STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675253	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalea Trail Nursing and Rehabilitation Center	411 Spring Creek Rd Grand Saline, TX 75140

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 5 residents reviewed for care plans. (Resident #1) The facility failed to care plan the bed alarm being discontinued on 07/21/25 for Resident #1. The facility failed to care plan Resident #1's fall with major injuries on 08/06/25. These failures could place residents at risk of not having individual needs met and not receiving needed services. Findings included: Record review of a face sheet dated 11/19/25 indicated Resident #1 was an [AGE] year-old female admitted on [DATE] with left hip fracture.Record review of Resident #1's significant change MDS assessment dated [DATE] indicated her BIMS was 03 which indicated severely impaired cognitive level. She was dependent on staff for personal hygiene and required maximal assistance toileting. She had a fall in the past month and with fracture. Record review of Resident #1 physician's orders dated August 2025 indicated on 07/21/25 the bed alarm was discontinued. Record review of Resident #1 progress note dated on 08/06/25, the Resident #1 fell and was sent to the hospital Record review Resident #1 progress note dated 08/09/25, the Resident#1 was readmitted with diagnosis of a fractured right hip. Record review of Resident #1's care plan dated 07/30/25 did not address the bed alarm being discontinued on 7/21/25. Record review of Resident #1's care plan dated 08/14/25 in the electronic record did not address her fall on 08/06/25. During an interview on 11/19/25 at 11:00 a.m., the DON said the facility had slowly been discontinuing the use of bed alarms because the bed alarms were restraints and can be only used for certain diagnoses like seizures. She said the medical director does not use bed alarms. During an interview on 11/19/25 at 11:45 a.m., the Medical Director said he discontinued the bed alarms at all the facilities because they are restraints and do not prevent falls, most of the time the residents have already fallen. He said we were just checking on the residents more frequently; however he did not say a time frame. He said with Resident #1 the bed alarm would not have prevented her from falling. During an interview on 11/19/25 at 1:00 p.m., CNA A said she checks on Resident #1 frequently and said when she goes up and down the hall she would checks on all residents with high risk for falls frequently. She pointed to the doors that had stars and said those get frequent checks. She was unable to say a time those checks were done. She said the high fall risk residents had alarms, but they were discontinued by the medical director. During an interview on 11/19/25 at 2:00 p.m. the DON said the electronic record did not contain an update after the fall on 08/06/25. She said they would search for the acute care plan in a binder at the nurse's station. She said her expectation was for the care plan to be updated as required. During an interview and record review on 11/19/25 at 3:00 p.m., DON presented an acute care plan dated 08/06/25 and it contained a new approach of frequent visual checks to monitor Resident #1. The frequent visual checks did not indicate how often or when to check on the resident. She presented a bowel and bladder schedule and said they did not have anything else. She said the care plan did not contain information about discontinuing bed alarms. Record review of Restraint Free Environment dated 07/01/25 indicated . The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint. Record review of the Resident Alarms dated 07/01/25 indicated It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs. Implementation of interventions . d Interventions shall be communicated to all relevant staff, including frequency/ time frames and responsibility.