

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2024
NAME OF PROVIDER OR SUPPLIER  Azle Manor Health Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  721 Dunaway LN Azle, TX 76020	

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)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894</b></p> <p>Based on observation, interview and record review the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 8 residents (Resident #50) reviewed for effective pest control on Hall 6.</p> <ol style="list-style-type: none"> <li>1) The facility failed to effectively treat for the flies in Resident #50's room.</li> <li>2) The facility failed to implement preventative measures to prevent flies.</li> </ol> <p>These failures could place residents at risk for the potential spread of infection, cross-contamination, and decreased quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #50's face sheet, dated 08/12/2024, reflected the resident was admitted to the facility on [DATE]. Resident #50 had diagnoses which included Paroxysmal Atrial Fibrillation (when a heartbeat returns to normal within 7 days, on its own or with treatment); Vascular Dementia, Unspecified, Severity with Other Behavioral Disturbances (changes in personality, behavior, and mood, such as depression, agitation, and anger); and Paraplegia, Incomplete (a partial loss of function in the legs and lower body that occurs when the spinal cord is not completely severed).</p> <p>Record review of Resident #50's, MDS (Minimum Data Set) dated 02/20/2024, reflected Resident #50's BIMS (Brief Interview for Mental Status) score was noted to be 15/15, which indicated memory was intact. Resident #50 required moderate to maximal assistance making decisions regarding tasks and providing daily care.</p> <p>Observation on 11/12/2024 at 11:00 a.m. revealed Resident #50 had 4 to 5 flies landing on his left leg. Resident #50 only wore a hospital gown and did not have a sheet or blanket on him. A small bloody area on his left shin with a piece of medical tape on the area was observed and the flies were landing on that area of his leg. Resident #50 expressed his frustrations with having to fight off the flies. The resident revealed the flies did bite him at times. He was unable to fully move to swat the flies away from him. The resident revealed he couldn't do anything to help with this.</p> <p>Interview on 11/13/2024 at 1:50 p.m. with the LVN C (Wound Care Nurse) revealed he completed a treatment on Resident #50 right leg for a skin tear. LVN C revealed a skin tear was not open for flies to touch.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2024
NAME OF PROVIDER OR SUPPLIER  Azle Manor Health Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  721 Dunaway LN Azle, TX 76020	

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)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/13/2024 at 4:46 p.m. with the Administrator revealed problems with flies in Resident #50's room.</p> <p>The Administrator called the pest control company to treat for flies immediately. Pest control company sprays for flies on a regular basis. Facility does not normally have problems with flies. The Maintenance Director is responsible for pest control in the building. The Administrator's expectations were for the staff to monitor all issues with pests and to report problems immediately to the Maintenance Director to contact pest control. By not controlling the flies in the building this could cause the spread of infection by the flies landing on the residents and cross-contamination to the residents.</p> <p>Record review of the facility's Pest Control policy, revised 01/24/2024, reflected, Policy Statement: Our facility shall maintain an effective pest control program. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents; Pest control services are provided by [NAME] G Pest Control. Garbage and trash are not permitted to accumulate and are removed from the facility daily; Maintenance services assist, when appropriate and necessary, in providing pest control services.</p>