26/23 at 1:00 p.m. with Resident #4's family member, she stated the hospice aid came about noon, and just left. She bathed him, she changed and shaved him. She said he had stool diaper with no dressing on it, so she went to get a nurse to dress it. Hospice aid told her she hasn't ever seen the wound it just happened last week. Interview on 4/26/23 at 1:12 p.m. with LVN X, she stated that there was not a bandage on Resident #4's wound, but she did not know if there was a bandage on it before. She said the family member came to inform her. She said she told hospice aid as well to come get her so she can provide the daily dressing. Interview on 4/26/23 at 1:15 p.m. with CNA R, she stated that she just changed him right before the hospice nurse came, he had two BMs. She said the wound was covered the first time, the second time the bandage was hanging off, so she took the bandage off, and she put diaper on it. She said she didn't report it to the nurse because she went straight to the dining room to pass trays. Then the hospice aid came in. She said she should report to the nurse, but she didn't get a chance to because she went straight to passing trays. Interview on 4/26/23 at 1:24 p.m. with Regional Nurse, she stated that the ADON and DON should review the MAR together daily and the DON and ADON should review the POC notes from CNA daily as well. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/26/2023 at 2:50pm via phone RN ZZ said the hospice nurse came to the NF at least once a week or more to examine the residents on hospice. RN ZZ said she did not remember the exact date when the hospice nurse came to the NF, or when she worked at the NF. RN ZZ said herself and the hospice nurse went to Resident #4's room together. RN ZZ said she did not do a head-to-toe assessment but stood back and let the hospice nurse assess Resident #4 because the hospice nurse was the primary nurse for Resident #4. The surveyor asked RN ZZ if the hospice nurse assess Resident #4 skin. RN ZZ said she refused to talk to the surveyor anymore because she was not at the NF and did not feel comfortable. RN ZZ told the surveyor to talk to the hospice Nurse. Interview on 04/27/2023 at 12:48pm, the NP said, nor he or the Doctor gave wound care orders to treat Resident #4's sacral wound. The NP said he saw Resident #4 once a month. The NP said he last saw Resident #4 on 04/26/2023 and Resident #4 was looking better compared to prior month. The NP said he was not aware of resident having a wound. The NP said any wound care orders would have come from the hospice agency or the wound care doctor or at the NF. Further interview with the ADON 04/27/2023 at 1:27pm, she said she was new to the NF, and it had been her understanding that residents who were on hospice services, the hospice agency would assume treatment for the wound care because the NF wound care doctor did not see hospice residents. The ADON said the hospice nurse told her that she called doctor at the NF for wound care orders on Resident #4. Interview on 04/27/2023 at 1:35pm, the doctor at the NF for Resident #4 said he did not give any orders for wound care treatment and his NP would know better if wound orders were given for Resident #4. Further interview on 04/27/2023 at 1:40pm, the hospice nurse said she believed she got wound care orders for Resident #4 from the Medical Director of hospice. The hospice nurse said it was RN ZZ that told her that Resident #4 had skin breakdown. The hospice nurse said she told RN ZZ that she would come to the NF to assess Resident #4. The hospice nurse said she could not provide the dates of these happenings because she was driving at the time. Interview on 04/27/2023 at 1:45pm, the Medical Director of the hospice company said he saw so many patients and could not remember Resident #4. The Medical Director said if a resident on hospice care developed a wound in the NF, hospice would collaborate with the NF wound care doctor for a treatment plan. The Medical Director said if the NF did not have a wound care doctor, he would provide orders for that resident on hospice care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/27/23 at 3:35 p.m. with ADON, she stated that she was aware of the sacral wound and became aware around the 8th, when the hospice nurse was notified, but she didn't remember exact date. She stated she reviewed the MAR and reviewed it every morning. She said she looks at it and looks at what wasn't done for example, if a medication was missed. She would look at any events or orders create from the day before. She said she doesn't look at the skin assessments in the system as much as she should but she does about a once a week. She said when wound care nurse left that's when she started looking it. She said she didn't notice the 4/4 skin assessment was missing until after surveyors brought it up. She said she cannot remember going back to ask for it and cannot say that she did. She said for POC and CNA documentation, she isn't really reviewing their documentation. She pulls their reports for compliance, to make sure they were documenting, but she doesn't look at what they were documenting. They just started doing competencies checks with the CNA's, so she doesn't know who was training CNA's before on the correct documentation. The competencies for the CNA's started on Friday (4/21/23), so Monday this week she started on the 24th with competency checks. She said she would agree that the CNA's were the first ones that would notice a skin break down. She stated that the nurse should be told if there was a bandage missing, or any skin breakdown immediately. She stated the risk to resident would be infection, pain, worsening of the wound, not wanting to eat, risk of weight loss if not eating. It can take an hour for a stage 2 or stage 3 wound to develop, it would depend on the resident and their bony prominence. All three hospice residents were on different services. She said she doesn't see hospice nurse review medical records for the facility, she doesn't believe they have access. She said she doesn't review hospice records. The facility has responsibility to hospice patients even when resident was on hospice. The hospice nurse would write the orders and can work with the facility doctor. She said the hospice services would get the air mattress for the residents. She said she sees the system break down with communication between the hospice agency, agency nurses, and the facility. Interview on 4/27/23 at 4:34 p.m. with LVN U, she said she remembered completing the skin assessment on 4/4/23. She said at the time, Resident #4 had a break down on the bottom for a while. She said she doesn't remember what she described on the report, but she said she remembered putting a bandage or patch on it. She said it was kind of a blanched and cracked area near the tip of the spine and buttocks in that area. She said it was open and kind of wrinkled a little bit. She said there was a little patch on it as well. She said she would say it was unstageable. She said the skin to the wound was beginning to open. She said there wasn't an order. She said with him being hospice she didn't know how it worked. She said she didn't tell the doctor or notify hospice. She said she believed that she did talk to Hospice Nurse, but she won't swear on the Bible about telling anyone. She said she remembered putting a patch on it for protection to help. She said the protocol was that she should have gotten an order for it and notify the doctor, but she didn't know the process for the hospice patients. She said she should have called her and told her there was break down. She said that on the 4th she had not been doing dressing changes, and it was new for her. She said she didnt' tell anyone. She said she didn't remember or know if anything was reported between the nurses. She should have spoken about it, and she knows she talked to hospice nurse, but she doesn't remember the exact day. Interview on 04/27/2023 at 5:50pm, the VP of Clinical Services and Clinical Service Director said they realize that the NF had a lot of problems regarding the care of the residents. The VP of Clinical Services said although the NF had a lot of problems it was the responsibility of the DON and ADON to ensure nursing care were being done. The VP of Clinical Services said it was ultimately the responsibility of the Administrator to ensure that the residents were receiving adequate care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview on 04/28/2023 at 8:17am with the hospice nurse regarding the location of Resident #4's wound care orders dated 04/11/2023 of the wound being on the buttock, the surveyor asked the hospice nurse was it an error. The hospice nurse said Resident #4's wound was to his left buttock. The hospice nurse said she could go back to the NF to do another skin assessment on Resident #4. Interview on 05/01/2023 at 10:35am, LVN X said she worked at the NF on a PRN basis. LVN X said she worked all halls including Hall 200. LVN X said she has never done any skin assessments on the residents because the wound care nurse did the skin assessments. Interview on 05/01/2023 at 11:14am with CNA R, she said she worked full time at the NF from 6am-2pm mainly the 200-Hall. CNA R said she had provided care for Resident #4. CNA R said she remembered Resident #4 having some redness to the tailbone area and she told the nurse. CNA R was unable to provide the surveyor the first time she noticed redness to resident tailbone. CNA R said whenever she observed a change in a resident skin like redness or break in the skin, she immediately reported it to the nurse on duty but could not remember the nurse's name. CNA R said a lot of agency nurses worked at the NF. CNA said she remembered one weekend she was providing incontinent care for Resident #4 and a family member assisted with turning Resident #4 on his side. CNA R said on that day, she observed the skin on Resident #4's tailbone area open, no dressing. CNA R said she told the nurse on duty. Record review of the NF staffing schedule on 04/16/2023 revealed that CNA R was Resident #4's CNA and RN TT (agency nurse) was Resident #4's nurse for the morning shift. Interview on 05/01/2023 at 12:25pm, RN TT said she worked at the NF on 04/16/2023 on the morning shift. RN TT said she did not remember anything else about working at the facility and that she would have to review her documentation. RN TT said she worked at the NF one time and that was on 04/16/2023. Interview on 05/01/2023 2:03pm, the wound care doctor said he was not aware that Resident #4 had a wound. The wound care doctor said he would have assessed and provided a treat plan for Resident #4's wound had he known. The wound care doctor said he was at the NF on 05/01/2023 and it was the first time hearing Resident #4 having a wound to the sacrum. The wound care doctor said he made wound care rounds with the Unit Manger on 05/01/2023 and the Unit Manager never mentioned resident wound. Interview on 05/01/2023 at 2:20pm with the ADON, Unit Manager, and VP of Clinical Services said they were not aware that the wound care doctor saw wounds for hospice residents. Record review of the NF policy on Pressure Ulcers revised 2017 revealed in apart: .Pressure ulcers will be evaluated and treated in accordance with professional standards of practice to heal and prevent pressure ulcers .The date and onset is included in the information for the weekly wound tracking sheet and carried over week to week until healed . Record review of the NF policy on Care Design revised 2017 revealed in part: .The facility leadership will plan patient/resident care that will meet the level of the care required by the patient/resident/family and, community . Record review of the NF policy on Hospice Care revised 2016 revealed in part: (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice. It is the nursing home's responsibility to continue to furnish 24-hour room and board care, meeting the resident's personal care and nursing needs .The collaborative care plan will include skin integrity-The care plan should include, for resident who has skin integrity issues or a pressure injury or at risk of developing a pressure injury, approaches in accordance with resident choices, including, to the extent possible, attempting to improve or stabilize the skin integrity/tissue breakdown and to provide treatments if a pressure injury is present .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41870 44333 Based on observation, interview, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing care to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 3 of 9 days reviewed for sufficient staffing. The facility failed to ensure there was sufficient staffing for 04/22/2023 on the 6:00pm-6:00am shift with a facility census of 62 residents where 51 residents required one or two persons assist with transfers. The facility failed to ensure there was sufficient staffing to supervise and provide service for secure unit on 4/22/2023 on the 6:00pm- 6:00am shift for a secure unit census of 19. The facility filed to ensure there was adequate staffing to evacuate 62 residents in the event of an emergency. These failures could place residents at risk of not receiving care and services to meet their needs and could pose a risk in the event of an emergency with evacuation. Findings include: Record review of facility census on 4/21/23 revealed 61 residents. Record review of the facility's CMS 672 form dated 4/21/23 revealed the following: 51 residents required one or two staff assist with transfer 10 residents are dependent in transferring 16 residents have behavioral healthcare needs 56 residents frequently incontinent of bladder 42 residents frequently incontinent of bowel Review of the facility time sheets for 04/22/2023 revealed two staff (LVN U and RN BB) were assigned to 6:00pm -6:00am shift. CNA S was assigned to 2pm-10pm shift. CNA T was assigned to 2pm-10pm and 10pm - 6am shift. Record review of the memory care census revealed 19 residents with diagnosis of Alzheimer's /Dementia, 18 residents that were a fall risk, and 6 residents had behaviors. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 4/22/23 at 7:23pm of the secure unit revealed residents were left unattended in secure unit for 15minutes or more (7;23pm -7:40pm). Observation of each room of the secure unit revealed no staff was present. Four residents were observed in their rooms. Fifteen residents were observed in the main area of the secure unit siting and some walking. A foul urine odor was present. In an Interview on 4/22/2023 at 7:45pm with CNA T (assigned to the secure unit on 4/22/2023), she stated she was asked by LVN U to give other residents on a different hall a smoke break due not having sufficient staff. She stated she thought that the nurse would come and supervise the residents. She said it was difficult to manage the resident's behaviors and monitor residents that were a high fall risk with only one staff. She stated the nurse comes in time to time. She stated that she was responsible for incontinent care, showers, dressing, getting the residents to bed, passing trays, and assisting residents. She reported that it was difficult with one staff to appropriately cater to all the resident's needs. She stated eight residents had behavioral needs. She stated she redirects residents by distracting them with snacks, tv or activities. She stated she tries to keep the residents in one area so she can supervise them all. She stated she does resident incontinent care one by one until she was finished with all residents. She stated she was asked by management to work 10pm - 6pm because there was no staff available. She stated some residents were combative, some had behaviors to include spitting, falling, and physical altercations. She stated she thinks that there should be more staff on the unit. She stated in the event of an emergency she would try her best to evacuate the residents, but she does not think it would be an easy task due to residents on the unit having cognitive communication concerns, memory concerns and not being mentally able to follow directions. In an interview on 4/22/23 at 6:55pm with RN BB, he stated he has worked for the facility for two months. He reported that 2 nurses are assigned to 6pm- 6am shift. He reported staffing is an issue due to people calling in. He stated on the weekends there are many times that CNA's and nurses do not show up for their assigned shift. He stated on 4/22/23 the facility was staffed with 2 nurses and 2 CNA's. He reported that this can cause medications to be administered late as well as call lights being unanswered for a significant time due to no staff being available to help. He reported he normally works on the 100 hall and many of his residents require assistance in the event of an emergency. He stated he would not know how to manage an emergency with the current staffing issues. He reported that he informed the ADON upon commencement of his shift on 4/22/23 when he realized there was not sufficient staff present for the shift. Her response was she was going to speak to the scheduling person and ask her to come to the facility to help. In an interview on 4/22/23 at 7:20pm with LVN U, she stated that CNAs called in and that the facility is short staffed. She stated she doesn't know all the residents that are two persons assist but its many of them. She stated that in the event of an emergency she would try her best to remove residents that are in immediate danger perhaps moving them to another area. She stated it would be difficult with the amount of staff present. She stated that the RN and LVN assigned to the 6pm-6am shift split the medication pass and that they do run a little behind because it's so many residents and short of staff. She stated she would notify ADON about the staffing to see what could be done. She reported that the facility is starting to use agency staff. In an interview on 4/27/23 at 6:10pm with RN BB, he stated the Staffing Coordinator arrived at the facility a little after 8pm and left before 11pm on 4/22/23. He stated she worked on 100 hall completing the duties of a CNA. He stated the secure unit needs more assistance because the CNA is left alone with 19 residents if the nurse must respond to other residents needs within the facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview on 4/27/2023 at 2:58pm, the staff coordinator stated that she makes the schedule for the entire month, she puts it in a binder for staff to sign up for days and utilize agency when staffing is not adequate. She stated that she does staffing biweekly based on the needs of the facility. She stated that she is also considered on call. She stated that there is an on-call rotation to include ADON, CNA N and LVN O and Staffing coordinator. The rotation is changed weekly. The person that is on call will have to come in and cover the shift if a nursing staff calls in. She stated that LVN U texted her on 4/22/23 and told her that there was only one CNA in the building. She stated that the staffing should be 4 CNAs on 2pm-10pm shift to accommodate the needs of the facility. She stated that weekends and holidays staff call in, and that she comes in to assist when situations like this occur. She stated that the secure unit has 19 residents and 1 staff is always present. She stated it is not ideal. She stated that 2 CNA's and 1 nurse would be the ideal staffing to meet the needs of the residents on the secure unit on the 2pm-10pm shift. She stated that she has communicated this to the management and administration staff to include the ADON, DON and administrator. She stated that she does not believe she would be able to evacuate the residents with the staffing on 4/22/23. She stated at no point in time is the secure unit supposed to be left without staff to supervise the residents due to their cognitive needs. She stated she came in on 4/22/23 at 8:28pm and clocked out at 11:17pm. She stated she came to assist with coverage and the needs of the facility. She stated she assigned herself to hall 100 for the time she was at the facility on 4/22/23. She stated that CNA NN was assigned to 10pm-6am shift. She stated CNA NN came in for her assigned shift at 10:58pm-6:52am. She stated that ideally there would be three CNAs for the 10pm- 6am shift to cater to the needs of the census of the facility. She stated that the RVP, Human resources, ADON and DON are aware of the staffing concerns. She stated they facility is combating the issue by utilizing agency staff and on call rotation. She stated they started utilizing agency staff around 4/13/23. In an Interview on 4/27/23 at 3:35pm with ADON, she stated the facility is adequately staffed on the 2pm-10pm shift with 4 CNAs and 2 nursed from 6am-6pm. She stated that the goal for the secure unit to be adequately staffed would consist of 2 CNAs from 2pm-10pm and 1 nurse at 6pm-6am. She stated that she does not have a dedicated nurse for the 6pm-6am shift on the secure unit at this time. She stated that she was not aware of residents being left unsupervised on the secure unit on 4/22/23. She stated that it is her expectation that she would be notified of staffing needs and incidents where residents are left unsupervised. She stated that residents on the memory care unit being left unsupervised could result in injury to residents, elopement, ingestion of things such as sanitizer, and falls. She stated that in the event of an emergency if staff are not present that could pose an imminent risk to the residents on the secure unit. She stated she was made aware at about 7:30pm on 4/22/23 by RN BB that only one CNA was present from 2pm-10pm shift and that CNA was assigned to the secure unit. She stated she contacted the staffing coordinator and was told there is another CNA present at the facility. She stated CNA S was in the break room. She stated that the staffing coordinator was asked to go into the facility to fill in. The ADON stated there is no policy for staffing on the secure unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview on 4/27/23 at 4:27pm with LVN U, she stated she saw CNA T leave the memory care unit on 4/22/23 and she was aware that no staff was supervising the residents on that hall. She stated she did not tell her to go give residents a smoke break and she is not sure where she went. She stated she was gone for about 15minutes. She reported not going to the secure unit to supervise the residents once she noticed CNA T leave the unit due to being busy doing other task and the facility being short staffed. She stated that it could be fatal if a resident fell or needed immediate care, and no one was there to supervise. She stated some residents have behaviors and that would also be a concern, as the residents are vulnerable. She stated in case of an emergency if no one was on the secure unit to supervise the resident it could mean that residents will not know what to do. She stated she knows that there is a lot to be fixed regarding staffing at the facility and meeting the needs of the residents. She stated the residents are not normally left alone. In an Interview with the RVP on 4/27/23 at 4:49pm, she stated that she is now functioning as the Administrator overseeing the facility as of 4/12/23. She stated that she was not aware of any staffing issues on 4/22/23. She stated that she is not aware of any incidents regarding residents being left unsupervised in the secure units. She stated that staff would let her know when there is a staffing issue. Then she would respond by posting a shift online. She stated that both ADON and Staffing coordinator work on call in the event there is a staffing issue. The RVP reported that she believes that the facility has the daily staffing necessary to meet the needs of the facility. She stated that she is actively trying to hire new staff. She stated that in the event of an emergency she thinks the residents on the memory care unit would be alert enough to try to push the emergency door open. She stated that in the event of an emergency the nurses would be alerted by an alarm, and they would respond to the memory care unit. She reported that some of the residents would be able to exit the facility without assistance. She stated she does not know the diagnosis of the residents on the secure unit but believes many of them are there due to wandering. She stated if left unsupervised the residents could fall or if there was a medical emergency needing immediate response it could be detrimental. She stated that some on the residents could have behaviors if triggered. She stated residents are put on the secured unit due to wandering, typically. She stated that there is a dedicated nurse for memory care unit. She does not know who the nurse is. She stated that the staffing system that she has in place is sufficient. She stated there is no policy on the number of staff needed to supervise residents on the secure unit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on interview and record review the facility failed to provide pharmaceutical services that assure accurate acquiring, dispensing, and administering of all drugs and biologicals to meet the needs of residents for each resident 1 out of 8 (Resident #3) residents reviewed for pharmacy services. in that: -The facilityNF failed to administer Resident #3's insulin Lantus as ordered by the physician . Resident #3 did not experience actual harm. This failure could placed Residents #3 at risk for hyperglycemia, diabetic ketoacidosis, and hospitalization . Findings included: Record review of Resident #3's face sheet revealed a 63year old male resident was admitted to the NF on 01/21/2022. The resident's with the following diagnoses that included Type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage from pain and numbness in feet to issues with the functions of internal organs such as the heart and bladder), end stage renal disease (kidney disease), dependence on renal dialysis, absence of left leg below knee, hypertension (elevated blood pressure), and heart failure. Record review of Resident #3's MDS dated [DATE] revealed that resident had a BIMS score of 14 indicating that resident's cognition was intact. Record review of Resident #3's Care Plan dated 02/15/2023 revealed that resident was being care planned for risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diagnosis of diabetes mellitus. Resident interventions included administer medications as ordered per MD, evaluate/record/report effectiveness/adverse side effects. Further review did not reveal that resident was being care planned for refusing his insulin. Record review of Resident #3's Physician Orders revealed the following orders: -dated 12/06/2022 dialysis Tuesday, Thursday, and Saturday -dated 02/08/2023 Lantus 20 units subcutaneous (beneath the skin) for diabetes mellitus once a day at 7:00am -dated 02/07/2023 Blood glucose checks twice a day at 7:00am and 8:00pm -dated 04/12/2023 for a hemoglobin A1C (blood test that measures your average blood sugar levels over the past 3 months). Record review of Resident #3's Nursing Progress Notes dated 04/10/2023 documented by LPN T revealed in part: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Resident refused scheduled long actin insulin. PA notified. Blood sugar was 130 at breakfast time. Checked resident's blood sugar at lunch 179. Resident is in stable condition resting in bed eyes closed call light in reach. Will continue to monitor . Further review of Resident #3's Nursing Progress Notes dated 04/11/2023 documented by LPN T revealed in part: .Resident refused insulin due to no appetite and his scheduled dialysis day. Blood sugar 137 resident is resting eyes closed stable condition shows no s/s (signs or symptoms) of pain or discomfort will continue to monitor. Family and PA (Physician Assistant) notified . Record review of Resident #3's MAR for January 2023 revealed on dialysis days the insulin Lantus was not administered on 8 dialysis days (01/02/23, 01/05/23, 01/14/23, 01/17/23, 01/19/23, 01/24/23, 01/26/23, and 01/28/23). Resident insulin was held on 2 non-dialysis days (01/02/23 and 01/04/23). Resident blood sugars on following days: -01/02/23: Blood sugar at 7:00am 168, 8:00pm 163 -01/05/23: Blood sugar at 7:00am 106, 8:00pm 170 -01/14/23: Blood sugar at 7:00am 128, 8:00pm 205 -01/17/23: Blood sugar at 7:00am 97, 8:00pm 150 -01/19/23: was not documented done at 7:00am. at 8pm blood sugar 230 -01/24/23: was not documented done at 7:00am at 8pm blood sugar 125 01/26/23: was not documented done at 7:00am at 8pm blood sugar 191 01/28/23: Blood sugar at 7:00am 129 at 8pm blood sugar 134 Record review of Resident #3's MAR revealed for the month of February 2023 the insulin Lantus was held 4 times on dialysis days (02/02/23, 02/21/23, 02/25/23, and 02/28/23) with blood sugar ranging from 93-238. Resident insulin was held 1 time on non-dialysis day (02/24/23) resident blood sugar at 7:00am was 90 and at 8:00pm blood sugar was 224. Record review of Resident #3's MAR for the month of March 2023 revealed that the insulin Lantus was held on 8 dialysis days (03/02/23, 03/04/23, 03/07/23, 03/09/23, 03/11/23, 03/14/23, 03/16/23, and 03/18/23), with resident blood sugars ranging from 82-289 and on non-dialysis days the insulin was held 6 days (03/01/23, 03/06/23, 03/08/23, 03/12/23, 03/17/23, 03/19/23, with resident blood sugars ranging from 94-246. Record review of Resident #3's MAR for the month of April 2023 revealed that resident did not receive insulin on 4 dialysis days (04/01/23, 04/04/23, 04/06/23, and 04/11/23) with blood sugars ranging from 120-254 and 2 non-dialysis days with blood sugar ranging from 92-234. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/2023 at 12:50pm, LPN T said she was working the 100-Hall and was Resident #3's nurse. Further interview with LPN T said Resident #3's blood sugar was 130 at 7:00am and anytime it was below 150 she would hold resident's morning insulin Lantus because she was familiar with resident's food consumption. The surveyor asked LPN T if it was the physician order to hold resident insulin Lantus? LPN T said there was not an order to hold resident insulin Lantus, she just done it that way. LPN T said she did not notify the physician about holding Resident #3's insulin and that Resident #3 and herself agreed to hold the insulin when resident blood sugar was below 130. Interview on 04/11/2023 at 1:49pm, LPN T said on the days that Resident #3 did not receive his insulin for the month of April was because resident had refused and that she had documented. Interview on 04/11/2023 at 2:13pm thepm, the mobile DON said that if a resident was refusing their insulin as ordered by the physician, the physician should be notified so that interventions could be put in place to better care for the resident. Interview on 04/11/2023 at 3:05pm via phone with the NP for Resident #3, he said no one from the NF had called him regarding Resident #3 refusing his insulin on 04/10/2023 or any other day. The NP said if Resident #3 had been refusing his insulin, he would first talk to the resident educating resident on the benefits of taking his insulin before making any changes to his medications. Further interview with the NP said Resident #3 did not have PA (Physician Assistance) just himself and the doctor. Interview on 04/12/2023 at 9:00am with the mobile DON and ADON stated confirmed that Resident #3 had a NP that came to see him and not a Physician Assistance. Interview on 04/12/2023 at 9:20am with the RP for Resident #3 stated confirmed that they had never received a call from the NF on 04/10/23 or any other day that resident was refusing his insulin, or that resident insulin was being held on certain days. Observation on 04/12/2023 at 9:46am Resident #3 sitting in wheelchair at the front entrance of the NF wearing street clothing. Resident #3 had a left below the knee amputation (removal of a limb). Interview on 04/12/2023 at 9:46am, Resident #3 said he went to dialysis on Tuesday, Thursday, and Saturday. Resident #3 said he sometime refused his insulin on these days because he sometimes did not feel good but did not refuse his insulin on Monday 04/10/2023. Interview on 04/12/2023 at 10:05am, LVN X said if a resident refused their insulin, she would notify the doctor/NP and document the happenings. Interview on 04/12/2023 at 10:42am via phone RN U said the reason she did not administer Resident #3's morning insulin Lantus on 04/04/2023 was because resident was scheduled to go to dialysis. RN U said she was afraid resident might become hypoglycemic (low blood sugar) and therefore held resident insulin. RN U said she did not inform the doctor/NP of her holding the insulin and that it was nursing judgement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/12/2023 at 11:30am, the mobile DON said she had reviewed Resident #3's MAR for 04/09/2023 and saw where resident insulin Lantus was not being administered as order by the physician. The mobile DON said she had begun to in-service the nurses on administration of insulin. The mobile DON said when insulin wasis not administered as order by the physician, resident blood sugar readings would not be consistent but up and down. The mobile DON said nurse LPN T could not come back to the NF to work and that the NF had suspended LPN T pending further investigation. The mobile DON said LPN T could not be trusted to work at the NF. Further interview on 04/12/2023 at 11:48am, the NP said he learned from the surveyor and speaking with Resident #3 on 04/12/2023 that the insulin Lantus was not being administered as ordered. The NP said by not administering resident insulin as ordered placed resident at risk for becoming hyperglycemic (increase in blood sugar) or go into diabetic ketoacidosis (when the body does not have enough sugar to meet its energy needs, it will break down fat instead) which was not good. The NP said he would look at possibly making changes to resident insulin on dialysis days but first had to draw labs to see what resident Hemoglobin A-1 C level was. Further interview on 04/12/2023 at 12:38pm, the mobile DON said it was herself and the ADON that monitored the resident MARs to ensure that the physician orders were being followed. The mobile DON said she had been working at the NF for 4 weeks. The mobile DON said how herself and the ADON was checking the MARS by reviewing the facility report that showed if all medications had been administered or not given. The mobile DON said she discovered that Resident #3 insulin was not being administered as ordered by the physician on 04/09/2023. The mobile DON said she began to in-service the staff regarding following physician orders and notifying the doctor when a resident (s) insulin is held or if the resident refused the medication. Record review on 04/12/2023 of in-service done with the NF staff on insulin medication administration documentation, 5 rights of medication administration, and when a resident refuses to take insulin the doctor and RP must always be notified, dated 04/10/2023. Record review of physician orders for residents on dialysis revealed that Resident #3 was the only resident that received insulin. Interview on 04/13/2023 at 1:55pm, the ADON said the NF ran a facility report on the MARS each morning and it was reviewed by herself and the DON. The ADON said if a resident refused their insulin, the unit nurse should be calling the physician to notify that resident refused their insulin. The ADON said she had to be honest that due to her being pulled in so many directions and the only ADON, she had not had time to review the facility report and follow-up with the nurses to ensure that physician orders were being carried out. The ADON said LPN W was and Agency nurse. The ADON said she did not know if the NF had in-serviced agency staff on notifying the physician if a resident refused their insulin or if the insulin had to be held. The ADON said she was never involved in any in-services or training with agency staff. Interview on 04/13/2023 at 2:50pm, RN V said she worked at the NF PRN. RN V said she remembered caring for Resident #3. RN V said if the medication insulin was held, she documented that she notified the doctor via text or phone. The surveyor informed RN V that the surveyor was unable to locate in the Nursing Progress Notes that Resident #3's physician or NP had been notified of insulin refusal or that the insulin was held until 04/10/2023 by LPN T. LPN T did not respond after the surveyor informed her of this. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview on 04/13/2023 at 4:35pm with the NP said he had reviewed Resident #3 blood sugars and resident blood sugars were good overall. The NP said he had ordered a hemoglobin A1C 3 days ago and was waiting on the results. Record review of Resident #3's Hemoglobin A1C labs revealed the following: -dated 04/16/2023 reading 6.3 (normal range 4.5-5.7) -dated 11/20/2022 reading 6.0 -dated 06/27/2022 reading 5.1 Interview on 04/17/2023 at 1:05pm, the Regional Nurse and mobile DON said it was the responsibility of the DON to ensure that staff was being trained and in-serviced on when to notify the physician of any changes regarding the residents medical care including refusal of medications or if a medication his held. The mobile DON said she could not locate the staff training/in-service binder for the NF. The DON said the NF had not had a steady DON for a while. Attempted interview on 04/17/2023 at 1:45pm via phone with LPN W regarding Resident #3's insulin not being administered as ordered, no answer, left voicemail with a call back number. Interview on 04/17/2023 at 1:50pm via phone LPN W said she was an agency nurse that had been coming to work at the NF for about 2 months on a prn basis (as needed). LPN W said she had not received any in-service on when to notifying the physician regarding medications. LPN W said she did not remember Resident #3. LPN W said if she held insulin Lantus, it was a nursing judgement call and that she did not call the doctor every time she held insulin. Interview on 04/19/2023 at 10:30am, the mobile DON and the Regional Nurse said the NF did not have a policy on insulin administration. The surveyor asked the mobile DON and Regional Nurse for the NF policy on management of medication administration for dialysis residents. The Regional nurse said she would have to look and see if the NF had such a policy. The mobile DON said Resident #3 was the only dialysis resident that had an order for insulin. The mobile DON said she had done in-service on blood glucose monitoring check off list with the staff and in the following weeks she would be ensuring that all staff had their competencies check off list done. The DON said she would be doing a QAPI (Quality Assurance Performance Improvement) and PIP (Performance Improvement Project) on insulin administration. Interview on 04/19/2023 at 10:48am, the Doctor for Resident #3 said he and his NP were the only medical health care providers that gave orders on Resident #3 at the NF. The doctor said he learned from his NP that the Nursing staff at the NF werewas not administering resident's insulin Lantus as ordered. The doctor said a conversation needed to be had with him and the NF regarding resident refusing medication Lantus, that he could look at other alternatives involving resident medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/19/2023 at 11:08 am, the Pharmacist said she came to the NF each month and that she was coming to the NF on 04/20/2023 to do the NF Drug Regimen Review. The Pharmacist said she had been working at the NF for 6 months and that the NF had 4 DON's working at the NF in that time frame. The Pharmacist said she reviewed Resident #3's medications on last month and did not make any recommendations. The Pharmacist said she did not review the residents MARS because she did not have access to the MARS therefore did not know that the nursing staff was not administering resident insulin as ordered by the physician. The Pharmacist said the nursing staff should not have been holding Resident #3's Lantus unless they had parameters given by a physician. The Pharmacist said it would have been okay to administer the insulin on dialysis days. The Pharmacist said if she had known that Resident #3 was refusing his insulin-on-dialysis days, she would have made a recommendation to the doctor to administer the insulin in the evenings after dialysis that way resident could still receive the insulin. The Pharmacist said when the insulin wasis not administered as order, the blood sugar level could rise damaging the kidneys further and Resident #3 was already on dialysis. Record review of the NF Policy on Medication Management Program revised 2017 revealed in part: .The facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements .The facility will collaborate with the Medical Director and the attending physician on the application of the drug formulary and therapeutic change . Record review of the NF Policy on documentation-Licensed Nursing pertaining to the patient/resident will be recorded with regulatory requirements revised in 2017 revealed in part: .If a scheduled medication is withheld or not give as ordered, the nurse documents this and list the reason for the patient/resident not receiving the medication. The attending physician or physician extender must be notified. Route must be charted .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 44333 Based on interview, record review and observation, the facility failed to ensure each resident was provided with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 59 of 61 residents that receive food from the kitchen. 1.The facility failed to have an effective system in place to ensure sufficient and routine replenishment of food for all residents. 2.The facility failed to have a trained Dietary manager on staff to supervise staff, ensure sanitary work environment and ensure balanced meals were being provided to residents at assigned mealtimes. 3.The facility failed to provide approved and adequate substitutions. 4.The facility failed to have an effective system in place to ensure food was properly stored and that expired or spoiled food items were discarded. This failure had the potential to affect all facility residents who consumed food from the facility's kitchen. The findings included: Observation of the kitchen inventory of food supplies on [DATE] beginning at 11:08am revealed: The food supply on hand was only sufficient for one lunch or dinner meal to feed the entire census (59 residents eat food from the kitchen) based on the amount per serving of available food items: The facility has a 10 lbs. chuck roast which could serve 50 residents giving them 3 oz of protein. They also had 7 and ,d+[DATE] quarts of mix scrambled eggs, which would feed 50 residents. For produce, the facility had tomatoes that were rotten, spinach that was slimy and rotten. They had some parsley. Observation of the refrigerator in the main kitchen area on [DATE] beginning at 11:08am revealed the following: A container of eggs, with a used by date of [DATE]. Unlabeled, undated container of what appears to be peaches. Unlabeled, undated container of what appears to be macaroni and cheese. Unlabeled, undated, open container of what appears to be sliced meat. Unlabeled, undated open sliced cheese. Unlabeled, undated box of chicken with liquid residue spilling onto refrigerator. Undated open carton of scrambled eggs. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with [NAME] D on [DATE] at 11:15am, he stated he did not have the food available to cook that was on the menu for today. He stated that he would substitute spaghetti, but he does not have the ground meat. He stated he does not know what he will cook and was trying to figure it out. He stated the substitution items also were not available. He stated that he was not the one who orders food supply for the kitchen. He said the previous dietary manager who no longer works at the facility was responsible for ordering the food. He stated the administrator was now the person that orders the food. He stated that they do not have produce, as the produce they do have was molded. He stated the administrator was made aware they needed food on [DATE] and she told him she would work on it. He stated food should be labeled and dated so that they do not serve food that was not edible or within the use by date. Observation of lunch being served on [DATE] revealed lunch service began at 1:40pm and the last trays for lunch was served 2:24 pm. 6 to 7 residents received grilled cheese. Record review and observations for lunch and dinner on [DATE], revealed the items on the menu was not served. Lunch menu for [DATE] revealed teriyaki chicken, fluffy rice, seasoned mixed vegetables, fresh baked roll, frosted cake. Lunch menu served to residents on [DATE] was sliced pork, mashed potatoes, and cauliflower. Some residents observed eating grilled cheese sandwiches at lunch. Undated dinner menu revealed hot roast beef sandwich, baked potato, broccoli & cauliflower, gelatin cubes with whip topping. Dinner menu served to residents revealed chopped ham mixed with corn, beans, and cauliflower. Observation on [DATE] at 2:00pm of the refrigerator in the main kitchen area near the steam table revealed a box of molded rotten tomatoes, 1 bag of parsley, 5 bags of spinach with black liquid. Observation of lunch being served on [DATE] revealed lunch service began at 1:30pm and the last trays for lunch was served at 2:25pm. Record Review of Mealtimes posted in the dinning room of the facility revealed Breakfast is between , d+[DATE]am, Lunch 12pm and dinner 5pm. Record review and observations for lunch and dinner on [DATE], revealed the menu item was not served. Lunch menu for [DATE] revealed red beans, rice & sausage, seasoned greens, fresh baked roll, cinnamon baked apples. Lunch menu served to residents revealed fries and sliced sausage. Dinner menu dated [DATE] revealed Turkey club sandwich macaroni salad, pickled beets, frosted chocolate cake. Dinner menu served to residents revealed chuck roast and beans. Observation of lunch being served on [DATE] revealed lunch service began at 2:30 p.m. Interview with Resident #2 on [DATE] at 1:48pm, he stated he has been waiting for 45 minutes for lunch. He stated he was very hungry and asked a dietary aide whose name he can't remember when food will be ready. He stated he was told it would be soon, but he has been waiting a long time. Interview with Resident #5 on [DATE] at 1:55pm, she stated she has been waiting for food and she was hungry. She stated the facility needs to hire more dietary aides and cooks because residents were hungry and have been waiting a long time. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Resident #6 on [DATE] at 1:56pm, she stated she has been waiting 1hr and 30 mins for lunch. She stated breakfast was a long time ago and she was starving. Interview with Resident #7 on [DATE] at 2:02pm, she stated she came to the dining area around 11:30am. She stated the staff normally start serving lunch between 12pm and 12:30pm. She stated there was no snack other than the vending machine because when she goes to the kitchen, they are busy or shorthanded and no one comes to the door. She stated there was no snacks at the nursing station. Interview with Resident #10 on [DATE] at 2:08pm, she stated she had not been served lunch and that she was still waiting. She stated she was hungry. Observation on [DATE] at 2:09pm Resident #4, observed still awaiting lunch. Interview with Resident #8 on [DATE] at 2:15pm, she stated that she was hungry and waiting on lunch. Interview with Resident #9 on [DATE] at 2:25pm, she stated she had been waiting for 2 hours for lunch and was offered a grilled cheese sandwich. She stated she asked for ham and there wasn't any ham left. Observation and interview on [DATE] at 2:28pm with Resident #7 she stated the staff ran out of food and gave me a grilled cheese sandwich. Observation revealed a half-eaten grill cheese sandwich on the plate in front of Resident #7. Observation of the kitchen on [DATE] at 2:20pm during lunch revealed the food serving trays were empty and the administrator was preparing grilled cheese sandwiches. Interview at [DATE] at 2:21pm with Administrator she stated [NAME] D abandoned his shift and she was now the cook and the administrator. She stated she had her food handler's certificate. She stated she was making grilled cheese sandwiches because residents requested it. When asked if there were any other food options for residents, she stated the residents requested grill cheese. Interview on [DATE] at 11:45am with [NAME] C he stated he did not know what he was cooking that day and that he did not have the food supply to cook what was on the menu for that day. He states he contacted the Administrator, and she told him to find a substitute. He stated the person responsible for ordering food was the dietary manager who no longer works at the facility. He stated that the administrator was responsible for ordering food and that the last time he worked was [DATE] and he told the administrator on [DATE] that they needed food supplies. Interview on [DATE] at .with Dietary Aide A, she stated she last worked on [DATE] and she informed the administrator that the kitchen needed juice and snacks for the residents. She said the administrator told her she would handle it. She stated that she came back to work today [DATE] and there was not enough food supplies and still no juice or snacks ordered from her request that was made on [DATE]. Observation of the steam table on [DATE] at what time before lunch service revealed green peas at 25 degrees, chopped pork at 99 degrees, pureed peas at 125 degrees, pureed meat at 120 degrees. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In interview with RVP on [DATE] at 12:00pm, she stated the administrator oversees the facility, and the kitchen as much as she can. She did not review the sanitation report but had received it via email. She has not been in the kitchen, only to the door. She reported it's between the dietician and the administrator when they review the sanitation report, they discuss how they would solve the issue. She can' not confirm what the issues were [DATE] regarding the sanitation report. She stated Administrator oversees the overall operation of the facility. Stated she does not expect to be told everything that was going on in the building as that was not her role, she was the consultant. She said the administrator was the top of the chain at the facility, and she does not overstep her position. She stated she believed the facility was running well but based in this interview she would agree the system the administrator was using was not working. In an interview with the Dietician on [DATE] at 12:45pm, she stated that the administrator contacted her on [DATE] about substituting menu for hotdog on a bun and peaches. She stated the administrator did not inform her of the menu that was supposed to be served. The Dietician stated she instructed her to substitute bread for bread, protein for protein, starch for starch and fruit and vegetable for fruit and vegetable. She stated residents consuming food that is expired and have no use by date, can have an increased risk of being sick. The Dietician stated there was a list for approved substitutions and was represented by replacing protein for protein, vegetable for vegetable, bread for bread, starch for starch and fruit for fruit. The Dietician stated the approval for [DATE] was not represented in the meal served. She stated without the appropriate substitution, residents can be at risk of not getting the appropriate amount of protein and caloric nutrition, which can lead to weight lost. In an interview with Administrator on [DATE] at 2:00pm, she stated a Dietary manager has been hired but has not started. Stated the facility has been without a dietary manager since the beginning of [DATE]. She stated on Thursday [DATE] she did rounds in the kitchen and observed the cleanliness, food storage and did not take inventory. She stated on [DATE] the kitchen was clean, and all items were labeled and dated. She stated human resources did rounds on Friday [DATE] in the kitchen as well ensuring it was clean and food items were stored correctly. She stated she would expect the kitchen to get dirty during service and cleaned daily. She stated that she did not keep a log of her kitchen audits because it was not a regulation. She stated that her audits are by pop ins and the area she audits varies. She stated she reviewed the sanitation report with the dietician and corrected all the issues. She stated she did go a little low on emergency food supply and she ordered more food on [DATE]. She stated the kitchen currently has adequate shelving. She stated she cleaned off the can opener because it was a little dirty and did not purchase a new one. She stated if the kitchen was unsanitary, it can pose a risk to residents due to cross contamination. She stated certain meat if not kept at the right temperature can cause residents to get sick. She stated that food not dated or labeled can cause the kitchen staff to not be able to tell how long it can be used. She stated she could not answer whether everything was dated, labeled and in accordance with professional standards of food service because she had not been back there today. She stated if dishes are not being sanitized correctly it could cause the dishes to be cross contaminated. In an interview with Medical Director on [DATE] at 3:00pm, he stated he was not informed of food issues and diet substitutions at the facility. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's undated nutritional policy revealed that resident's will be served liberalized diets that a resident would eat at home, unless otherwise indicated by Physician/registered dietician nutritionist assessment. The policy also revealed that meals will be served at consistent times daily with controlled portions. The key points of the policy revealed that the facility should: o Meet nutrition needs and enhance quality of life. o Identify the resident's nutrition care preferences/choices. o Optimize meal intake and increase satisfaction with meals. o Promote enjoyment and consumption of meals to prevent unintended weight loss and under nutrition. Record Review of the facility's undated nutrition policies related to purchasing reflected: - a system is in place to identify items needed, based on the menu, from the grocery, bread, dairy, and produce vendors. No salesperson is permitted to inventory and order food or supplies for the facility. - Check in each order as it is delivered, making certain that items are delivered as ordered and are not damaged. - Order and receive non-food supply according to need from supply inventory sheet in the same manner as food orders.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 15976 44333 Based on observation, interview and record review, the facility failed to provide enough support personnel to carry out the functions of the food and nutrition service safely and effectively as evidenced by: The facility failed to have to sufficient staff who were trained in the kitchen to prepare meals and to have delivery of meals in the required time frame. The facility failed to ensure that the Cooks were trained to prepare modified diets in a form and consistency to meet resident's needs. This failure had the potential to place residents at the facility at risk of mealtime irregularity and loss of appetite resulting in weight loss and decreased psycho-social well-being. Findings Included: In an interview on 04/10/2023 at 11:00am with Dietary Aide G revealed that lunch was supposed to be served between 11:45 am and 1:00pm. She said that they were running late because the dietary aide had called in and [NAME] C was the only one working that morning. She said she came in to help [NAME] C. Observation on 04/10/2023 at 11:15am revealed [NAME] C preparing potatoes to put in the oven to bake for lunch. No other menu items were noted at that time. Interview on 4/10/2023 at 11:15am [NAME] C said he was behind and had not done preparing all the menu items for lunch because he was the only one working that morning. He said, he was going to prepare chopped pork and green peas with the bake potatoes for lunch. Observation of the facility's kitchen on 4/8, 4/9, 4/10 and 4/16/2023 between 11:00 am and 5:00 pm revealed the following: The hand washing sink beside the stove had brown stains all over it. The grill had an accumulation of burnt food particles on it. The stove top and had burnt food particles and grease on it, inside the oven were burnt food particles, food spillage and grease on the inside. The sides of the grill and stove had dried food on them. The wells of the steam table were black from burnt food particles and the water in the wells was brown. The sneeze guards had dried food particles on them. The shelf under the steam table had food stains and dried food particles on it. The floor of the kitchen had had debris, food spillage and dirt on it. The three-compartment sink was full of dirty dishes, dishes from breakfast was not washed they were still on the cart at the entrance door to the dish room from the dining room. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the steam table on 4/10/23 at 1:40pm before lunch service revealed green peas at 125 degrees, chopped pork at 99 degrees, pureed peas at 125 degrees, pureed meat at 120 degrees. These menu items had to be reheated to 165 degrees F. Observation and interview on 04/10/2023 beginning at 1:45pm during the preparation of the pureed menu items revealed [NAME] C preparing the pureed diet for the lunch meal. [NAME] C took some pork and put it in the food processor and added water and blend it. For the peas he used 6 scoops using the #12 scoop which is equivalent to 2 and 3/4 ounces and put 6 scoops in the food processor and added some water and blend it, for the bake potatoes he put 8 potatoes in the food processor added water and blend it. [NAME] C did not peel the potatoes, he blended it with the skin. Observation revealed, and he did not measure any of the menu items, used plain water, and he did not use a recipe. At that point Dietary Aide, C said she was going to do another set of pureed baked potatoes, because the one on the steam table has skin and it was not smooth. She took the potatoes, peeled them and blended them. In an interview on 4/10/2023 at 2:00pm Dietary Aide C said that pureed meals needed to be smooth so that the resident could not choke on it and that was why he peel the potatoes. She said [NAME] C should peel the potatoes before he blends them to prevent residents from choking. Interviews with multiple residents between 4/8/2023 and 4/9/2023 during lunch revealed that they were waiting for lunch which was supposed to be served around 12 noon. Residents stated they have been waiting for two hours and they are hungry. Residents were told they ran out of food and was offered grilled cheese. Residents stated the kitchen was short staffed and they do not normally eat this late. Observation of lunch service on 4/8/23, and 4/09/2023 revealed the last trays for lunch was served 2:24 pm. On 04/10/2023 at 2:10pm revealed lunch was not served, and residents were observed waiting in the dining room. Further observation revealed residents asking for lunch. Lunch was served at 2:30pm. In an interview with [NAME] C on 4/10/2023 at 2:05pm he said he did not have a recipe for the pureed diet. He further stated he was not trained on preparing pureed diet. Asked why he did not peel the potatoes he did not answer. In an interview on 4/11/2023 at 12:55pm with Dietitian A she said that the staff were in-serviced on pureed diet when she was last in the facility. She said she was not sure if the current staff in the kitchen were trained and that she was going to in-service them again. She stated that the last time she was in the facility was 3/28/2023 and she did a sanitation audit. She said she had given a copy to the Administrator but was not sure if she had followed upon the concerns. Interview on 4/12/1023 between 12:30pm and 1:00pm with residents who eat in the dining room revealed lunch was always late. They said they need more staff in the kitchen to get lunch early. Observation on 4/12/2023 during the lunch services revealed that lunch was served at 1:45 pm. Observation of the kitchen on 4/16/2023 at 4:45pm revealed [NAME] D and Dietary Aide G in the kitchen preparing for the evening meal. Disposables were being used to serve the dinner meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/16/2023 at 4:50 pm with the Dietary Aide G she said the dietary aide who was supposed to work the morning shift called in and now that was why they are running late. She said that [NAME] D came in to help [NAME] C. She said she came in and did what she was supposed to do. She said the dirty dishes from lunch was still on the table in the dining room. The trays with dirty dishes from lunch was observed at the door of the dish room doorway. Observation on 4/16/2023 at 6:00pm revealed residents sitting in the dining room waiting for their meals. They stated it was 6:03pm and they had not gotten their dinner yet. Dinner tray was served at 6:05pm. In an interview on 4/16/2023 between 6:00pm and 6:10pm with residents who ate in the dining room revealed meals were late at times. They said lately meals were served very late. In an interview on 4/16/2023 at 6:10pm with [NAME] D he said [NAME] C was the only one who worked on the morning of 4/16/2023. He said he came in a little early to help [NAME] C, because they were short staff, but they try to ensure that residents got their meals. He said he was going to clean the dishes and pans before he left for the day because they were unable to clean the dishes after lunch because of they did not have the staff and that was why they had to use disposable for dinner. Further interviews conducted with [NAME] D and Dietary Aide G on 4/16/2023 at 6:15pm said they were not in-service on the issues in the kitchen. They said they have new dietary manager, and they will be in-servicing them starting 4/17/2023. In an interview with the Dietary Manager on 4/17/2023 at 10:30am she said they were short on staff. She said she heard about the staff issue Sunday morning after the fact. She said they were interviewing and hope they will be adequately staffed soon. Record review of the Leadership policies and procedures dated 11/1/2017 read in part . Subject: Staffing The facility leadership will provide enough staff to successfully implement patient/resident functions. Purpose: To provide sufficient staff with appropriate competencies and skills to provide nursing and related services to assure resident's safety and maintain the highest practical, physical, and mental wellbeing. Procedures: Provides qualified personnel based on organizational mission, scope of service provides the population served, and federal and state certification and licensure requirement. Nutritional Needs: Employs sufficient support personnel competent to carry out the functions of dietary services.'

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	675214	A. Building B. Wing	05/01/2023

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41870 44333 Based on observations, interviews, and record reviews, the facility failed to ensure that the menus were followed and served on time for 4 of 4 observed meals in that: 1. Residents were served sliced pork, mashed potatoes, and cauliflower instead of teriyaki chicken, fluffy rice, seasoned mixed vegetables, fresh baked roll and frosted cake for lunch on 4/8/2023. 2. Residents were served chopped ham mixed with corn, beans, and cauliflower instead of hot roast beef sandwich, baked potato, broccoli & cauliflower, and gelatin cubes with whip topping for dinner on 4/8/2023. 3. Residents were served fries and sliced sausage instead of red beans, rice & sausage, seasoned greens, fresh baked roll, cinnamon baked apples for lunch on 4/09/2023. 4. Residents were served chuck roast and beans instead of Turkey club sandwich macaroni salad, pickled beets, frosted chocolate cake for dinner on 4/9/2023. This deficient practice could affect residents who received meals and snacks from the kitchen by contributing to dissatisfaction, poor intake, and/or weight loss. The findings included: Interview with [NAME] D on 4/8/2023 at 11:15am, he stated he did not have the food available to cook what was on the menu for today. He stated that he would substitute for spaghetti, but he does not have the ground meat. He stated he does not know what he will cook and is trying to figure it out. He stated the substitution items also were not available. He stated that he does not order the food supply for the kitchen, the previous dietary manager who no longer works at the facility was responsible for ordering the food. He stated the administrator is now the person that orders the food. He stated that they do not have produce, as they are molded. He stated the administrator was made aware they needed food on 4/7/2023. He stated she said she would work on it. He stated food should be labeled and dated so that they do not serve food that is not edible or within the use by date. Interview with Resident #2 on 4/8/2023 at 1:48pm, he stated he has been waiting for 45 minutes for lunch. He stated he was very hungry and asked a dietary aide whose name he can't remember when food will be ready. He stated he was told it would be soon, but he has been waiting a long time. Interview with Resident #5 on 4/8/2023 at 1:55pm, she stated she has been waiting for food and she was hungry. She stated the facility needs to hire more dietary aides and cooks because residents were hungry and have been waiting a long time. Interview with Resident #6 on 4/8/2023 at 1:56pm, she stated she has been waiting 1hr and 30 mins for lunch. She stated breakfast was a long time ago and she was starving. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the menu for lunch on 4/8/2023 revealed the menu item posted was not served. The posted menu consisted of Teriyaki chicken, fluffy rice, seasoned mixed vegetables, fresh baked roll, and frosted cake. Observation of the lunch menu served on 4/8/23 at 2:34pm revealed sliced pork, mashed potatoes, and cauliflower. Some residents observed eating grilled cheese sandwiches. Record review of the undated dinner menu on 4/8/2023 revealed hot roast beef sandwich, baked potato, broccoli & cauliflower, and gelatin cubes with whip topping. Observation of dinner on 4/08/2023 at 6:00pm served to residents revealed chopped ham mixed with corn, beans, and cauliflower. Interview on 4/9/2023 at 11:45am with [NAME] C he stated he did not know what he was cooking that day and that he did not have the food supply to cook what was on the menu for that day. He states he contacted the Administrator, and she told him to find a substitute. He stated the person responsible for ordering food was the dietary manager who no longer works at the facility. He stated that the administrator was responsible for ordering food and that the last time he worked was 4/7/2023 and he told the administrator on that date that they needed food supplies. Interview on 4/9/2023 at 11:50am with Dietary Aide A, she stated she last worked on 4/7/2023 and she informed the administrator that the kitchen needed juice and snacks for the residents. She stated the administrator stated she would handle it. She stated that she came back to work today 4/9/2023 and there aren't enough food supplies and still no juice or snacks ordered from her request on 4/7/2023 Record review of the posted menu for lunch on 4/9/2023 revealed red beans, rice & sausage, seasoned greens, fresh baked roll, cinnamon baked apples the menu items posted were not served. Observation of the lunch Menu served on 4/9/23 between 1:30 and 2:24pm revealed the meal served to residents were fries and sliced sausage. Record review of the dinner menu on 4/9/2023 revealed Turkey club sandwich macaroni salad, pickled beets, and frosted chocolate cake. The menu was not served Observation of dinner service on 4/9/2023 at 6:00pm revealed that residents were not served what was on the menu, they were served chuck roast and beans. Record review of the Nutrition Policies and Procedures dated 8/1/2020 read in part . Subject: Menus Policy: Menu will be planned to meet the Nutritional Needs and preferences of the patients in accordance with the recommended dietary allowances of the food and nutrition board. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Two four-weeks menu cycles per year are utilized. They are plans to include 5 servings of grains, 5 servings of fruits, and vegetables, 2 servings of milk, eggs or cheese (as protein source) per day. Procedures: 1.Utilize a facility menu to best fit the preferences of the patient or resident. The NSD is encouraged to hold a meeting for all residents prior to the start of the cycle menu. The NDS may modified the menu to meet the preference of residents, substituting foods of similar nutritive value for those items that were replaced. The facility's dietitian approves and signs all menus, diet modification, and menu changes. 5. The current menu is posted in the facility, so it's available to the residents and staff. 6. Plan menu in advance and keep file for 6 months. 7. Make appropriate substitutions when items on the menu are not available. 8. Substitutions offer similar nutritive value. 9. Provide an alternative entree, vegetables, and starch at lunch and dinner to allow choice and meet the needs of resident who refuse the original menu.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 15976 44333 Based on observation, interview and record review, the facility failed to prepare food by methods that conserve nutritive value, flavor, and appearance to 8 residents who received a pureed diet in that. The facility failed to follow the recipe for pureed menu items. The facility failed that foods were prepared by methods that conserved nutritive value and flavor. These failures could affect all residents who received pureed meals by placing them at risk of weight loss, altered nutritional status and diminished quality of life. Findings included: Observation on 04/10/2023 at 1:45pm during lunch preparation of pureed menu items revealed [NAME] C preparing the pureed diet for the lunch meal. [NAME] C took some chopped pork put it in the food processor and added water and blend it. For the peas he used the #12 scoop which is equivalent to 2 and 3/4 ounces and put it in the food processor and add some water and blend it, for the potatoes he put the potatoes in the food processor and blend it. [NAME] C did not peel the potatoes he blended it with skin, and he did not measure any of the menu items. [NAME] C did not use a recipe. Record review of the of the undated recipe for Pureed Potatoes revealed 1 portion of potato place in food processor and add juice from meat until desired pudding like consistency was reached. Puree should be smooth texture, no lumps, liquid must separate from solid, may not be sticky. Shows some very slow movement under gravity, but cannot be poured, hold shape on spoon & fall off spoon in a spoonful. In an interview on 4/10/2023 at 1:55 p.m. with [NAME] C he said he did not have a recipe to follow for the pureed food. He said he was preparing pureed meals for 8 residents. He said he used water as liquid. It was explained that she did not measure the portion size of the menu items or the liquid. At that point he did not say anything. He said he was not trained to prepare pureed menu items. Observation on 4/12/2023 at 12:30pm revealed [NAME] C preparing pureed meat. He put the meat in the food processor went to the juice machine and got some juice and was about to pore the juice on the chicken. At that point the Surveyor intervened and asked what kind of juice he had, and he said it was lemonade. At that point he made some broth and blend the chicken. Interview with [NAME] C on 4/12/2023 at 12:45pm regarding the use of lemonade to puree the chicken he said he eats everything. Asked what should be used to puree the meat he did not answer. Record review of the undated pureed recipe for baked potato for 10 residents (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Potatoes, [NAME] 10 each Ground Pork 1 3/8 lbs. Cheese Cheddar grated 5/8 lbs. Sour Cream 5/8 cups. Puree: Smooth texture, no lumps, liquid must separate from solid, may not be sticky. Shows some very slow movement under gravity, but cannot be poured, hold shape on spoon & fall off spoon in a spoonful. Record review of undated Seasoned [NAME] Peas for 10 Peas, green frozen 1 3/4 lbs. Pepper black 1/4 Tsp Salt 5/8 Tsp Margarine 0.05lbs. 1. Place peas in pot. Cover with minimum amount of boiling water. Simmer about 5 minutes until tender. Do not overcook. 2. Pureed Instructions: (Portion size=#8 dipper) Measure 1/2 cup cooked peas and 1 TBSP water for each serving needed into food processor. Blend until smooth. Pour into baking pan, cover, and reheat to 165 degrees before serving. Discard any leftover product at the end of meal service. Notes: 1. 4Pureed: Smooth texture. No lumps, liquid must not separate from solid, may not be sticky. Shows some very slow movement under gravity, but cannot be poured, hold shape on spoon & fall off spoon in a single spoonful. In an interview on 4/11/2023 at 12:55pm with Dietitian she said that the staff were in-serviced on pureed diet when she was last in the facility. She said some of the kitchen staff were new and she was not sure if they were in serviced. She said she said that she was going to in-service them again. Observation of Test Tray done on 4/14/2022 at 1:50pm revealed the following: Pureed carrots had no flavor it was bland, Pureed Lasagna was very spicey (hot from black pepper). Chicken had no flavor (bland). The meal did not look appetizing it had all the same color. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Dietary Manager on 4/14/2023 at 1:55pm she said the lasagna was very spicy/peppery, the carrots and chicken had no flavor. She said she was going to have the staff in-service on the use of black pepper and ensure the menu items had flavor and the colors were not the same. Regarding the color she said she told one of the tray aides, the colors were the same when the tray line was set up. Observation and interview on 4/21/2023 beginning at 12:20pm of lunch revealed [NAME] E serving lunch, [NAME] E took a plate put some pureed vegetables, pureed meat, and pureed bread on the plate. He then put regular Twice Baked Potato Casserole on the plate. At that point the Surveyor asked what modified diet he was serving, and he said it was a pureed diet. Asked at that point if that was pureed Twice Baked Potato Casserole and he did not answer. Further observation revealed no pureed starch on the steam table. [NAME] E then took some Twice Baked Potato Casserole and put it in a pan pour some water from the faucet and pour it on the Twice Baked Potato Casserole, put it in the food processor and blend it. He did not measure the ingredients. In an interview on 4/21/2023 at 12:40pm [NAME] E was asked if he was trained on pureed diet he said No. The Surveyor at that point asked if he had tasted the pureed potato for flavor, he said it had flavor because the regular Baked Potato Casserole had flavor. At that point he was asked to take the temperature of the pureed baked potato casserole and it was 96.7 degrees F. He then took the pureed potato off the steam table and reheat it to 165 degrees F. Record review of Ingredients for baked potato casserole Bacon 1/10 pounds bacon Potato pearls dry 1/2 pounds Cold water 3 5/8 cups Dry Mince onion 1 1/4 Tsp Sour Cream 3/8 cups Shredded Cheddar Cheese 1/8 pound 5. Puree & Mechanical Soft Instructions: Portion size is 1/2 cup. Measure 1/2 cup prepared casserole for each serving needed into food processor. Blend until smooth. Pour into greased pan, cover, and reheat to 165 degrees F or higher. Discard any product left at the end of meal service, do not reheat. Notes: 1. For Pureed: Measure desired # of servings into food processor. Blend until smooth. Add liquid if product needs thinning. Add commercial thickener if needs thinning. Add commercial thickener if product needs thickening. 2. For Pureed: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Smooth texture. No lumps, Liquid must not separate from, may not be sticky. Shows some very slow movement under gravity, but cannot be poured, hold shape on spoon & fall off spoon in a single spoonful. Record review of the monthly audit dated 3/28/2023 revealed that the kitchen staff was in-service on food storage/dry food storage, storage in refrigerator and freezer, dish machine, kitchen sanitization. Record review of the Nutritional Policies and Procedures date 8/1/2020 read in part . Subject: Food Preparation: Policy: Food will be prepared and attractively served using methods that conserve nutritive value, flavor, and appearance. 5. Batch cook vegetables to conserve nutrient value and maintain flavor and color. 6. Prepare altered consistency foods such as ground, chopped and puree foods to meet the patient's/resident's individual needs and satisfaction. The facility will use the international Dysphagia Diet Standardization Initiative (IDDS) as the foundation for texture modified foods and thickened drinks provided to residents.

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	675214	A. Building B. Wing	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 44333 Based on observation, interview and record review, the facility failed to ensure that foods are store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen in that. The facility failed to ensure that foods were sealed, labeled, and dated. The facility failed to ensure that equipment was cleaned and in good operating condition. The facility failed to ensure that kitchen floors were cleaned. The facility failed to ensure that plates with dried food particles were not stored with clean plates. The facility failed to ensure that chipped plates were not stored with unchipped plates. The facility failed to ensure that menu items on the steam table was maintained at 135 degrees F and above. The facility failed to ensure the expired food was not stored with foods that are not expired. The facility failed to ensure that groceries received were not store directly on the floor. The facility failed to ensure that the dish machine had soap and was sanitizing at the proper PPM. An Immediate Jeopardy (IJ) situation was determined to have existed on 04/ ,d+[DATE] at 10:38am. While the IJ was removed on [DATE] at 5:26PM, the facility remained out of compliance at actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of a pattern due to the facility's needs to evaluate the effectiveness of the corrective systems. These failures affected all residents who ate foods prepared by the kitchen and placed them at risk of foodborne disease and other illness. Findings included: Observations of the kitchen on [DATE] at 11:00am revealed the following: A bag of onions, and rice and a box of iced tea, were noted directly on the floor. There were undated, unlabeled cookies in a plain zip loc bag, rice, pasta, and frosted flakes. There were containers with rice, and flour opened that were not labeled or dated. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation of the kitchen floor on [DATE] at 11:05am revealed debris, particles of food, utensils on the kitchen floor. Observation of the refrigerators and freezer in the kitchen on [DATE] at 11:08am revealed the following: A container of eggs, with a used by date of [DATE]. There were containers in the refrigerator that appears to be peaches, one appears to be macaroni and cheese, and sliced meat, that were open, unlabeled, and undated. There was an open sliced cheese not labeled or dated. There was a box with chicken with liquid residue spilling in the refrigerator not labeled or dated and contaminating other food items. There was an open carton of scrambled open carton and undated. There were missing shelfs from the freezers. Observations of the kitchen on [DATE] at 10:20am revealed the following: Debris was noted on the floor. The three-compartment sink was full of dirty dishes, steam table had an accumulation of burnt food particles in the wells and on the top. The sneeze guard had dried food particles on it. The grill has an accumulation of dried food particles on it and the stove had burnt food particles on it. Observation on [DATE] at 2:00pm of the refrigerator in the kitchen opposite the steam table revealed a box of molded rotten tomatoes, one bag of parsley and five bags of spinach with black liquid in the bags. Observation of the facility's kitchen on [DATE] between 10:45am and 12:00pm revealed the following: The hand washing sink beside the grill had brown stains all over it. The grill had an accumulation of burnt food particles on it. The stove top and had burnt food particles and grease on it, the inside of the oven had burnt food particles and grease. The sides of the deep fat fryer and the stove had dried food on them. The grill had an accumulation of burnt food particles on the surface and back splash. The wells of the steam table were black from burnt food particles and the water in the wells was brown. The sneeze guards had dried food particles on them. The shelf under the steam table had food stains and food particles on it. The floor of the kitchen had excess debris on it, food spillage and dirt. Observation on [DATE] at 12:05pm of the operation of the dish machine by Dietary Aide C revealed the litmus paper did not change color on testing to ensure that the dishes were sanitized. Further observation revealed there was no soap in the container that was attached to the dish machine. Dishes from breakfast was observed on the trolley in the dining room not washed. Pots and pans from breakfast were still in the three compartments sink not washed. In an interview with Dietary Aide C on [DATE] at 12:10 she said she was called in to assist the cook because the schedule aide had called in and that was why the dishes were not cleaned. She said they were short staffed. She stated she washed some dishes utilizing the dishwasher that morning. She stated she was not trained on using the dishwasher and she only knew how to turn it on. She stated that if dishes that were not washed properly it could cause residents to get sick due to cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation of the dishwasher on [DATE] at 12:10pm revealed there were two buckets one with liquid soap and liquid sanitizer. The bucket with the soap was crystallized. The tubing from the sanitizer to the dish machine was clogged. Surveyor determined it was clogged/ tubing was not working due to testing the dishwasher for sanitizer with litmus paper and it did not change color which would indicate sanitizer was not being used or getting through the tubing. Observation of the dry storage room on [DATE] at 1:00pm revealed the following: Macaroni, breadcrumbs, rice crispy, corn flakes in plain plastic open not labeled and dated. Grocery was stored directly on the floor not on pallets. Further observation on [DATE] at 1:05pm of the free-standing freezer revealed cookie dough and hash brown open not sealed. Observation of the kitchen's steam table on [DATE] at 1:55pm revealed the following menu items were not at the correct holding temperature: The menu items were green peas at 125 degrees F., chopped pork at 99 degrees F., Pureed peas at 123 degrees F., and Pureed pork meat at 120 degrees F. The surveyor observed Dietary Aide C about to plate items from the steam table. In an interview with [NAME] D on [DATE] at 1:57 pm he said the reheating was 120 degrees Fahrenheit. At that time, he was asked by the Surveyor if he was in-service on food temperature he said No. The surveyor at that time inform him the menu items needed to be reheated to the correct reheating temperature of 165 degrees Fahrenheit. Observation of meal service on [DATE] at 1:59pm revealed Dietary Aide C removed the food items and reheat them to 165 degrees Fahrenheit after being prompted by the surveyor. Observation on [DATE] at 2:00pm revealed chipped plates stored with unchipped plates. The divided plates had dried food particles in them. The plates were pointed out to Dietary Aide C, and she discarded the chipped plates and return the divided plates to the dish room to be rewashed. Interview on [DATE] at 2:00pm with Dietary Aide C she said that when dishes were washed, they should check them to ensure they were clean and not chipped before they were stored. This she said could prevent cross contamination. In an interview with the Dietician on [DATE] at 12:45pm she stated she comes to the facility on ce month typically on the 3rd week of the month. She stated at that time she reviews the menu, ask for a test tray, and audits the kitchen. She stated the last audit of the kitchen was [DATE]. She stated prior to exiting the facility she reviews the sanitation audit with the administrator in detail and discusses concerns. She stated she follows up the next time she was in the facility. She stated she met with the administrator on [DATE] and discussed the sanitation audit report with the administrator. She stated that the administrator should have addressed the concerns noted in the document. She stated if the dishes were not sanitized it could cause an increased risk of food borne illness. She stated that food that were not properly stored, labeled, and dated could pose a risk to residents as they can consume food that were expired or spoiled which can pose an increased risk of food borne illness. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In interview with RVP on [DATE] at 12:00pm, she said that the administrator oversees the facility, and the kitchen as much as she can. She said she received the sanitation report via email, but she did review the sanitation report. She had not been in the kitchen, only to the door. She reported It's between the dietician and the administrator when they review the sanitation report, they discuss how they would solve the issue. She can't confirm what the issues were in March regarding the sanitation report. She stated Administrator oversees the overall operation of the facility. She said she did not expect to be told everything that goes on in the building as that was not her role, as she was the consultant. She said the administrator was the top of the chain at the facility, and she does not overstep her position. She stated she believed the facility was running well but based on this interview she would agree the system the administrator was using was not working. In an interview with Administrator on [DATE] at 2:00pm, she stated a Dietary manager was hired but has not yet started. She stated the facility has been without a dietary manager since the beginning of [DATE]. She stated on Thursday [DATE] she did rounds in the kitchen and observed the cleanliness, food storage but did not take an inventory. She stated on [DATE] the kitchen was clean, and all items were labeled and dated. She stated human resources did rounds on Friday [DATE] in the kitchen as well as ensuring it was clean and food items were stored correctly. She stated she would expect the kitchen to get dirty during service and cleaned daily. She stated that she did not keep a log of her kitchen audits because it was not a regulation. She stated that her audits are by pop ins and the area she audits varies. She stated she reviewed the sanitation report with the dietician and corrected all the issues. She stated she did go a little low on emergency food supply and she ordered more foods on [DATE]. She stated the kitchen currently has adequate shelving. She said the can opener was cleaned off because it was a little dirty and she did not purchase a new one. She stated if the kitchen is unsanitary, it can pose a risk to resident's health and safety due to cross contamination. She said if certain meats were not kept at the right temperature, that could cause residents to get sick. She stated that foods that are not dated or labeled can cause the kitchen staff not able to determine the correct best used by dates. She stated she could not answer to whether everything was dated, labeled and in accordance with professional standards of food service because she had not been back there that day. She stated if dishes were not being sanitized correctly it could cause cross contaminated. In an interview with Human Resource L on [DATE] at 10:00am, she stated she did not complete rounds in the kitchen and that would be the responsibility of the administrator. She stated she did not complete rounds in the kitchen on [DATE]. Observation on [DATE] between 4:45pm and 6:00pm revealed the following: Dirty dishes were noted in the dining room and on the hallway. Three compartment sinks were filled with dirty pans and baking sheets. The kitchen floors had debris, food particles and food spillage. Two dirty plates were observed on the dining table from lunch at 5:00pm. The sneeze guard had dried food particles on it. In an interview on [DATE] at 5:00pm with Dietary Aide G she said that [NAME] C was the only one working that morning as the aide who was schedule had called in. She said [NAME] D came in later that morning. She said everything was late and as a result the dishes were not cleaned, and she had to use disposables. She said she came in for her regular shift and was doing her duties. She stated that the three compartment sink was not used to wash or sanitize dishes from breakfast. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] [NAME] D at 6:15pm he stated that the Aide for the morning shift had called in and the cook had to work by himself until he got to work at about 10:30am that morning. He said because he had to help [NAME] A to set up and get lunch ready, he was behind and did not get a change to clean up. He said he was going to clean the kitchen up and wash the dishes before he leaves that day. In an interview with the RVP on [DATE] at 11:30 she said that there was some breakdown in communication and that was why it took longer than usual to get help that morning. She said the Aide said she send a text and the current management team was not on that text and did not receive the text as a result they were not notified. She said they were unable to get help in a timely manner. She said they were looking at another method of communicating that would include management staff. Observation of the steam table on [DATE] at 12:30pm revealed [NAME] E sharing lunch. He opens the cooler and without changing his gloves he started plating the food. He took up the breadstick and bend it in half and placed it on the resident's plate. He also used the same gloved hands to fix the food on the tray. An interview was attempted on [DATE] at 12:35pm with the [NAME] E but he did not respond when he was asked about changing his gloves. At that point he changed his gloves. The Dietary manager at that point discarded the food gave him tong to pick up the breadstick. The Dietary Manager told him at that time to use a tong to pick up ready to eat foods. Observation of the kitchen on [DATE] at 2:45pm revealed the stove was not cleaned it had an accumulation of dried food particles on the stove top. The Oven had an accumulation of grease and burnt food particles on the inside. Grill has an accumulation of grease and burnt to the back splash. Observation of the storage room on [DATE] at 2:55pm revealed foods in the Free-standing freezer were not labeled and dated: A plain plastic bag with steak fries not labeled or dated A box with Folded cheese omelets was opened and not sealed. A box with beef patties opened and not sealed. Fish patties and Pepperoni were in plain plastic bags, and they were not labeled or dated. Observation on [DATE] at 3:04pm of the refrigerator opposite the steam table revealed the following: Mushroom and green onion open not sealed, cheese sauce and apple sauce in plain plastic bag not labeled or dated. Can green peas, mashed potatoes and barbeque sauce, tomato paste, and peaches were not labeled and dated. Cornbread and garlic bread in plain plastic bags were not labeled and dated. In an interview with the Cooperate Dietitian on [DATE] at 3:45pm regarding the issues in the kitchen. She said that she was going to ensure that foods were sealed, dated, and labeled by in servicing the staff on labeling and dating of food items in the dry storage room, cooler and freezer. She also said she will have to do some cleaning. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview with the Dietary Manager on [DATE] at 4:00pm she said that she expected the staff to labeled, sealed, and dated all food items. She said she had in-serviced the staff on cleaning of the kitchen floor and the equipment. She said that she was going to ensure that the kitchen was cleaned by Wednesday. In an interview with the RVP on [DATE] at 4:15pm she said she was going to ensure the kitchen was cleaned starting [DATE]. She said that she was checking the kitchen and when she was not available the HR person would sit in for her. She said she was going to talk with the Dietitian so they can come up with a plan to maintain compliance in the kitchen. In an interview with the Dietary Manager on [DATE] at 4:15pm she said it was the expectation of the staff to label, seal, and date all food items when they are opened. She said they are expected to clean the equipment and clean the floor after each meal. She said they will have daily reminder until it becomes a normal routine, and not be reminded of what to do. Record review of the Nutrition Policies and Procedures dated [DATE]: Subject: safe Food Handling: Policy: Food acquisition, and distribution will comply with accepted food handling practices. Proper food handling is essential in preventing foodborne illness. Procedures: 4. Handle food carefully to avoid contamination with potential harmful debris, such as broken glass or glass chips, sweeping and the like. 5. Dishes, flatware, and glassware are free from chips, cracks, or stain. Food/Beverages Prepared and Served by Facility Staff for Patients or residents. 4. All foods are stored, prepared, and served at temperatures that prevent bacterial growth. Hot foods are maintained at 135 degrees F or higher and cold foods are maintained at 40 or below at point of service. At point of delivery hot foods should be 120 F, cold foods ,d+[DATE] degrees F or per state regulations. 6. Food is served with clean, sanitized utensils. There is no bare hand contact. 7. The food preparation area and utensils used to prepare food are cleaned and sanitized prior to each use, using approved washing and sanitizing techniques. Subject: Sanitation & Food Safety in food and nutrition Services The Nutrition Services Director (NSD) will assume responsibility for food safety and sanitation of the Nutrition Culinary Department 4.The Sanitation Review is completed monthly by the Dietitian and copied to the Administrator. The NSD completes the form at least weekly. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. The Audit and the action plan are submitted to the administrator and the facility quality improvement coordinator/infection control coordinator. Record review of the sanitation report dated [DATE] revealed a score of 0 (which means it is not up to standard) for the following items: All items covered, labeled, dated. Walls, floors, ceilings, vents, and doors clean. Daily cleaning schedule completed and followed. Can opener clean. Microwave clean. No cross contamination between clean and dirty side. All items air dried. Walls, racks, floors, clean. All carts and racks clean and in good repair. All painted surfaces clean with no chip. Emergency food and supplies available per facility policy and procedure. Comments: Missing shelving from coolers/freezers, order new can opener blade, replace cutting boards, post new cleaning schedule, paint all services with chipped paint, clean and paint ceiling vents. Steam table with food debris inside wells, steam table wells need repair. Dish machine logs, cooler/freezer logs not completed. Record review of facilities sanitation policy revealed that equipment and utensils will be sanitized after each use. A three-compartment sink is to be used for manual, washing, rinsing, and sanitizing utensils and equipment. If chemical sanitization is used it is recommended that the facility, follow the manufactures instructions. The Administrator was notified on [DATE] at 10:30AM an Immediate Jeopardy (IJ) situation was identified due to the above failures. The template was provided at this time. The Plan of Removal was submitted by the facility and was accepted on ,d+[DATE] /2023 at 2:20pm and included: Plan of Removal (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	F812 IJ Ecolab was contacted [DATE] to inspect the dish machine. Ecolab was onsite [DATE] and confirmed the dish machine is working properly and tested . The dishes were washed and sanitized using dishwashing liquid and / or sanitizer on [DATE] Food in the refrigerators, freezers and dry pantry was discarded that was spoiled, undated and unlabeled and on the floor by [DATE] The floor was cleaned to remove the debris. The three compartment is no longer full of dirty dishes. The steam table was cleaned to remove the burnt food particles in the wells. The sneeze guard was cleaned to remove dried food particles. The grill was cleaned to remove dried food particles and the stove was cleaned to remove burnt food particles. This will be completed by [DATE]. The Dietary Departmental Leadership Policy, Sanitation and Food Safety in Food and Nutrition Services, Food service In a Disaster Policy, Food Preferences Diet History Policy, Meal Service for New Patients or Residents, Food Preparation, Menus Policies were reviewed by the Interim Certified Dietary Manager, Administrator, and New Certified Dietary Manager on ,d+[DATE]; ,d+[DATE]; ,d+[DATE]. No revisions were needed. Ecolab onsite [DATE] to confirm dish machine was set up with chemicals. The Interim Certified Dietary Manager was re-educated by the National Director of Nutrition Services as the trainer on [DATE]. The Interim Dietary Manager began working at the facility on [DATE] and was onsite ,d+[DATE]; ,d+[DATE]; , d+[DATE]. New Certified Dietary Manager started [DATE]. Proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes Labeling, dating, and monitoring refrigerated or frozen food and pantry food items, including, but not limited to leftovers, so it is used by its use-by date, or frozen or discarded Temperatures are critical in preventing foodborne illness. Cooking food to the temperature and for the time specified below will either kill dangerous organisms or inactivate them sufficiently so that there is little risk to the resident if the food is eaten promptly after cooking. Low Temperature Dishwasher (chemical sanitization): o Wash -120 degrees - 140 degrees F; and o Final Rinse -50 ppm (parts per million) hypochlorite (chlorine) The dietary staff will be re-educated on the following by the Interim (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Certified Dietary Manager on [DATE] (date): Proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes Labeling, dating, and monitoring refrigerated or frozen food and food in pantry, including, but not limited to leftovers, so it is used by its use-by date, or frozen or discarded Temperatures are critical in preventing foodborne illness. Cooking food to the temperature and for the time specified below will either kill dangerous organisms or inactivate them sufficiently so that there is little risk to the resident if the food is eaten promptly after cooking. Low Temperature Dishwasher (chemical sanitization): o Wash -120 degrees - 140 degrees F; and o Final Rinse and checking of chlorine strips - 50 ppm with each cycle Cleaning schedules for the kitchen we established. Dietary competencies using the skills check protocol from the Food and Nutrition Services Policy Manual will be completed on the dietary staff by the Interim Certified Dietary Manager beginning on [DATE] and completed by [DATE]. This education and competencies will be completed by [DATE]. Any member of dietary staff not receiving this information by this date will receive prior to next scheduled shift The Interim Certified Dietary Manager/designee will make rounds in the kitchen 3 times daily for 5 days to validate kitchen sanitation and food storage using the Sanitation Rounds tool and validate proper dishwashing technique and appropriate food temperatures, the 3 X weekly for 4 weeks then weekly thereafter starting [DATE] New Certified Dietary Manager will receive training regarding cleaning schedules, Emergency supplies/food, and sanitation on [DATE] by Interim Certified Dietary Manager. The Regional [NAME] President of Operations will oversee compliance of this plan. Regional VP/designee will complete sanitation inspection of the kitchen weekly effective [DATE]. The Medical Director was notified of the Immediate Jeopardy and the contents of the plan of removal on [DATE]. An Ad Hoc (when necessary or needed) Quality Assurance Performance Improvement meeting was held on [DATE] to review contents of this plan. Surveyor Verification of Plan of Removal was as follows: (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of in-service records dated [DATE] -[DATE] revealed that the Dietary Manager, Cooks and Dietary Aides were in-serviced on proper storage of leftovers, emergency supplies, food safety, food temperature, dish machine, sealed, labeling, and dating of food and appropriate liquids for pureed diet. Observation on [DATE] at 5:00pm of the dish machine located in the kitchen revealed, the dish machine was working and the litmus paper changed color indicating that the sanitizer was present. Observation on [DATE] at 11:00am of the Kitchen revealed food iwas dated, labeled, sealed and stored appropriately. Kitchen Observed clean. In an interview with [NAME] D on [DATE] at 11:00am she stated he was in-serviced on kitchen sanitization, food temperature, storage of left over and dating and labeling of foods. The staff was able to demonstrate understanding of training. Interview conducted with [NAME] C on [DATE] at 1:45pm, revealed he was in-serviced on sanitizing of dishes, pots and pans, food storage, food temperature, dating and labeling of foods. The staff was able to demonstrate understanding of the training. In an interview with [NAME] D on [DATE] at 2:00pm he stated he was in-serviced on kitchen sanitization, food temperature, storage of left over and dating and labeling of foods. The staff was able to demonstrate understanding of training. In an interview with Dietary Aide G on [DATE] at 1:55pm she stated she was in-serviced on kitchen sanitization, the dish machine, food temperature, storage of left over and dating and labeling of foods. The staff was able to demonstrate understanding of training. In an interview on [DATE] at 4:30pm with the RVP she said they were doing kitchen checks had three time a day for five days and then two time and then once a day until the facility complies and all staff are trained. She said they will be doing weekly and random audits to ensure continued compliance. In an interview with the Dietitian on [DATE] at 3:45PM she said that she was going to ensure that foods were dated and labeled. She said she will have to in-service the staff on labeling and dating of food items in the cooler and freezer. She also said she will have to do some cleaning. In an interview with the Dietary Manager on [DATE] at 4:00pm she said that expectation of the staff was to label, sealed and dated all food items. She said had in-serviced the staff on cleaning of the kitchen floor and the equipment. She said that she was going to ensure that the kitchen was kept clean all the time and will always be complying. The RVP was notified that the IJ was lowered on [DATE] at 5:26pm. However, the facility remained out of compliance at a severity of level of actual harm that is not immediate jeopardy and a scope of pattern due to the facility needing more time to monitor the plan of correction's effectiveness.

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	675214	A. Building B. Wing	05/01/2023

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, interview, and record review the facility failed to be administered in a manner that enables it to use its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, staff, and visitors for (59 of 61 residents) residing in the facility and having meals prepared from the only kitchen, and for the staff and residents in the building during gas leak. The Administrator failed to immediately take action when staff and residents reported a smell of gas in the facility for 3 days. The facility administration failed to ensure sufficient and replenished food supply for residents, proper storage, preparation, distribution and serving of food in accordance with professional standards of food safety in the absence of a Dietary Manager. The facility administration failed to ensure the kitchen was a sanitary work environment. The facility administration failed to have an effective system in place to ensure sufficient and routine replenishment of food for all residents. The facility administration failed to have a trained Dietary manager on staff to supervise staff, ensure sanitary work environment and ensure balanced meals were being provided to residents at assigned mealtimes. The facility administration failed to provide approved and adequate substitutions. The facility administration failed to have an effective system in place to ensure food was properly stored and that expired or spoiled food items were discarded. An Immediate Jeopardy (IJ) was identified on [DATE] at 5:58 p.m. While the IJ was removed on [DATE] at 4:13 p.m., the facility remained out of compliance at the severity level of actual harm that is not immediate jeopardy, and a scope of pattern while the facility continued to monitor the implementation of effectiveness of their plan of removal. A second Immediate Jeopardy (IJ) situation was determined to have existed on [DATE] at 10:38am. While the IJ was removed on [DATE] at 5:26PM, the facility remained out of compliance at actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of a pattern due to the facility's needs to evaluate the effectiveness of the corrective systems These failures placed all residents, staff, and visitors at risk of getting sick due to prolonged exposure to gas fumes and/or carbon monoxide and at risk of food borne illness. Findings include: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of public record request # PIR-,d+[DATE] on [DATE], revealed that Incident # 23002345 stated the FD was dispatched to the facility due to a 911 call concerning smell of gas inside. Fire Chief B was the reporter. It read in part on [DATE], E16 dispatched emergency traffic for smell of smoke or gas. upon arrival to scene to a single-story nursing home nothing was showing, and investigation commenced. once inside we were directed to the end of the 100 hall. Halfway down the hallway CO readings began to read 31 ppm. The reading continued to be reading between 18 and 30ppm in the end corridor. nursing staff was instructed to move residence out of Hall 100. All rooms and halls were investigated with 5 gas monitoring. Boiler room was noticed to have furnace that when turned on readings reached 700ppm of CO. (31ppm and 700 ppm indicates how many parts of carbon dioxide there is in one million parts of air). Maintenance was informed of this leak and gas supply was then turned off. maintenance informed us that plumbers would fix the leak tomorrow. the 100 hall was then ventilated until CO readings consistently maintained O ppm. End of call. Further review of the incident report revealed that there were four firemen on the scene. They were at the facility from 17:13:47(5:13 p.m.) to 18:39:01 (6:39 p.m.). Observation of the Fire Department Body camera dated [DATE] revealed: 17:25 (5:25 p.m.) Body cam #3: entered front door of facility, asked staff about kitchen, or any gas hook ups. Staff reported not knowing anything about the building. 17:25 (5:25 p.m.)- entered 100 hall. A staff stated to FD they had to raise a resident's window (this was near the end of hall, room [ROOM NUMBER] seen on video) 17:26 (5:26 p.m.) Resident on hall in wheelchair traveling down hall, heard FD stated reading of CO at 30 ppm. Then stated a big spike in the reading over there on the CO (the FD is at the back on 100 hall near therapy door) 17: 33 (5:33 p.m.) observed staff go into room [ROOM NUMBER] to assist resident 17:35 (5:35 p.m.) Observed resident in wheelchair on hall 100 near 106 17:46 (5:46 p.m.) heard a resident on 200 hall tell FD yesterday the gas smell was strong 17:49 (5:49 p.m.) staff ask FD if fire truck was in the front, he said yes, she was seen on her phone 17: 49 (5:49 p.m.) FD states maintenance said this happened about a week ago 17: 49 (5:49 p.m.) FD explained to staff they are getting readings of high CO levels but can't find where it is coming from. Staff heard on phone reporting to somewhere that there are high CO levels. 17:50 (5:50 p.m.) staff telling staff let's move residents 17:52 (5:52 p.m.)- 3 staff standing on 100 hall, not moving residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	17:53 (5:53 p.m.) staff comes to FD and states: I don't know what's going on, the administrator does not want to admit that there is high CO in the building do you want to talk to her? FD responded I don't care what she admits to. Staff dials a number and gives phone to FD- he said he was with FD, and he says one of your nurses said you might want to talk to me. He says to the person on the phone that they told staff to clear out the hall where they are getting CO reading and, clearing out the hallway was an immediate thing. 17:56 (5:56 p.m.) confirmed with staff that administrator was told to clear out that hallway, explains to staff that if they cannot find the leak and isolate the leak then they cannot let them stay operating and would have to shut the building down. Explained if fire started over here (100 hall) it could impact the other side of building. 18:06 (6:06 p.m.) FD says its strong reading going up and up 50 to 55, to 75. 18:07 (6:07 p.m.) shut off valve to gas line and started opening windows and doors. FD upset the maintenance saying that had a gas leak a week ago and didn't say anything. 18:09 (6:09 p.m.) FD stated every time that thing (referring to the furnace or hot water heater) would kick on they would have the CO emitted. Says probably been going on a while. Staff requested name and phone number in case she gets terminated. FD explained to her she was doing what they asked her to do. 18:12 (6:12 p.m.) FD moved outside stating it wasn't good to be standing around it. 18:19 (6:19 p.m.)- staff approached FD and asked about moving residents. FD stated it was recommended to move the patients. Staff Requested FD to call administrator, FD stated he already called her. Staff stated that she (person on the phone) told one of the nurses to not move the patients. FD said to tell her the other option is to have ambulances come and move all the patients. Explained they could get CO poisoning. 18:20 (6:20 p.m.) resident seen on 100 hall and FD told resident to go the other way. FD explained to nurses what carbon monoxide poisoning is. A Nurse told another nurse to call ADON- he said he got off phone with the assistant and he was told that the assistant said to keep the residents in the room. FD was saying it was very serious. And it wasn't up to the nurse, it was FD decision. Nurse called the administrator, administrator did not answer, and she left a message. FD told them to move residents again. FD said administrator texted and said she was driving; she didn't answer the phone. 18:23 (6:23 p.m.) staff started moving residents. FD stated that he already talked to the lady to move residents about 30 minutes ago. FD says it smells terrible almost like it had been leaking for a year. 18:35 (6:35 p.m.) FD explained to staff that they killed the gas. End of video (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with Fire Chief A of the local fire department (FD) on [DATE] at 9:24 a.m., revealed him to state that A shift responded to an anonymous 911 call from Solidago Nursing and Rehab on [DATE]. He stated that they found the area near the lobby/nursing station had a carbon monoxide reading of 35 parts per million (PPM) on their 5-gas monitoring device which samples air and is used to detect oxygen (O2), carbon monoxide (CO), hydrogen sulfide (H2S ppm) and volatile organic compounds (VOC ppm) and low explosives level (LEL). He said that they must always do an air sample when there is complaint of a gas smell. As they moved further down Hall 100 and entered the boiler room located at the back of the building (where Halls 100 and 500 intersect), they found that the reading was 700 parts per million of carbon monoxide. Chief C informed RN V that they needed to evacuate the residents from Hall 100. He said that Chief C talked to the Administrator and maintenance director and when he noticed that staff were not moving residents off the hall, he announced that he would shut the whole building down. He stated that they decided to shut the main gas line down because natural gas not burning properly created the carbon monoxide. So, cutting the gas supply would eliminate any carbon monoxide because even a small amount of carbon monoxide can be harmful to the residents. He said they opened doors and allowed the carbon monoxide to dissipate before they left the facility. FD recommended that the facility contact a certified plumber. FD stated some symptoms of carbon monoxide poisoning included dizziness, headaches, shortness of breath, and loss of consciousness. An interview was conducted with LVN U on [DATE] at 3:25pm, she stated that she worked on [DATE]. She said that someone from Solidago called the fire department anonymously to report the gas smell. She said that she did smell gas in the building on or about [DATE] when she returned from being off on [DATE]. She said that she checked with the residents down Hall 100 and most said that they could not smell gas. She said that Resident #2 mentioned that he could smell gas and she heard from other staff (unwilling to provide names) that they had been smelling gas for about 1 week. She said that she did not report it to the Administrator. She said, they knew it smelled like gas. She said that (they) were the Administrator and ADON. She did not explain how they knew about the gas smell. An interview was conducted with the maintenance director on [DATE] at 3:45p.m., he said that staff reported that they could smell gas near 100 hall on or about [DATE]. He said that he put soap and water on all the valves (process called soaping the joint) near Halls 100 and 500. He said that he did not find a leak. He said if there was a leak the soap would bubble. He stated that this is a skill he was taught through previous work experience. He stated that it was reported to the Administrator during their morning meeting on or about [DATE]. He said that the Administrator as well as Therapy Director, BOM, SW, Wound Care nurse and ADON were present for the meeting. He stated that the therapy director was the first person to inform him of the gas smell. He said that the plumber came out on [DATE] but did not have the part to repair the gas valves on the furnace and hot water heater. He said that the FD turned the gas line off on [DATE]. The plumber returned on today ([DATE]) and replaced the valves on the furnace and the hot water heater. Observation rounds on [DATE] at 3:50 p.m., revealed a closet located at the back of the building near Halls 100 and 500 had a hot water heater and a furnace. The gas smell was strong. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with the Administrator on [DATE] at 4:12pm, she stated that RN V text her on [DATE] and said that there was a gas smell in the facility and the fire department had been called. She stated this is when she first learned that there was a gas leak and that they found carbon monoxide. She said that it was reported to her that the fire department had found a small gas leak. She said from what she understands, the alarm would have been triggered if there was over 50 parts per million of carbon monoxide in the building. She said that she did not believe that the small leak was harmful. She said the problem was resolved within an hour. She stated that carbon monoxide poisoning could cause headache, sleepiness, nausea and if super high could cause death. She confirmed that she was present for the morning meetings the week of ,d+[DATE]-[DATE] but denied anyone mentioning a gas leak. She informed me that she take the notes for their morning meetings.She stated she didn't smell any gas odors during the week of , d+[DATE]-[DATE]. She stated the FD did not tell her to evacuate the residents. According to her, she informed her corporate RVP and VP of Clinical Services Director and was advised to follow directives of the fire department, keep them informed and take the residents vitals. She stated that the DON, ADON are charge in her absence and any emergencies are supposed to be handled by the maintenance director. An interview was conducted with Resident # 9 on [DATE] at 10:28am, revealed her to state that the Administrator was aware of the gas smell, and she did not do anything about it. She said that they had been smelling gas for about 1 week and nothing was done until the fire department was called on [DATE]. She said that she had all her faculties and that she told the Administrator that she could smell gas on or about [DATE]. She said that the Administrator is not telling the truth about the gas leak. She said the Administrator should have called the gas company. She said that the Administrator told her and others that the smell was coming from some flooring on Hall 500, but she did not believe her. She said that the Administrator was not trustworthy and did not care about the residents. Resident #9 resided on Hall 100. Record review of Resident #9 MDS dated [DATE] revealed C0500. BIMS summary score was 15. An interview was conducted with CNA N on [DATE] at 10:48 a.m., revealed that she was off a few days during the week of ,d+[DATE]-[DATE] but believe she returned to work on ,d+[DATE] or [DATE] and could smell gas. She said she called the ADON on ,d+[DATE] around 9:30 a.m. on the on-call phone to inform her that she could smell gas. She said the ADON told her she would call Administrator and let her know, but maintenance was aware of the problem. She said that she had a headache and was feeling sleepy on [DATE]. She said that someone called 911 and the fire department told RN V that they found high levels of carbon monoxide in the building. She said there is no freedom to voice concerns in the building, but she did report the gas smell to ADON. She said she made the ADON aware of it on Saturday [DATE], but ADON and Administrator allowed another day to go by without doing anything. An interview was conducted with CNA Q on [DATE]at10:50 a.m., stated that she was ill from the gas fumes. She said they wanted the fire department to come because they were worried about the residents. She said that the CNA's cares more about the residents than the Administrator does. She said that she works Hall 200 mostly but she also helps with Hall 100. She said that there was a gas smell in that area (Halls 100 and 500) for over a week. She said that she was having headaches and nausea from the gas smell. She said staff would talk amongst themselves, but they were afraid to call and get help. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with RN V on [DATE] at 2:49 p.m., she stated that the fire department came while on her 6a-6pm shift on [DATE]. She said that upon their arrival she immediately text the ADON (per chain of command). She said that there were approximately 4 or 5 on the fire team. She said that they began to walk throughout and around the outside of building checking for carbon monoxide. She said she was informed by a member of the FD that the carbon monoxide levels were high in the room where the puzzles were located (at the end of 100 and 500 halls) and boiler room. She said that the ADON said that she let both the Administrator and Maintenance Director know that the fire department was there due to the gas leak. At first, she said that the Administrator told her that the fire department was not there because she had checked the cameras. She said that she took a picture of the fire truck on her cell phone and text it to her. She said that she allowed Chief C to communicate with the Administrator from her cell phone. She said that she started soliciting help to evacuate the residents, getting them dressed and helping transfer them to their wheelchairs, because the FD told her that she needed to evacuate the residents from Hall 100. She said this is what Chief C told her to do. She said when she got back on the phone, the Administrator said that she was told that the levels were low and there was no need to evacuate the residents. She said that it was obvious that the FD felt they were not moving the residents fast enough, because Chief C announced that he would shut the whole building down if they did not start moving the residents. She said she text the Administrator again because she wanted to make sure she was okay with them moving the residents. She said that the Administrator responded, You were already moving them RN V. She said there was a lot of commotion because it was also time for change of shift. She said one fireman was observed coming from the outside and another from the back of the building. She said that only a few residents had been evacuated to the front lobby when she was informed that the fire department was going to shut down the gas line. The residents were taken back to their rooms. She was told that they were airing out the building and had propped open the back door for air to circulate. In an interview with Fire Chief A of the local fire department (FD) on [DATE] at 9:24a.m. revealed that A shift responded to an anonymous 911 call from the facility on [DATE]. He stated that they found the area near the lobby/nursing station had a carbon monoxide reading of 35 parts per million (PPM) on their gas monitoring device which samples air and is used to detect oxygen (O2), carbon monoxide (CO), hydrogen sulfide (H2S ppm) and volatile organic compounds (VOC ppm). He said that they must always do an air sample when there is complaint of a gas smell. As they moved further down Hall 100 and entered the boiler room located at the back of the building (where Halls 100 and 500 intersect), they found that the reading was 700 parts per million of carbon monoxide. Chief C informed RN V that they needed to evacuate the residents from Hall 100. He said that Chief C talked to the Administrator and maintenance director and when he noticed that staff were not moving residents off the hall, he announced that he would shut the whole building down. He stated that they decided to shut the main gas line down because natural gas not burning properly created the carbon monoxide. So, cutting the gas supply would eliminate any carbon monoxide because even a small amount of carbon monoxide can be harmful to the residents. He said they opened doors and allowed the carbon monoxide to dissipate before they left the facility. FD recommended that the facility contact a certified plumber. FD stated some symptoms of carbon monoxide poisoning included dizziness, headaches, shortness of breath, and loss of consciousness (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with Therapy Director on [DATE] at 10:45 a.m., revealed that a gas odor was strong between [DATE]-[DATE] as the therapy room is in the corner of Hall 500 (where the highest concentration of carbon monoxide was found). She reported the gas odor to the Maintenance Director on or about [DATE]. He said that he would investigate it. She said that she kept the door to therapy closed. She said that the maintenance director talked about the gas leak multiple days in the morning meeting. She said that she mentioned it in the meeting too because the smell was strong. She said the maintenance director said he was working on it. She recalls the Administrator, ADON, SW, BOM, WCN and maintenance director being present for those meetings during the week of [DATE]-24, 2023. Record review of resident #1 face sheet revealed he was a [AGE] year-old male who was diagnosed with chronic obstructive pulmonary disease (COPD-a condition involving constriction of the airways and difficulty or discomfort in breathing) heart failure, cellulitis (a bacterial skin infection), muscle weakness, chronic pain, polyneuropathy (malfunction of many peripheral nerves through the body), chronic atrial fibrillation(an irregular and often rapid heart rhythm and mood disturbance and anxiety. He resided on Hall 100. Record review of Resident #1 MDS dated [DATE], section C0500. BIM summary score was 15. An interview was conducted with Resident # 1 on [DATE] at 11:15 a.m., he said that it was difficult for him to breath due to the strong gas odor on or about [DATE]. He described the smell as a heater furnace just being turned on for the first time in the winter. He said that a nurse (later known as RN V) came to open his window to allow a flow of air. He was later moved to the lobby. He utilizes an oxygen concentrator. He said he told the nurse that he was having difficulty breathing earlier in the day on [DATE]. He did not specify which nurse. He says multiple different staff came to his room. But, it was not the same nurse that opened his window. He said that the night nurse took his vitals. Record review of resident # 2 face sheet revealed that he was a [AGE] year-old male who is diagnosed with unspecified dementia, muscle weakness, abnormalities of gait and mobility, generalized arthritis, insomnia, post-traumatic stress disorder (PTSD). He resided on Hall 100. Record review of Resident # 2 MDS dated [DATE], revealed section C0500 BIM summary score was 8. An interview was conducted with Resident #2 on [DATE] at 11:26 a.m., he said that he experienced fast heartbeat and was light-headed on or about [DATE]. He said LVN U asked him if he could smell gas earlier in the week and he said that he did not smell anything at that time. But, on [DATE] he could smell gas and was light-headed. He said he does not usually feel that way. Resident # 2 resided on Hall 100. An interview was conducted with the ADON on [DATE] at 11:31am, she said that she was informed of the gas leak during morning meeting on [DATE], if she can recall correctly. She denied smelling gas. She said the maintenance director announced that he was trying to resolve the problem. She said she received a text from staff on [DATE] stating they could smell gas. She said she immediately informed the Administrator via text message. She said she was told that the maintenance director was working on fixing the problem. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted on [DATE] at 10:42 a.m. with Texas master licensed plumber, with plumbing company. Stated he was completing another job for the facility related to draining and an employee said that they had an issue with gas. He stated he used a gauge test with air after shutting off the gas to check the pressure and the gauge was dropping slowly at 10psi. He stated it was letting air go through which would mean there is a leak. He replaced the valves on the meter on which had the central heating and water heater because it was where the leak was found. He called the gas natural gas. He did not check for carbon monoxide. He does not normally check for carbon monoxide. Record review of a letter from plumbing company, dated [DATE]th, 2023, revealed that they were working at facility on [DATE] doing some repairs to sewer line, same day that a facility staff personnel asked technicians to check on a smell of gas in the mechanical room. Technicians proceed to test the gas line with 10 PSI of air for 15 minutes and pressure dropped very slow, indicating that there was a leak in line. Technician turned gas off until parts were ordered, and service could be completed. The technicians ordered new valves for the water heater and furnace and returned to the facility the following day [DATE] to replace valve and perform another test at 10 PSI for another 15 minutes and pressure held indicating there was no more leaks at this unit. There is no mention of Carbon Monoxide check. A group interview ensued with Chief A, Chief C and attempted interview with Chief B on [DATE] at 10:30 a.m. , Chief A stated that they found carbon monoxide at the facility. Chief B -was dispatched just before the interview started. Chief A stated that he arrived about 15 minutes after the team arrived to assist. Chief C stated that he spoke with the Administrator and Maintenance on [DATE]. He told the Administrator that the carbon monoxide was found in the building and numbers were highest in the back of the building near Halls 100 and 500. At that time, he stated that they needed to evacuate the residents down Hall 100. He said that the Administrator was pushing back. She said that maintenance told her that the levels were , d+[DATE] ppms. He said he was the person that talked to maintenance, and he never told him that. He said the carbon monoxide numbers were not as high in the front of building or outside, but they were at 700ppms in the boiler room. He said that he handed the phone to RN V and when he did not observe them moving the residents, he announced at the front nursing station he would shut the whole building down. By that he said he would have called ambulances to transport the residents to a nearby hospital because any amount of carbon monoxide can be hazardous to people who are already ill. He said that he has never dealt with an administrator that would not follow his orders. He said the nurse handed her phone to him maybe twice, he felt like the Administrator was giving the nurse pushback too. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with Med Aide A on [DATE] at 2:32 p.m., she stated she had headaches and the stated that the gas smell started on or about [DATE], she was told it was not gas. That they were working on flooring down Hall 500. She said therapy was complaining about the smell too. She said her normal shift consisted of passing medication on Halls 100 and 200. She said that called in to work on [DATE] because she was not feeling well. She had a bad headache and nausea. A subsequent interview was conducted with the Administrator on [DATE] at 2:51 p.m., she stated that she was not informed by maintenance nor any other personnel that there was a gas smell in the building. She first learned about the gas leak/carbon monoxide on [DATE]. She denied the fire department staff told her to evacuate the residents. She said that it was RN V that wanted to move them, so she asked to speak to Chief C. She said that the risk of being exposed to carbon monoxide above 50ppms could cause headaches. She said that the carbon monoxide was low otherwise the alarm panel would have alarmed, according to her understanding of the fire panel at Solidago. She said that Occupational Safety and Health Administration (OSHA) standards says 50ppm of carbon monoxide is not hazardous. She did not provide any literature for OSHA Therefore, she did not see the harm. She did not call in an incident report to Health and Human Services for this reason. Review of the facility's activity report dated [DATE], revealed that Resident #13 family came to visit. They were concerned about the smell of gas. RN V said that she would report it to administration. Resident #13 was not interview able. He resided on Hall 100. Record review of the facility census dated [DATE], revealed that Resident #13 resided on Hall 100 close to the end of the hall where Hall 500 intersects. An interview was conducted on [DATE] at 12:57pm, the former Wound Care Nurse stated in morning meeting on approximately [DATE] or [DATE], therapy director reported that there was a strong smell of gas. She told the administrator that she had been smelling gas for a while. The Administrator stated that the 500 unit used to be on a separate gas line. That is why they could be smelling gas. He said multiple days it was bought up in the morning meeting. He said he felt like he was walking uphill for over a week. He said he would not return to work as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, interview, and record review the facility failed to provide a safe, functional, and sanitary environment for residents, staff, and the public for 3 of 4 days (March 23, 24, and 25) . The facility failed to contact the fire department to report a gas leak for 3 days after multiple reports of a gas smell. The facility failed to evacuate or move the residents which resulted in the residents being exposed to carbon monoxide for 3 days. An Immediate Jeopardy (IJ) was identified on 4/6/2023 at 5:58 p.m. While the IJ was removed on 4/11/2023 at 4:13 p.m., the facility remained out of compliance at the severity level of actual harm that is not immediate jeopardy, and a scope of pattern while the facility continued to monitor the implementation of effectiveness of their plan of removal. These failures placed all residents, staff, and visitors at risk of getting sick due to prolonged exposure to gas fumes and/or carbon monoxide, which could lead to death. Findings Include: Record review of public record request # PIR-2023-706 on 4/10/23, revealed that Incident # 23002345 stated the FD was dispatched to the facility due to a 911 call concerning smell of gas inside. Fire Chief B was the reporter. It read in part on March 26, 2023, E16 dispatched emergency traffic for smell of smoke or gas. upon arrival to scene to a single-story nursing home nothing was showing, and investigation commenced. once inside we were directed to the end of the 100 hall. Halfway down the hallway CO readings began to read 31 ppm. The reading continued to be reading between 18 and 30ppm in the end corridor. nursing staff was instructed to move residence out of Hall 100. All rooms and halls were investigated with 5 gas monitoring. Boiler room was noticed to have furnace that when turned on readings reached 700ppm of CO. (31ppm and 700 ppm indicates how many parts of carbon dioxide there is in one million parts of air). Maintenance was informed of this leak and gas supply was then turned off. maintenance informed us that plumbers would fix the leak tomorrow. the 100 hall was then ventilated until CO readings consistently maintained O ppm. End of call. Further review of the incident report revealed that there were four firemen on the scene. They were at the facility from 17:13:47(5:13 p.m.) to 18:39:01 (6:39 p.m.). Observation of the Fire Department Body camera dated 3/26/23 revealed: 17:25 (5:25 p.m.) Body cam #3: entered front door of facility, asked staff about kitchen, or any gas hook ups. Staff reported not knowing anything about the building. 17:25 (5:25 p.m.)- entered 100 hall. A staff stated to FD they had to raise a resident's window (this was near the end of hall, room [ROOM NUMBER] seen on video) (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	17:26 (5:26 p.m.) Resident on hall in wheelchair traveling down hall, heard FD stated reading of CO at 30 ppm. Then stated a big spike in the reading over there on the CO (the FD is at the back on 100 hall near therapy door) 17: 33 (5:33 p.m.) observed staff go into room [ROOM NUMBER] to assist resident 17:35 (5:35 p.m.) Observed resident in wheelchair on hall 100 near 106 17:46 (5:46 p.m.) heard a resident on 200 hall tell FD yesterday the gas smell was strong 17:49 (5:49 p.m.) staff ask FD if fire truck was in the front, he said yes, she was seen on her phone 17: 49 (5:49 p.m.) FD states maintenance said this happened about a week ago 17: 49 (5:49 p.m.) FD explained to staff they are getting readings of high CO levels but can't find where it is coming from. Staff heard on phone reporting to somewhere that there are high CO levels. 17:50 (5:50 p.m.) staff telling staff let's move residents 17:52 (5:52 p.m.)- 3 staff standing on 100 hall, not moving residents 17:53 (5:53 p.m.) staff comes to FD and states: I don't know what's going on, the administrator does not want to admit that there is high CO in the building do you want to talk to her? FD responded I don't care what she admits to. Staff dials a number and gives phone to FD- he said he was with the FD, and he says one of your nurses said you might want to talk to me. He says to the person on the phone that they told staff to clear out the hall where they are getting CO reading and, clearing out the hallway was an immediate thing. 17:56 (5:56 p.m.) confirmed with staff that administrator was told to clear out that hallway, explains to staff that if they cannot find the leak and isolate the leak then they cannot let them stay operating and would have to shut the building down. Explained if fire started over here (100 hall) it could impact the other side of building. 18:06 (6:06 p.m.) FD says its strong reading going up and up 50 to 55, to 75. 18:07 (6:07 p.m.) shut off valve to gas line and started opening windows and doors. FD upset the maintenance saying that had a gas leak a week ago and didn't say anything. 18:09 (6:09 p.m.) FD stated every time that thing (referring to the furnace or hot water heater) would kick on they would have the CO emitted. Says probably been going on a while. Staff requested name and phone number in case she gets terminated. FD explained to her she was doing what they asked her to do. 18:12 (6:12 p.m.) FD moved outside stating it wasn't good to be standing around it. (continued on next page)

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	18:19 (6:19 p.m.)- staff approached FD and asked about moving residents. FD stated it was recommended to move the patients. Staff Requested FD to call administrator, FD stated he already called her. Staff stated that she (person on the phone) told one of the nurses to not move the patients. FD said to tell her the other option is to have ambulances come and move all the patients. Explained they could get CO poisoning. 18:20 (6:20 p.m.) resident seen on 100 hall and FD told resident to go the other way. FD explained to nurses what carbon monoxide poisoning is. A Nurse told another nurse to call ADON- he said he got off phone with the assistant and he was told that the assistant said to keep the residents in the room. FD was saying it was very serious. And it wasn't up to the nurse, it was FD decision. Nurse called the administrator, administrator did not answer, and she left a message. FD told them to move residents again. FD said administrator texted and said she was driving; she didn't answer the phone. 18:23 (6:23 p.m.) staff started moving residents. FD stated that he already talked to the lady to move residents about 30 minutes ago. FD says it smells terrible almost like it had been leaking for a year. 18:35 (6:35 p.m.) FD explained to staff that they killed the gas. End of video An interview was conducted with Fire Chief A of the local fire department (FD) on 4/4/2023 at 9:24 a.m., revealed him to state that A shift responded to an anonymous 911 call from Solidago Nursing and Rehab on 3/26/23. He stated that they found the area near the lobby/nursing station had a carbon monoxide reading of 35 parts per million (PPM) on their 5-gas monitoring device which samples air and is used to detect oxygen (O2), carbon monoxide (CO), hydrogen sulfide (H2S ppm) and volatile organic compounds (VOC ppm) and low explosives level (LEL). He said that they must always do an air sample when there is complaint of a gas smell. As they moved further down Hall 100 and entered the boiler room located at the back of the building (where Halls 100 and 500 intersect), they found that the reading was 700 parts per million of carbon monoxide. Chief C informed RN V that they needed to evacuate the residents from Hall 100. He said that Chief C talked to the Administrator and maintenance director and when he noticed that staff were not moving residents off the hall, he announced that he would shut the whole building down. He stated that they decided to shut the main gas line down because natural gas not burning properly created the carbon monoxide. So, cutting the gas supply would eliminate any carbon monoxide because even a small amount of carbon monoxide can be harmful to the residents. He said they opened doors and allowed the carbon monoxide to dissipate before they left the facility. FD recommended that the facility contact a certified plumber. FD stated some symptoms of carbon monoxide poisoning included dizziness, headaches, shortness of breath, and loss of consciousness. An interview was conducted with LVN U on 3/28/2023 at 3:25pm, she stated that she worked on 3/26/23. She said that someone from Solidago called the fire department anonymously to report the gas smell. She said that she did smell gas in the building on or about 3/24/23 when she returned from being off on 3/23/23. She said that she checked with the residents down Hall 100 and most said that they could not smell gas. She said that Resident #2 mentioned that he could smell gas and she heard from other staff (unwilling to provide names) that they had been smelling gas for about 1 week. She said that she did not report it to the Administrator. She said, they knew it smelled like gas. She said that (they) were the Administrator and ADON. She did not explain how they knew about the gas smell. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with the maintenance director on 3/28/23 at 3:45p.m., he said that staff reported that they could smell gas near 100 hall on or about 3/23/23. He said that he put soap and water on all the valves (process called soaping the joint) near Halls 100 and 500. He said that he did not find a leak. He said if there was a leak the soap would bubble. He stated that this is a skill he was taught through previous work experience. He stated that it was reported to the Administrator during their morning meeting on or about 3/24/23. He said that the Administrator as well as Therapy Director, BOM, SW, Wound Care nurse and ADON were present for the meeting. He stated that the therapy director was the first person to inform him of the gas smell. He said that the plumber came out on 3/27/23 but did not have the part to repair the gas valves on the furnace and hot water heater. He said that the FD turned the gas line off on 3/26/23. The plumber returned on today (3/28/23) and replaced the valves on the furnace and the hot water heater. Observation rounds on 3/28/23 at 3:50 p.m., revealed a closet located at the back of the building near Halls 100 and 500 had a hot water heater and a furnace. The gas smell was strong. An interview was conducted with the Administrator on 3/28/2023 at 4:12pm, she stated that RN V text her on 3/26/23 and said that there was a gas smell in the facility and the fire department had been called. She stated this is when she first learned that there was a gas leak and that they found carbon monoxide. She said that it was reported to her that the fire department had found a small gas leak. She said from what she understands, the alarm would have been triggered if there was over 50 parts per million of carbon monoxide in the building. She said that she did not believe that the small leak was harmful. She said the problem was resolved within an hour. She stated that carbon monoxide poisoning could cause headache, sleepiness, nausea and if super high could cause death. She confirmed that she was present for the morning meetings the week of 3/20-3/24/23 but denied anyone mentioning a gas leak. She informed me that she take the notes for their morning meetings.She stated she didn't smell any gas odors during the week of 3/20-3/24/23. She stated the FD did not tell her to evacuate the residents. According to her, she informed her corporate RVP and VP of Clinical Services Director and was advised to follow directives of the fire department, keep them informed and take the residents vitals. She stated that the DON, ADON are charge in her absence and any emergencies are supposed to be handled by the maintenance director. An interview was conducted with Resident # 9 on 3/29/23 at 10:28am, she stated that the Administrator was aware of the gas smell because on or about 3/21/23, she told her that she had been smelling gas for a few days. She said that the Administrator told her that the smell was coming from some flooring on Hall 500, but she did not believe her. She said the Administrator should have called the gas company. She said that the Administrator was not trustworthy and did not care about the residents. Record review of Resident #9 MDS dated [DATE] revealed C0500. BIMS summary score was 15. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with CNA N on 3/29/23 at 10:48 a.m., revealed that she was off a few days during the week of 3/20-3/24/23 but believe she returned to work on 3/24 or 3/25/23 and could smell gas. She said she called the ADON on Saturday (3/25/23) around 9:30 a.m. on the on-call phone to inform her that she could smell gas. She said the ADON told her she would call Administrator and let her know, but maintenance was aware of the problem. She said that she had a headache and was feeling sleepy on 3/25/23. She said that someone called 911 and the fire department told RN V that they found high levels of carbon monoxide in the building. She said there is no freedom to voice concerns in the building, but she did report the gas smell to ADON. She said although she made the ADON aware of it on Saturday 3/25/23, but ADON and Administrator allowed another day to go by without doing anything. An Interview was conducted with CNA Q on 3/29/23 at 10:50 a.m., states that she was ill from the gas fumes. She said they wanted the fire department to come to Solidago because they were worried about the residents. She said that the CNAs care more about the residents than the Administrator does. She said that she works Hall 200 mostly, but she also helps with Hall 100. She said that there was a gas smell in that area (Halls 100 and 500) for over a week. She said she was having headaches and nausea from the gas smell. She said staff would talk amongst themselves, but they were afraid to call and get help. An interview was conducted with RN V on 4/3/23 at 2:49 p.m., she stated that the fire department came while on her 6a-6pm shift on 3/26/23. She said that upon their arrival she immediately text the ADON (per chain of command). She said that there were approximately 4 or 5 on the fire team. She said that they began to walk throughout and around the outside of building checking for carbon monoxide. She said she was informed by a member of the FD that the carbon monoxide levels were high in the room where the puzzles were located (at the end of 100 and 500 halls) and boiler room. She said that the ADON said that she let both the Administrator and Maintenance Director know that the fire department was there due to the gas leak. At first, she said that the Administrator told her that the fire department was not there because she had checked the cameras. She said that she took a picture of the fire truck on her cell phone and text it to her. She said that she allowed Chief C to communicate with the Administrator from her cell phone. She said that she started soliciting help to evacuate the residents, getting them dressed and helping transfer them to their wheelchairs, because the FD told her that she needed to evacuate the residents from Hall 100. She said this is what Chief C told her to do. She said when she got back on the phone, the Administrator said that she was told that the levels were low and there was no need to evacuate the residents. She said that it was obvious that the FD felt they were not moving the residents fast enough, because Chief C announced that he would shut the whole building down if they did not start moving the residents. She said she text the Administrator again because she wanted to make sure she was okay with them moving the residents. She said that the Administrator responded, You were already moving them RN V. She said there was a lot of commotion because it was also time for change of shift. She said one fireman was observed coming from the outside and another from the back of the building. She said that only a few residents had been evacuated to the front lobby when she was informed that the fire department was going to shut down the gas line. The residents were taken back to their rooms. She was told that they were airing out the building and had propped open the back door for air to circulate. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview with Fire Chief A of the local fire department (FD) on 4/4/2023 at 9:24a.m. revealed that A shift responded to an anonymous 911 call from the facility on 3/26/23. He stated that they found the area near the lobby/nursing station had a carbon monoxide reading of 35 parts per million (PPM) on their gas monitoring device which samples air and is used to detect oxygen (O2), carbon monoxide (CO), hydrogen sulfide (H2S ppm) and volatile organic compounds (VOC ppm). He said that they must always do an air sample when there is complaint of a gas smell. As they moved further down Hall 100 and entered the boiler room located at the back of the building (where Halls 100 and 500 intersect), they found that the reading was 700 parts per million of carbon monoxide. Chief C informed RN V that they needed to evacuate the residents from Hall 100. He said that Chief C talked to the Administrator and maintenance director and when he noticed that staff were not moving residents off the hall, he announced that he would shut the whole building down. He stated that they decided to shut the main gas line down because natural gas not burning properly created the carbon monoxide. So, cutting the gas supply would eliminate any carbon monoxide because even a small amount of carbon monoxide can be harmful to the residents. He said they opened doors and allowed the carbon monoxide to dissipate before they left the facility. FD recommended that the facility contact a certified plumber. FD stated some symptoms of carbon monoxide poisoning included dizziness, headaches, shortness of breath, and loss of consciousness An interview was conducted with Therapy Director on 4/4/23 at 10:45 a.m., revealed that a gas odor was strong between 3/22/23-3/26/23 as the therapy room is in the corner of Hall 500 (where the highest concentration of carbon monoxide was found). She reported the gas odor to the Maintenance Director on or about 3/22/23. He said that he would investigate it. She said that she kept the door to therapy closed. She said that the maintenance director talked about the gas leak multiple days in the morning meeting. She said that she mentioned it in the meeting too because the smell was strong. She said the maintenance director said he was working on it. She recalls the Administrator, ADON, SW, BOM, WCN and maintenance director being present for those meetings during the week of March 20-24, 2023. Record review of resident #1 face sheet revealed he was a [AGE] year-old male who was diagnosed with chronic obstructive pulmonary disease (COPD-a condition involving constriction of the airways and difficulty or discomfort in breathing) heart failure, cellulitis (a bacterial skin infection), muscle weakness, chronic pain, polyneuropathy (malfunction of many peripheral nerves through the body), chronic atrial fibrillation(an irregular and often rapid heart rhythm and mood disturbance and anxiety. He resided on Hall 100. Record review of Resident #1 MDS dated [DATE], section C0500. BIM summary score was 15. An interview was conducted with Resident # 1 on 4/4/23 at 11:15 a.m., he said that it was difficult for him to breath due to the strong gas odor on or about 3/25/23. He described the smell as a heater furnace just being turned on for the first time in the winter. He said that a nurse (later known as RN V) came to open his window to allow a flow of air. He was later moved to the lobby. He utilizes an oxygen concentrator. He said he told the nurse that he was having difficulty breathing earlier in the day on 3/26/23. He did not specify which nurse. He says multiple different staff came to his room. But, it was not the same nurse that opened his window. He said that the night nurse took his vitals. (continued on next page)

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	675214	A. Building B. Wing	05/01/2023

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of resident # 2 face sheet revealed that he was a [AGE] year-old male who is diagnosed with unspecified dementia, muscle weakness, abnormalities of gait and mobility, generalized arthritis, insomnia, post-traumatic stress disorder (PTSD). He resided on Hall 100. Record review of Resident # 2 MDS dated [DATE], revealed section C0500 BIM summary score was 8. An interview was conducted with Resident #2 on 4/4/23 at 11:26 a.m., he said that he experienced fast heartbeat and was light-headed on or about 3/26/23. He said LVN U asked him if he could smell gas earlier in the week and he said that he did not smell anything at that time. But, on 3/26/23 he could smell gas and was light-headed. He said he does not usually feel that way. Resident # 2 resided on Hall 100. An interview was conducted with ADON on 4/4/23 at 11:31am, she said that she was informed of the gas leak during morning meeting on 3/24/23, if she can recall correctly. She said the maintenance director announced that he was trying to resolve the problem. She said she received a text from RN V on 3/26/23 stating they could smell gas. She said she informed the Administrator. She said she was told that the maintenance director was working on fixing the problem. She was informed by the night nurse that the fire department had shut off the gas line on 3/26/23 due to them finding CO in the building. An interview was conducted on 4/5/23 at 10:42a.m. with Texas master licensed plumber. He stated he was completing another job for this facility on 3/27/23 related to draining and an employee said that they had an issue with gas. He stated he used a gauge test with air after shutting off the gas to check the pressure and the gauge was dropping slowly at 10psi. He stated it was letting air go through which would mean there is a leak. He replaced the valves on the meter on which had the central heating and water heater because it was where the leak was found. He called the gas natural gas. He did not check for carbon monoxide. He said he does not normally check for carbon monoxide. A group interview ensued with Chief A, Chief C and attempted interview with Chief B on 4/6/2023 at 10:30 a.m., Chief A stated that they found carbon monoxide at the facility Chief B -was dispatched just before the interview started. Chief A stated that he arrived about 15 minutes after the team arrived to assist. (continued on next page)

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Chief C stated that he spoke with the Administrator and Maintenance on 3/27/23. He told the Administrator that the carbon monoxide was found in the building and numbers were highest in the back of the building near Halls 100 and 500. At that time, he stated that they needed to evacuate the residents down Hall 100. He said that the Administrator was pushing back. She said that maintenance told her that the levels were 13/19 ppms. He said he was the person that talked to maintenance, and he never told him that. He said the carbon monoxide numbers were not as high in the front of building or outside, but they were at 700ppms in the boiler room. He said that he handed the phone to RN V and when he did not observe them moving the residents, he announced at the front nursing station he would shut the whole building down. By that he said he would have called ambulances to transport the residents to a nearby hospital because any amount of carbon monoxide can be hazardous to people who are already ill. He said that he has never dealt with an administrator that would not follow his orders. He said the nurse handed her phone to him maybe twice, he felt like the Administrator was giving the nurse pushback too. Record review of the morning meeting sign-ins revealed: 3/20/23- did not have a sign-in sheet provided 3/21/23- Administrator, DON, ADON, Wound Care Nurse, BOM, Therapy, SW, HR, Maintenance signed in for the meeting 3/22/23- Administrator, DON, ADON, Wound Care Nurse, BOM, Therapy, SW, HR, Late -Maintenance Assistant was here was written in on the line where maintenance signs. 3/23/23-Administrator, DON, ADON, Wound Care Nurse, BOM, Therapy, SW, HR, Late -Maintenance Assistant was here was written in on the line where maintenance signs. 3/24/23- Administrator, DON, BOM, Therapy, SW, Maintenance, HR There were no notes concerning a gas leak in the morning minutes. Record review of resident rights policy revised on 10/1/2020, stated in part 26. Homelike Atmosphere. Each resident has the right to a safe, clean, comfortable, and homelike environment. A subsequent interview was conducted with ADON on 4/6/2023 at 12:44pm, she stated that it was on Thursday in stand-up, maintenance director said that a plumber was coming. She said that she made a mistake on the date of the stand-up meeting because she worked on Thursday night (3/23), so she was not in the morning meeting on 3/24. It was on 3/23/2023, if she recalls correctly. She said that the Maintenance director only said that he had a plumber coming. She said that they knew there was a boiler issue on Hall 500. The managers talk all day long, so she is not sure when the boiler issue first came up. She said that she first learned that it was gas leak when she received a text by RN V on Sunday (March 26th). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	RN V text her at 3:55pm, Hey the gas leak is a concern do we have a Co2 detector?. She said she asked her what is a co detector?. She notified the Administrator immediately via text. She said that the Administrator was driving but said she would call maintenance. She said RN V said she was concerned that it was carbon monoxide poisoning. She said that she told RN V, Maintenance and Administrator are aware and that they were in communication, if it was carbon monoxide the alarm would have gone off. She said she never talked to the fireman, she said that was something that Administrator needed to talk to them about. She said she talked to RN BB and he said fire department wanted them to evacuate the residents. Then, RN BB told her that the FD said don't move the residents because the carbon monoxide was so low that they did not have to move the residents. She said that she was going to head to the facility, but RR BB told her to hang tight, he didn't think he needed her to come because the fireman was coming back to him to report. She stated at 6:23p.m., RN BB text and said that fire chief wants everyone off Hall 100. Minutes later he said no need to evacuate because the fireman said the gas was being turned off. She denied that anyone reported or informed her that they smelled gas in the facility. She said the risk of carbon monoxide depends on the levels of gas exposure, headache, altered mental status the risk of gas or carbon monoxide exposure. She stated, If she was the Administrator, she would have immediately called the fire department or have maintenance shut the gas down. She stated that Resident # 13's family member reported the gas smell to her on March 26, 2023. A subsequent interview was conducted with maintenance director on 4/6/23 at 1:14pm, he said this is how he recalls the week of March 20-26, 2023: Thursday - (3/23)- report of gas smell from therapy director and an unnamed nurse. He stated that he went by the Administrator's office and reported it to her. He said both himself and his assistant worked on soaping the joints to try to find a leak on both Thursday and Friday. He said that they sprayed gas lines in 5 mechanical rooms. No leak found. Saturday (3/25)- came to the facility to soap more of the lines. No leak found. Sunday (3/26)- call from RN V said FD was there and wanted to speak with him. He said that he is not sure of the FD personnel that he spoke with, but he did say that they found carbon monoxide. He said he is not sure what amount. But high because he said that they were going to evacuate the residents. Then, he was told that the FD was just going to cut the gas line supply off and that he would need to get a plumber to fix the valves. An interview was conducted with BOM on 4/6/23 at 2:00 p.m., he stated that he recalls maintenance director informing them in morning meeting during the week of 3/20-3/24/23 about a gas leak. He stated that he attended morning meetings every day that week. He said that he recalls the Administration, Wound care nurse, Therapy Director, maintenance, and ADON in these meetings. An interview was conducted with Med Aide A on 4/6/23 at 2:32 p.m., she stated she had headaches and the stated that the gas smell started on or about 3/21/23, she was told it was not gas. That they were working on flooring down Hall 500. She said therapy was complaining about the smell too. She said her normal shift consisted of passing medication on Halls 100 and 200. She said that called in to work on 3/24/23 because she was not feeling well. She had a bad headache and nausea. (continued on next page)

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A subsequent interview was conducted with the Administrator on 4/6/2023 at 2:51 p.m., she stated that she was not informed by maintenance nor any other personnel that there was a gas smell in the building. She first learned about the gas leak/carbon monoxide on 3/26/23. She denied the fire department staff told her to evacuate the residents. She said that it was RN V that wanted to move them, so she asked to speak to Chief C. She said that the risk of being exposed to carbon monoxide above 50ppms could cause headaches. She said that the carbon monoxide was low otherwise the alarm panel would have alarmed, according to her understanding of the fire panel at Solidago. She said that Occupational Safety and Health Administration (OSHA) standards says 50ppm of carbon monoxide is not hazardous. She did not provide any literature for OSHA Therefore, she did not see the harm. She did not call in an incident report to Health and Human Services for this reason. Review of the facility's activity report dated 3/26/2023, revealed that Resident #13 family came to visit. They were concerned about the smell of gas. RN V said that she would report it to administration. Resident #13 was not interview able. He resided on Hall 100. Record review of the facility census dated March 29, 2023, revealed that Resident #13 resided on Hall 100 close to the end of the hall where Hall 500 intersects. An interview was conducted on 4/10/2023 at 12:57pm, the former Wound Care Nurse stated in morning meeting on approximately 3/20/23 or 3/21/23, therapy director reported that there was a strong smell of gas. She told the administrator that she had been smelling gas for a while. The Administrator stated that the 500 unit used to be on a separate gas line. That is why they could be smelling gas. He said multiple days it was bought up in the morning meeting. He said he felt like he was walking uphill for over a week. He said he would not return to work as he was not feeling well. He believes that the gas smell was making him sick because otherwise he had been healthy. He said that he would start to feel ill once he came in to work for almost a week or so. He said he had experienced headache and nausea. He said that it's scary because they have a lot of smokers in the facility and a lot of things that could have happened. His last day working at the facility was on 4/4/23 because he kept getting sick and other Administrative issues, which he did not want to discuss. An interview was conducted with the SW on 5/1/23 at 11:25 a.m. he stated that he attended morning meetings and stated that they were informed by maintenance that there was a gas leak sometime between 3/20-3/24/23, and he said that he informed the Administrator that he could smell gas directly as he his office was in the back of the building near Halls 100 and 500. He said that the Administrator told him that the smell was flooring down Hall 500. He said that he knew it was a smell of gas. He did not push the issue because he was a new employee. He said that his date of hire was on 2/20/23. Record review of a letter from plumbing company, dated April 10th, 2023, revealed that they were working at the facility on March 27 doing some repairs to sewer line, same day that facility staff asked technicians to check on a smell of gas in the mechanical room. Technicians proceed to test the gas line with 10 PSI of air for 15 minutes and pressure dropped very slow, indicating that there was a leak in line. Technician turned gas off until parts were ordered, and service could be completed. The technicians ordered new