STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34463 Based on interview and record review the facility failed to have evidence that all alleged violations were thoroughly investigated and reported the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation was verified appropriate corrective action was taken for 6 of 6 Residents (Resident #7, #8, #9, #10, #11, #12) reviewed for allegations involving abuse, physical environment, and infection control. 1. The facility failed to complete a Provider Investigation Report for 3 of 3 intakes involving Resident #7, #8, #9, #10, #11, #12. These failures could place residents at risk for abuse, injury, and a diminished quality of life. Findings include: Record review of the facility Provider Investigation Reports reflected the facility did not have a PIR for Intake #493566, #503304 and #503492. Record review of TULIP (Texas Unified License Information Portal) system on 5/21/24 reflected the facility failed to submit a PIR through TULIP for Intake #493566, received date 3/28/24, allegation infection control, involving Resident ##7, #8, #9, #10, #11. Record review of TULIP system on 5/21/24 reflected the facility failed to submit a PIR through TULIP for Intake #503304, received date 5/9/24, allegation physical environment. Record review of TULIP system on 5/21/24 reflected the facility failed to submit a PIR through TULIP for Intake#503492, received date 5/10/24, allegation abuse, involving Resident #12. In an interview on 05/21/24 at 2:14 PM the Administrator stated she thought the facility did not have to complete a PIR 3613-A report. She thought the facility just had to send an email to CII. She did not have a 3613-A form or Provider Letter on hand. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/21/24 at 2:57 PM the Administrator stated she was familiar with the 3613-A PIR form, and she knew how to use the form. The Administrator said she thought the PIR was no longer required and she just needed to send an email to TULIP with her findings of her investigation. Nobody told her she was doing something wrong. In an interview on 05/21/24 at 3:10 PM, Regional Nurse B stated the Administrator was trained on her job duties by the corporate team. Once the facility notified the corporate team a self-report was identified, the facility sent the 5-day reports to the corporate team prior to submission. The facility had to make the corporate team aware that this occurred. The Regional Nurse said she was not aware of any self-reports, other than a recent allegation of abuse. She was not aware of any other reports. It was important for the facility to investigate incidents so they could find out if the incident occurred and to put measures in place to prevent incidents from reoccurring. Record review of the facility's policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, reflected .Follow-Up Report 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. 3. The follow-up investigation report will provide as much information as possible at the time of submission of the report. 4. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on interview and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for 2 of 2 residents (CR#1 and CR#2) reviewed for quality of care. 1. The facility failed to ensure emergency medical treatment was provided in a timely manner to CR #1, after he missed 3 to 4 days of dialysis, his doctor gave orders for hospital evaluation and treatment, and the Dialysis Nurse expressed concerns of fluid overload. 2. The facility failed to ensure emergency medical treatment was provided in a timely manner to CR#2, after his doctor gave orders for a blood transfusion, which was an emergency situation. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not receiving needed care and services to meet their physical, mental, and psychosocial needs. Findings include: 1. Record review of CR#1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. CR #1 had diagnoses which included Acute and Chronic Respiratory Failure with Hypoxia (not enough oxygen in the body all at once-acute, or over time-chronic); hypokalemia (low blood potassium levels); End-Stage Renal Disease (an individual's kidneys no longer function and require a regular course of long-term dialysis or a kidney transplant to maintain life); and hypertensive heart disease without heart failure (changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation). Record review of CR#1's care plan, dated [DATE], reflected CR#1 was at risk of falls related to weakness and impaired mobility. Record review of CR#1's progress notes, dated [DATE], reflected the following: at 12:06 PM, CR#1 was found unresponsive at 11:25 AM. Nurse called out to resident, no response, sternal rub performed, no response. Pulse checked, undetected. Nurse immediately called code blue and began ambu (provides respiratory support to patients in emergency and non-emergency situations) bagging resident. When RT Aide walked in to assist with bagging, nurse began compressions. No blood pressure reading obtained due to condition, blood glucose 215 at time of first round of compressions. 11:30 AM AED pads placed on resident no shock advised. 911 was called and CPR continued until arrival of EMS. Multiple rounds of CPR done, when EMS arrived monitor placed, and no pulse detected. EMS called of death 11:45 AM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of CR#1's progress notes, dated [DATE], reflected the following: Dialysis nurse verbalized concerns for fluid overload due to inability to perform dialysis Saturday and today [DATE]. CR#1 received orders to be sent out to the ER do restores function to port and receive dialysis in hospital. Transport scheduled to pick up resident with 2 hours. Resident in bed resting, no distress noted at this time vs WNL, no c/o pain or discomfort at this time. Record review of CR#1's Dialysis Center Treatment Detail Report, reflected the following: [DATE], Treatment Nurse Assessment: Time: Pre-6:42 AM and Post: 10:31 AM-Comment: Patient Treatment terminated early due to problematic CVC. MD notified. Record review of CR#1's dialysis center patient notes, reflected the following: CR#1 treatment terminated early due to problematic access . Patient had 118 minutes remaining at the time of treatment was discontinued. Notified Dialysis MD, ordered the patient be sent out to the hospital to treat and evaluate catheter. Record review of CR#1's Dialysis Communication form, reflected the following: [DATE], Dialysis Access Notes: problematic, alarmed throughout treatment, catheter problematic treatment terminated early. MD notified. 2. Record review of CR#2's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. CR #2 had diagnoses which included diagnoses of Metabolic Encephalopathy (problems with your metabolism, like low blood sugar or excess brain fluid, cause brain dysfunction); Dysphagia (difficulty swallowing); End-Stage Renal Disease (an individual's kidneys no longer function and require a regular course of long-term dialysis or a kidney transplant to maintain life); Type 2 Diabetes (a chronic condition that happens when an individual has persistent high blood sugar levels, due to their pancreas' inability to produce enough insulin, or their body not utilizing insulin properly, or both); Chronic Obstructive Pulmonary Disease (chronic inflammatory lung disease causing restricted or obstructed airflow and breathing problems); and, Unspecified Acute Myocardial Infarction (also known as a heart attack, which occurs when blood flow to the heart muscle is abruptly cut off, causing permanent damage to the heart muscle). Record review of CR#2's admission MDS, dated [DATE], reflected the resident's BIMS score was 8, which indicated moderate cognitive impairment. The resident had minimal difficulty in hearing, unclear speech pattern, was able to make himself understood sometimes and usually understood verbal content. The resident was dependent on staff for all ADL's and maximal assistance with oral hygiene. The resident was receiving oxygen therapy, scheduled suctioning, ventilator, dialysis, and speech therapy five days a week for 45 minutes. Record review of CR#2's care plan, last revised on [DATE], did not reflect goals or interventions related to dialysis. Further review of the care plan reflected the resident was dependent on staff for all activities of daily living, had some confusion, needed assistance with communication. The resident also received tube feedings via enteral pumps and was at risk for swallowing problems and weight loss. Interventions included monitoring by aides and nursing staff for choking/aspiration hazard. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#2's progress notes, dated [DATE] at 9:43 AM, reflected the following: At 6:30 AM, the dialysis nurse reported CR#2 had low hemoglobin of 6.7 and received orders from the doctor to be transported to the nearest hospital for a blood transfusion via non-emergency medical services. Non-emergency services arrived at 9:45 AM, CR#2 was stable, transported to the hospital, RP and MD/NP notified . During an interview on [DATE] at 1:00 PM, Dialysis Nurse A said CR#1 had a Central Venous Catheter. She said on [DATE], CR#1 started dialysis, but CR#1 was not able to complete the full treatment. She said his ordered treatment for dialysis was for three hours and 30 minutes . She said he only completed one hour and 30 minutes of treatment . She said the resident's dialysis machine kept beeping. She said CR#1 recently received a new catheter, and the catheter was not working on [DATE]. She said she contacted the Dialysis MD who gave an order to transfer CR#2 to the hospital to have his catheter assessed and to receive further dialysis treatment. Dialysis Nurse A said CR#2 was taken back to his room. She said she verbally informed CR#1's assigned nurse, RN A , the resident needed to be transferred to the hospital to have his catheter assessed and receive further dialysis treatment. She said RN A verbally told her that RN A was going to call an ambulance to have CR#2 transferred to the hospital. She said this conversation occurred around 8:30 AM on [DATE]. She said hours later she heard a code blue being called. She said if an ESRD patient went without dialysis treatment they were at risk for experiencing confusion, fluid overload, and sepsis . In an interview with RN A on [DATE] at 3:00 PM, she said CR#1 was on Dialysis. She said the protocol for residents on in-house dialysis was to check their vital signs prior to being transported to dialysis. She said the facility nurses assigned to dialysis residents and the dialysis nurses communicated verbally. She said there was also a communication form that consisted of information on the resident, pre and post dialysis treatment. She said when she arrived at work on [DATE], CR#1 was already in dialysis. She said around 8:30 AM, Dialysis Nurse A informed RN A, CR#1 could not be dialyzed, and the Dialysis MD ordered CR#1 to be sent to the hospital. She said Dialysis Nurse A told RN A, CR#1's port was malfunctioning. She said she scheduled non-emergency medical transportation for CR#1 to be transferred to the hospital. She said the transportation service told RN A it would be 2 hours before non-emergency medical transportation would arrive at the facility. She said she did not call 911. She said she assessed CR#1 and the resident did not show any signs of distress. She said CR#1 verbalized to RN A he was tired. She said being tired was a common side effect after dialysis. She said she checked on CR#1 at 11:15 AM, and RN A found CR#1 unresponsive in his bed. She said she called a code blue throughout the facility. She said CPR was started on CR#1, EMS arrived, and CR#1 was pronounced deceased at 11:45 AM. She said if a resident did not have dialysis treatment, the resident was at risk for fluid overload, sepsis, and other serious injuries, which included death . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN C on [DATE] at 2:42 PM, she said one of the things she was responsible for was getting report from the nurses on which residents were sent out to the hospital that day and why, so she knew what beds in the facility remained empty and available. She said she was familiar with CR#2. She said the resident would open his eyes if you spoke to him, but he was difficult to understand. She said from what she could remember CR#2 was sent to the hospital on [DATE] for respiratory distress and hypoxia. She said that day, before the dialysis center began the resident's treatment, his bloodwork results showed his hemoglobin levels were low. She said she could not remember if it was nurse on the 300 hall or the DON who informed her about CR#2. She said the dialysis center was not able to perform dialysis due to CR#2's low hemoglobin. She said dialysis informed the facility nurse, and the facility set up transportation for him to be sent to the hospital. She said the facility had contracts with transportation companies set up. She said she reviewed the information entered into CR#2's electronic health record that day but could not recall all of the documentation off the top of her head. She said if the resident's pulse oximeter was good, 90 and above, it was not an emergency and 911 did not need to be call for the resident. She said she did not know how long it took non-emergency medical transportation to arrive at the facility to take CR#2 to the hospital. She said she did not know what care CR#2 received after the doctor gave the order for the resident to be sent to the hospital and the time the transportation company arrived. She said a nurse assessment of a resident consisted of checking vital signs, capillary refill, and checking whether the resident was at their baseline or not. She said the resident was opening his eyes, which was his baseline. She said the DON was responsible for reviewing nursing documentation in the resident's electronic health records. She said nurses should document their assessment information underneath the progress notes or events within the resident's electronic health record. She said she did not review the documentation entered by the nurse on [DATE] for CR#2. She said she only checked the vital signs entered into CR#2's electronic health record because she wanted to know why the resident was sent out to the hospital. She said she always checked the vital signs in a resident's electronic health record when she was notified a resident was being sent out to the hospital. She said she did not review whether the nurse completed an assessment on CR#2 on [DATE]. She said she did not remember which nurse was working with CR#2 at the time because this all occurred before her shift started that day. She said CR#2 was ordered to be sent to the hospital for low hemoglobin and he needed a blood transfusion. She said the dialysis notified the nurse on the floor that the resident was ordered to be sent to the hospital for treatment. She said this was not an emergency. She said if the resident experienced a change in condition after coming back from dialysis, and the resident's doctor said the resident needed to be sent out immediately, they would have done that. She said the nurses received their orders directly from doctors and the doctor never specified the resident needed to be sent out immediately. She said if a resident became synoptic, their lips were turning blue, had low 02 saturation, had shortness of breath, then the resident would have been considered as having an emergency. She said she was not on the floor at the time, so she would not be able to say what sort of care would have been provided to between 6:30 AM and 9:45 AM. She said the aides and nurses were at least responsible for making sure the resident was ready and prepared to be sent out to the hospital before non-emergency medical transportation arrived at the facility. She said if the facility received confirmation of a critical lab result, the nurses were going to call the doctor for further instruction. She said CR#2's order to be sent out came directly from the nephrologist. She said it would have depended on what the residents baseline was, and what the nurse saw at the time to determine whether a situation was critical. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on [DATE] at 9:55 AM, she said CR#1 received dialysis treatment on Mondays, Wednesdays and Fridays. She said she reviewed all the information regarding the situation with CR#1 on [DATE] but could not recall details. She said she reviewed the 24-hour report every morning. She said because she reviewed so much information daily, it was difficult to recall specifics about what exactly occurred with CR#1 on [DATE]. She said in reviewing the documentation nothing stuck out to her. She said the situation was handled properly. She said CR#1's assigned nurse was aware his port was not working. She said a clogged port was not a reason to send a resident out to the hospital by 911, unless there was a significant change in condition , or the doctor gave a STAT order. She said she was aware transportation services were scheduled for CR#1 but did not know the length of time between the order given by the physician and the resident being found unresponsive. She said CR#1 was assessed by RN A and CR#1 did not exhibit signs of distress. She said that was the reason the contracted non-emergency medical transportation service was contacted and not 911.She said she believed CR#1's nurse used their best judgement after receiving orders from the physician for CR#1. She said she would have to review the details again to determine whether the length of time was an issue. In an interview with the DON on [DATE] at 4:42 PM, she said she reviewed documentation in CR#2's electronic health record on [DATE] but was not aware of what care was provided to the resident between 6:30 AM and 9:45 AM. She said nurses were trained to use their best judgment in knowing when to contact emergency services for residents. She said she did not know how long CR#2 remained at the facility after an order for CR#2 was given by his nephrologist. She said if the nephrologist would have given a STAT order or the nurse observed a change in condition or signs of distress, 911 would be contacted for emergency medical treatment. She said CR#2's baseline hemoglobin level was low and CR#2 never showed any signs or symptoms of distress on [DATE]. She said there was no standard timeframe for the contracted medical transportation company to arrive at the facility. She said the facility contracted with a particular company that had necessary equipment to provide life saving measures to individuals on ventilators and trachs. She said using the transportation company was a way of ensuring the safety of the residents. She reiterated that nurses would need to use their best judgement to utilize emergency services to send residents to the hospital after scheduling and waiting for the contracted transportation. She said the nurses knew to call 911 when residents were experiencing a medical emergency. She said she was not aware of the length of time between the physician's order was given and the time the transportation company arrived to take the resident to the hospital. She said based on CR#2's history; she did not see an issue with CR#2 waiting three hours to be transported to the hospital for a blood transfusion. She stated CR#2 was pronounced deceased at the hospital much later than [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Regional Nurse Consultant A and the DON on [DATE] at 3:10 PM, the Regional Nurse Consultant said the nurses who provided care to dialysis residents were going to be looking for desaturation and the ventilator machine was going to alarm which allowed them to know there was something malfunctioning. The nurses were going to be looking at vital signs and oxygen levels. She said if there was an issue with the port, the dialysis center would set up an appointment at the hospital to have the shunt replaced. She said it was not a guarantee or a proficient tool to visually assess how much fluid a resident on dialysis retained. She said where the fluid was going to go in the body, was going to be around the organs because the fluid had nowhere else to go. That was the reason why the nurses monitored for the vital signs and oxygen levels as signs and symptoms of distress in residents on dialysis . She said there was no way of seeing fluid overload during a visual assessment. She said the best practice was for nurses to go by the residents' blood pressure standards and airway standards. She said the best practice for contacting emergency services was for residents experiencing chest pain or a GI bleed, which was an automatic call to 911. She said the dialysis residents were just like any other residents when it came to acute situations. The nurses were trained to monitor the same vital signs for residents whether they were on dialysis, or not. Both the regional nurse and the DON agreed that most individuals on dialysis that might have experienced fluid overload did not experience pain. The regional nurse said they would more so experience shortness of breath. The DON said CR#1 was not showing any signs of distress or any signs or symptoms prior to beginning dialysis, because if he had, they would not have begun dialysis. She said the dialysis center ran labs and checked vital signs before starting a resident's dialysis, and CR#1's labs came back normal. She said it was part of the protocol for the dialysis center to check vital signs again at the end of dialysis treatment. The DON said the dialysis enter checked CR#1's vitals, and he was stable at that point. The DON said when CR#2 came from dialysis there was no indication the resident was experiencing any sort of symptoms or distress of any kind. Regional Nurse Consultant A said she reviewed CR#1's doctor orders, and he was only being sent to the hospital to have his shunt replaced. Regional Nurse Consultant A said there would have had to be a break, possibly a day or two, between the resident receiving dialysis treatment and having a shunt replaced. She said an individual would have to be NPO for a certain amount of time, a surgeon had to be available for, and schedule the surgical procedure to replace a shunt. The DON said having a shunt replaced would take some time to set up and was not an immediate kind of thing anyway. She said the nephrologist decided whether, a resident moved forward with dialysis treatment based on their assessment of the resident's weight and labs drawn the morning of the scheduled treatments. She said the results of the BUN/Creatinine ratio indicated to the nephrologist whether the resident was experiencing fluid overload. She said CR#1 was not examined by the coroner's office. She said if there was no coroner's examination completed on a body, no definitive cause of death was provided. She said the coroner would look at a resident's medical history and decide the cause of death, based on their history. The DON said when CR#2 came from dialysis there was no indication the resident was in any sort of distress, based on his vital signs. She said there was a dialysis information sheet with data documented before and after dialysis. The DON said the form listed how much fluid in liters were pulled off the resident during dialysis. She said any pertinent information, like vital signs, pre and post weight, and issues or concerns were documented by the dialysis center nurse on the information sheet. The DON said if there was something that went on or was noticed during dialysis, the dialysis nurse would bring the information sheet directly to the nurse assigned to the resident on the hall. She said if there was an emergency during dialysis, they would call 911 immediately from the dialysis center. She said if there was no issue, once dialysis was closed for the day, the dialysis nurse placed the information sheet in a folder on the medication cart of the nurse assigned to the resident's hall. She said the nurse assigned to the resident was responsible for reviewing the information sheet by the end of their shift. The DON said after the information sheet was reviewed it went to the nurses' station for filing with medical records. The DON said none of the residents' primary doctors were responsible for monitoring dialysis care. She said dialysis was monitored specifically by the residents' Nephrologist and Urologist. She said if it was not anything that was critical or acute going on with a resident on dialysis the nurses were not going to contact the residents' physicians. The DON said there was no special sort of care, monitoring or assessments done on residents who were on dialysis. Regional Nurse Consultant A said people who lived out in the community and were on dialysis were able to go home all the time after

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with RN C on [DATE] at 10:50 AM, she said if a resident's dialysis port was malfunctioning, she would call the doctor. She said if the MD ordered the resident be transferred to the hospital, she would call 911. She said because the resident had not had dialysis for days she would call 911. She stated when a resident was not dialyzed the resident was prone to fluid overload, electrolytes would not be good, the resident would be confused and the level of consciousness would be affected. In an interview with the Administrator on [DATE] at 8:38 AM, she said she became aware of the timeframe between the orders for CR#1 and CR#2 to be sent to the hospital and non-emergency transportation arriving at the facility when the facility received the IJ on [DATE]. She said it was her expectation of the DON to review the 24-hour report on a daily basis and discuss things like this during their afternoon daily call. She said it was her expectation of the nurses to be able to exercise good judgment and follow best practices when they provided care to residents. She said CR#2 should have been assessed after he returned from dialysis. She said after the IJ was called; the facility reviewed information they collected as part of an audit of residents on dialysis. She said she became aware of communication issues between the dialysis center staff and nursing staff, and a lot of the information required on the communication form between the center and nursing were not completed by nursing staff prior to residents being sent to dialysis. She said she did not think three hours was an appropriate amount of time for any resident who needed emergency medical treatment to wait for transportation, even if a doctor did not explicitly give an emergency order. She said any resident was put at high clinical risk in a situation like that. She said all staff were currently being trained and in-serviced. She said the nurses were being trained to recognize that an order for a resident not being dialyzed, even with notification to the doctor was an emergency and residents could be sent out via emergency services to receive the needed treatment at the hospital. She said the nurses could still utilize the non-emergency transportation, but only for things like routine visits, or when the timeframe of arrival was within reason, based on the resident's condition. She said three hours was not an acceptable timeframe for CR#2 or any other resident on dialysis that needed emergency medical treatment. She said nurses were also being trained to conduct full assessments on residents every 15 minutes, document their findings in the resident's chart, contact the doctor if a change in condition was noted, or call 911 and notify the doctor, the DON, and the RP after. In an interview with Regional Nurse Consultant B on [DATE] at 4:23 PM, she said she was made aware of the delays in transportation for emergency medical treatment for CR#1 and CR#2, understood and agreed they were cause for concern. She said she was working with the Administrator to get the DON and Regional Nurse Consultant A trained on facility expectations. She said she was also working with the DON and Regional Nurse Consultant A to ensure the rest of the staff were trained and exhibited competency in communication expectations, recognizing signs and symptoms in residents, conducting thorough assessments, documenting those assessments, and making proper notifications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Regional Nurse Consultant B on [DATE] at 12:58 PM, she said if there was any delay in non-emergency medical transportation for any reason, the nursing staff were aware they needed to contact the DON for further directives. She said if transportation was delayed for a doctor's appointment or a routine procedure, they could contact the doctor for further directives. She said however, if the resident was dealing with something that could cause an infection or worsening of their condition, the staff were aware they needed to contact 911 immediately. She said the staff also understood they were not doctors and could not determine how a delay in transportation would affect a resident. So, to air on the side of caution, the staff knew they would call 911 in those instances. She said they would still notify the doctor, but they were not going to wait on non-emergency medical transportation. She said identifying the IJ situations highlighted the fact that there was a missing piece of the puzzle with nursing staff. She said all the tools were there for all staff to use, they were not utilizing them. She said the DON was completing in-services and trainings with staff, but she was not requiring nursing staff to show competency. She said the DON was not following up or doing thorough reviews of nursing documentation enough to identify situations that needed to be addressed or improved. She said now, the staff were clear they were going to be required to show competency of their skills. She said the nursing staff were re-trained and re-in-serviced on change of condition, SBAR, completing a proper shift change with oncoming staff, communication, assessments, reporting, making the necessary notifications, and follow through. She said they were continuing to work through educating the entire staff. She said another big takeaway was the lack of communication, internally, when it came to nursing and the dialysis center staff. The staff were now clear that while the dialysis center functioned separately from the facility, there was overlap in work. She said the facility nurses and the dialysis nurses now understood they were all intertwined, and not separate. She said they were all essentially part of the same team and communication from dialysis was also to be shared with residents' primary physicians. Record review of the facility's Charting and Documentation policy, revised [DATE], reflected the following: All services provided the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .2. The following information is to be documented in the resident's medical record: a. objective observations; b. medications administered; c. treatments or services performed; d. changes in the resident's condition; e. events, incidents or accidents involving the resident; and f. progress toward or changes in the care plan goals and objectives .7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individuals who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused procedure/treatment; f. notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Change in a Resident's Condition or Status policy, revised February 2021, reflected the following: 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): .d. significant change in the resident's physical/emotional/mental condition .g. need to transfer the resident to a hospital/treatment center; i. specific instruction to notify the physician of changes in the resident's condition .2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; b. impacts more than one area of the resident's health status; c. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR Communication Form .8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resid [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on observation, interview and record review the facility failed to ensure a resident who needed respiratory care, including tracheotomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the 'residents' goals and preferences for one of two residents (Resident #1) reviewed for tracheotomy care. 1. The facility failed to ensure sterile technique when Resident #1 changed her inner cannula on 05/15/24. 2. The facility failed to ensure Resident #1's MD was notified Resident #1 changed her inner cannula on 05/15/24, per facility policy. These failures could place residents at risk for respiratory infections, hospitalization s, and a decline in overall quality of life. Findings include: Record review of Resident #1's face sheet, dated 05/23/24, reflected a female who was admitted to the facility on [DATE] with diagnoses which included Acute and Chronic Respiratory Failure with Hypoxia (not enough oxygen in the body all at once-acute, or over time-chronic); Dysphagia (difficulty swallowing); End-Stage Renal Disease (an individual's kidneys no longer function and require a regular course of long-term dialysis or a kidney transplant to maintain life); Type 2 Diabetes (a chronic condition that happens when an individual has persistent high blood sugar levels, due to their 'pancreas' inability to produce enough insulin, or their body not utilizing insulin properly, or both); Chronic Obstructive Pulmonary Disease (chronic inflammatory lung disease causing restricted or obstructed airflow and breathing problems); Hypertension (high blood pressure occurs when the force of blood pushing against your artery walls is consistently too high); and Congestive Heart Failure (a long-term condition that occurs when the heart cannot pump blood well enough to provide the body with a normal supply); and Stenosis of Larynx (narrowing of the upper airway between the larynx and the trachea). Record review of Resident #1's quarterly MDS, dated [DATE], reflected the resident's BIMS score was 15, which indicated the resident was cognitively intact. Resident #1 used a wheelchair and was dependent on staff for lower body dressing and putting on/taking off footwear; maximal assistance with toileting hygiene; moderate assistance with bathing; supervision or touching assistance with upper body dressing; setup or cleanup assistance with oral and personal hygiene; and ate independently. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 1's care plan did not reflect interventions related to the resident's ability or desire to independently change the inner cannula of her trach. Review of the care plan reflected she received oxygen via tracheostomy. Interventions included LVN's and RN's to change oxygen tubing per policy and to report significant changes to the resident's doctor. The resident required hemodialysis due to End stage renal disease. Interventions included transporting the resident to the nearest hospital for further evaluation when dialysis was cancelled of unable to be performed due to unforeseen problems. She required assistance from staff with ADL's due to diagnoses of Acute and Chronic Respiratory Failure, morbid obesity, generalized weakness, lack of coordination and impaired mobility. The interventions were 2-person assist with bathing, bed mobility, toileting, personal hygiene, and locomotion, and encouraging the resident to make her needs known to staff. The resident was at risk of ineffective airway clearance due to COPD and her tracheostomy. Interventions included nursing staff and respiratory therapists assessing the resident's airway for patency; assessing cough for effectiveness and productivity; monitoring the presence and quality of sputum, odor, color, amount and consistency; monitoring the quality, rhythm, depth, flaring of nostrils, accessory muscle use, need for positioning to ease breathing, pallor and cyanosis; monitor vital signs every shift and as needed; and to report abnormal findings to the resident's doctor. The resident was at risk for infection due to diagnoses of Respiratory Failure, Type 2 Diabetes, COPD, and the presence of a tracheostomy. Interventions included nursing staff to monitor for signs and symptoms of infection; monitor vital signs, observing proper hand hygiene when performing care; and wear gloves at all times. The resident was at risk for ineffective airway clearance due to increased secretions. Interventions included nursing staff and respiratory therapists monitoring progression of secretions and updating the doctor. The resident was at risk of impaired gas exchange due to cardiac/pulmonary disease, stasis of secretions and ineffective cough secondary to tracheostomy and subglottic stenosis (narrowing of the airway in the part of the voice box below the vocal cords) Interventions included nursing staff and respiratory therapists to assess respiratory rate, depth, effort and abnormal breathing patterns; monitoring for alterations in blood pressure and heart rate and continuous monitoring of oxygen saturation using pulse oximeter. The resident was at risk for airway resistance due to the trach in place. Interventions included nursing staff and respiratory staff performing trach care every day and as needed. Further review of the resident's care plan reflected the resident was alert, oriented, verbal, was understood and able to understand, and was able to make her needs known. Record review of Resident #1's progress notes reflected the following: Progress notes did not reflect an assessment for the resident completed by LVN A on 05/15/24. Review of the resident's progress notes did not reflect respiratory notes entered by nursing or respiratory staff on 05/11/24 or 05/03/24-05/10/24. On 05/16/24 at 2:20 PM, RT A noted the resident to have crackle lung sounds, regular breathing, small, white cough secretions. On 05/15/24 at 10:52 AM, LVN A suctioned the resident twice and administered a breathing treatment. On 05/14/24 at 9:21 PM, RT B noted the resident to have diminished lung sounds, regular breathing and scant tan cough secretions. 05/13/24, at 5:52 AM, RT C noted clear/diminished lung sounds, regular breathing, small white-yellow cough secretions. On 05/12/24 at 3:41 AM, did not reflect a description of cough secretions, but RT C noted diminished lung sounds, and regular breathing. 05/10/24 at 9:52 PM, did not reflect a description of cough secretions, but RT D noted diminished lung sounds and regular breathing. On 05/09/24 at 4:50 AM, did not reflect a description of cough secretions, but RT E noted diminished lung sounds and regular breathing. On 05/03/24 at 2:59 AM, RT F noted crackle lung sounds, regular breathing and small yellow cough secretions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1 progress notes reflected, on 05/16/24 at 1:41 PM, LVN A entered a late entry from 05/15/24 at 1:35 PM, with the following: Resident informed me while I was off the site on break that she changed her inner cannula herself. Checked on resident and resident appeared not be in any distress. Asked resident, do she need to be suctioned, resident stated no I am fine. Followed up with MD/NP, notified MD that residents want to be able to suction and change inner cannula herself. Waiting on pending order. POA notified. Record review of Resident #1's orders did not reflected an order certifying the resident's ability to change the inner cannula of her tracheostomy. In an interview with LVN A on 05/15/24 at 1:42 PM, she said the nurses were recently in-serviced due to staffing changes. She said management recently got rid of staff, and now the remaining staff had increased duties. She said the nurses were given a directive they would be responsible for assisting the Respiratory Therapy department by doing suctioning and administering breathing treatments to residents with trachs, as necessary. She said the nurses were in-serviced on the fact that they were now required to help the respiratory therapists out. She said the respiratory therapists, or the DON would be responsible for reviewing the nurses documentation on the trach care they provided to residents. She said while she was on her lunch break about an hour ago, Resident #1 texted her personal cell phone, at 12:32 PM, and said Resident #1 needed to be suctioned. She said she responded to Resident #1's text message and told Resident #1, LVN A was on her lunch break. LVN A said when she got back from her lunch break, she checked on Resident #1. She said she asked Resident #1 if she was okay, and if she still needed to have her tracheostomy suctioned. LVN A said Resident #1 told her she was okay, and Resident #1 changed the inner cannula of her tracheostomy on her own. She said she asked Resident #1 to repeat what she said to be sure she heard her right, and Resident #1 repeated she changed her inner cannula. She said Resident #1 was able to change her inner cannula because all Resident #1 had to do was pull the inner cannula out of Resident #1's throat and place another inner cannula in. She said Resident #1's trach supplies sat on a tray next to the 'resident's bed. She said the tray was always in Resident #1's room. She said she did not know why Resident #1's trach supplies were left in her room. She said that was a respiratory therapy thing, and they would have to be asked about the supplies in Resident #1's room. LVN A said the risk of Resident #1 changing her own inner cannula was improper placement, getting pneumonia, or contracting an infection. In an environmental observation of room [ROOM NUMBER] on 05/15/24 at 2:16 PM, the following was revealed: Resident #1 appeared well groomed and in good spirits. The resident was lying her bed on her cell phone and with a tablet device in her lap. The television on the wall directly across from the resident's bed was also on. A small trash can sat on the floor, on the right side of Resident #1's bed, near the wall. A small container, with its seal peeled halfway back and an object inside, was upside down and wedged between the trash can and the wall. In the right corner, behind Resident #1's bed was a black cart with a small oxygen tank, a medium sized clear plastic bag with a box of gauze inside, 2 boxes with the tops cut off, labeled Non-Woven Drain Sponges, sat on the cart. One of the boxes laid on the cart flat, with the bottom touching the oxygen tank, and several types of sealed medical supplies showing out of the open top. The other box, sat upright on the cart, with the open top facing the ceiling, and showed a set of tubing sealed in plastic. An inner cannula, with a red and yellow substance from the root to the end, lying in what appeared to be its original packaging with the seal peeled all the way back, with the very end still attached. A nebulizer sat on the end of the cart, closest to the wall on the right side of Resident #1's bed. Medical tape, with the torn end on the tubing of the nebulizer, and the roll in front of the nebulizer on the cart. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #1 on 5/15/24 at 2:16 PM, she said she had lived at the facility for two and a half years. She said she never had a nurse perform any sort of trach care on her. She said when she told a nurse she needed to be suctioned, majority of the time, they left her room, and found someone from respiratory therapy to do Resident #1's trach care. She said LVN A was one of the nurses who would suction Resident #1 if Resident #1 asked. She said she did not know why her trach care supplies were kept in her room. She said she did change her inner cannula on her own a few hours ago. She said she changed her inner cannula because she did not mind doing it on her own. She said she told LVN A she needed to be suctioned before she changed the inner cannula, but LVN A was on her lunch break. She said the inner cannula wedged between the wall and the side of her trash can was the one she removed herself. She said she put the old inner cannula in the container from the new inner cannula, and tried to throw the container into the trash can. She said the container got caught between the wall and the trash can instead. She said she did not know why another soiled inner cannula was on the trach tray behind her bed, or whether that was an additional inner cannula she changed on her own. She said she did not know how the soiled inner cannula ended up on the trach cart behind her. She said she could not reach the supplies on the trach cart, because the cart was in the corner behind her bed. She said she did not think the RT department was aware she had been changing her own inner cannula. She said she could not remember who gave her the inner cannula she used to replace the old one today. She said she thought the respiratory therapist gave her the inner cannula today. She said she told LVN A today, Resident #1 changed her inner cannula on her own. She said she did not know if LVN A or any other nurse was aware she had been changing her own inner cannula before today. She said she did not know how long, but Resident #1 had been recently changing her inner cannula two to three times a week. She said other times, she just waited for a respiratory therapist to change her inner cannula. She said the respiratory therapist on duty had not come to Resident #1's room today. She said she never spoke to the administrator about issues with getting consistent trach care. She said she knew Resident #2 was verbal and was also having issues getting consistent trach care. In an interview with the Respiratory Care Practitioner on 5/15/2024 at 3:02 PM, he said he had worked at the facility for [AGE] years. He said when he went on his lunch break, he spoke to the assigned nurses and other RT's, at the other end of the halls, to ensure the residents were covered while he was gone. He said he was responsible for residents with tracheostomies in rooms 101, 103, 105, 301, 303, 401, 403. He said trach care was performed for residents once a shift. He said there was no specific time trach care was to be performed on each resident. He said, as long as the resident received trach care during shift. He said trach care consisted of cleaning the stoma, suctioning and making sure everything was clean. He said he did not know Resident #1 changed her own inner cannula today. He said he did not believe changing an inner cannula was something Resident #1 knew how to do. He said based on the resident's physical capabilities, he could not believe Resident #1 changed her own inner cannula. He said Resident #1 was at risk of the inner cannula being displaced or dislodged. He said if the resident's hands were dirty, she could have contaminated the area and contracted an infection. He said he was not aware the resident changed her own inner cannula today. He said he did not give Resident #1 an inner cannula today and he would never do that. He said it was impossible for him to do that. He said he had not seen Resident #1 today. He said when he went by the resident's room earlier today, the Resident was out of the facility receiving her dialysis treatment. Resident #1 was one of the first few residents he planned to see after he returned from his lunch break. He said the nurse should have come to find him and at least told him the resident told the nurse Resident #1 changed her own inner cannula. He said the nurse could have also assessed Resident #1, herself. He said he did not know who was responsible for reviewing the nurse's documentation after they performed trach care on residents. He said the RT manager was probably responsible for training nurses on trach care. He said he was going to check on the resident, to find out what happened. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #1 on 05/15/24 at 3:43 PM, she said the RT on duty, did not give her the inner cannula she used to replace the old one, earlier today. She said she could not remember who gave her the inner cannula she used. She said no one saw Resident #1 when she changed the inner cannula. In an interview with the Respiratory Therapy Manager A on 05/15/24 at 4:10 PM, she said she worked at the facility for three years but had been in the position of Respiratory Manager for one month. She said during trach care on a resident, the RT or the nurse, used the trach care kit. She said they replaced old new inner cannulas with new ones and checked the resident's pulse oximeter. She said the nurses and RT both suctioned the tracheostomy before performing trach care, because if not, secretions would shoot out of the residents' stoma. She said they checked the residents' the vitals, and pulse and oxygen levels before performing trach care. She said during trach care, nurses or RT's, cleaned the stoma area, replaced the gauze, changed the trach tie, if necessary. She said trach ties were to be cleaned on shower days and bed bath days. She said if the staff noticed a dirty trach tie on resident the trach tie needed to be changed. She said trach care was done once every shift or as needed for each resident with a tracheostomy. She said the nurses were currently being trained on trach care. She said the respiratory manager before her, began training nurses on trach care back in November 2023. She said she was one of the RT's responsible for training nurses then. She said she believed, out of about 100 nurses, 80 nurses had already been trained on trach care. She said she did not personally train LVN A, however, the Respiratory Therapy Manager said LVN A told the manager herself she was trained on trach care. She said all of the nurses were to assist the respiratory therapists with the residents' trach care, as needed. She said the trach care training they were completing with nurses was a more of a re-training, since this was a new assigned task for the nurses. She said she believed the nurses completed basic trach care training during orientation. She said trach care was also covered in nursing school. She said the nurses knew how to change 'a residents' inner cannula and provide basic trach care. She said if a resident told a nurse the resident changed their inner cannula, the nurse should have told the residents' RT or, the nurse should have changed the inner cannula for the resident. In an interview with Regional Nurse Consultant A and the DON on 05/16/24 at 9:45 AM, the DON said the nurses were responsible for suctioning residents with tracheostomies. The DON said nurses were to stand at the residents' bedside and provide whatever the RT needed during trach care. She said the nurses did not need to document anything related to suctioning the residents' trachs. The DON said all documentation would be completed by the RT. She said the nurses did not necessarily, need to notify anyone know they suctioned a residents' trach. The DON said, unless there was a change in a resident's condition, the nurse would have to let the RT and the doctor know. The DON said she worked at the facility for about three months. She said the RT was responsible for doing trach care in-services and training with the nursing staff. The DON said she was sure the nurses received some sort of training, but she was not sure who had been trained. The DON said she knew the RT department was working with nurses and training them today. She said she knew RT manager A just began training nurses, but she did not believe the manager had gotten to the point where she had checked any of the nurses completely off the checklist. She said the nurses should have notified the RT about increased secretions, when the resident asked for more frequent suctions, if they heard alarms from the machines, and when the resident's O2 saturation dropped. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 05/16/24 at 9:56 AM, she said yesterday, 05/15/24, she came back from lunch around 1:00 PM. She said she started her rounds, she knocked on Resident #1's door and asked Resident #1 if she was okay. She said the resident told her she was good. She said she asked the resident if she was suctioned and Resident #1 told her no. She said Resident #1 told her the resident changed her own inner cannula. She said she asked the resident, you did what? LVN A said the resident repeated that she changed her inner cannula. LVN A said she asked the resident if she still needed to be suctioned and the resident told LVN A no. She said she asked the resident where she got the inner cannula from, and the resident told her she got it off the RT cart in her room. LVN A said she did not know how the resident got the inner cannula off the cart from behind her bed. She said the resident was heavy set but was slightly mobile. She said she could not see the resident reaching way back behind her bed to get the inner cannula, herself. She said, but the resident told LVN A she changed her inner cannula. She said she did not perform any sort of assessment or notify anyone about Resident #1 changing her inner cannula because she got distracted as soon as she came out of' Resident #1's room. She said she got stopped by another staff and the staff was asking her questions. She said she was already rushing trying to make sure Resident #1 got her medication on time. She said Resident #1 was not given a particular medication within a certain timeframe; the resident's phosphorus levels would drop. She said she would have notified the resident's RT, but she was in a rush, and it was the end of her shift. She said she told Respiratory Manager A about the incident this morning. She said she notified the nursing supervisor before she left because the nursing supervisor got report from LVN A. She said she should have checked Resident #1's respiration levels, made sure the resident was not in distress and was getting the proper respiration. She said she completed training with the RT department in the past where they showed LVN how to clean the trach. She said an RT was supposed to take a nurse off the floor and spend a whole 12-hour shift working with an RT, side by side, to learn how to do trach care. She said she had never done that. She said she did not remember when she was supposed to be taken off the floor to train exactly, but it had been a couple of months. She said she was trained on trach care in nursing school, but this was her first bedside nursing job. She said she always worked in clinics and never had to do trach care. She said she never performed trach care before. She said this morning, 05/16/24, the RT manager trained LVN A 1:1 on trach care. She said RT Manager A showed her, step by step, what to do to provide proper care, and what signs and symptoms to look for in residents with tracheostomies. She said the RT manager also showed her what to look for on the trach machines. She said, prior to this morning as far as trach care, LVN A said she thought nurses were only responsible for suctioning a resident's trach. She did not know about the high pressure and low pressure of the respiration machines, but the RT manager was able to show her those things this morning. LVN A said, now she had a better understanding and felt comfortable performing trach care. She said she would document in the residents' progress notes she performed suctioning, oxygen level, respiration level, if the resident had distress or difficulty breathing, and what the secretions looked and smelled like. She said Resident #1 was at risk for infection or going into respiratory distress from placing the inner cannula in her trach improperly. (continued on next page)

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	676064	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 05/16/24 at 10:31 AM, she said she was notified by RT Manager A yesterday, 05/15/24, Resident #1 changed her own inner cannula. She said she spoke to Resident #1 and LVN A, yesterday once she found out. She said LVN A told the DON, LVN A was not aware Resident #1 changed her own inner cannula. The DON said even if Resident #1 did tell LVN A she changed her own inner cannula, what the resident said was still hearsay. She said no one actually saw Resident #1 change her own inner cannula. She said they could not prove Resident #1 changed her inner cannula. She said if the resident did change her own inner cannula, at the very least, the nurse should have notified the RT and the doctor to let them know what the resident had done. She said the nurse should have also notified the DON. She said because no one witnessed the resident change her inner cannula, the nurse should have at least documented in the resident's progress notes, exactly what the resident told the nurse and exactly what the nurse observed. She said a resident changing their own inner cannula was at risk of infection. She said the resident was also at risk of going to the hospital in respiratory distress. She said she was going to speak to the resident's family member because he was really active in her care and the resident would do anything he said. She said she would see if he wanted to assess Resident #1 to independently change her inner cannula. She said 'he resident's doctor also had to sign off for the resident to be able to independently change her inner cannula. She said if it was determined to be unsafe for Resident #1, allowing her to independently change her inner cannula would not be done. She said LVN A received in depth training on the trach care process from the RT manager this morning. She said this morning, she read the 24-hour report, but nothing stuck out to her regarding LVN A's documentation of the incident with Resident #1. She said she had not specifically reviewed the resident's chart. The DON said if she checked LVN A's documentation, she would have looked to see if LVN A made a note in Resident #1's progress notes. She said the nurse should have documented notifying the RT for detailed observation, but at the very least she would have needed to check vital signs. If she showed signs of distress, she would have checked the resident's vital signs. She said the nurse should have at least checked the resident's vital signs. She said she would in-service LVN A on making appropriate notifications, but she would not be receiving any disciplinary action after the incident with Resident #1. She said LVN A was not the one who did anything wrong. She said Resident #1 said she changed her inner cannula, but hey had no proof the resident did it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 05/16/24 at 1:36 PM, she said she spoke with RT Manager A and asked her if any of her staff were aware Resident #1 was changing her own inner cannula. She said the RT manager told her no, nothing had ever been reported to the RT department. She said she interviewed 5 different RT's and they all said they were not aware Resident #1 was changing her own inner cannula. She said by the time she became aware of the incident, LVN A had already left for the day. She said she had not spoken to LVN A regarding the situation. She said the DON was speaking with LVN A regarding the incident. She said she spoke to the resident yesterday and Resident #1 admitted she changed her inner cannula. She said she spoke to the resident about not continuing to change her own inner cannula until they were able to assess her ability to do so independently, after they provided the resident appropriate education. She said staff went over risks, like infection and improper placement with Resident #1 She said she wanted the resident to be independent in changing her inner cannula if she wanted, but they wanted her to be safe. She said the resident requested to do her own suctioning, in addition to changing her inner cannula. She said the next step was to speak with the resident's husband to see if he agreed. She said LVN A should have immediately told the DON, or the Administrator after the resident told LVN A, Resident #1 changed her own inner cannula. She said LVN A should have done an assessment on Resident #1, and wrote detailed information, in 'Resident #1's electronic health record, on what the resident told LVN A she did. She said LVN A should have also included what LVN A did in her assessment of the resident. She said LVN should have checked 'he resident's vitals to make sure the inner cannula was placed in properly. She said LVN A should have also notified 'he resident's doctor and RP. She said the resident was placed at high risk of not being able to breath correctly and contracting an infection. She said she had a conversation with the DON about in-servicing the nurse. She said she was not sure what she was in-servicing LVN A on, but she would follow up with the DON to see what sort of disciplinary action and follow up was put in place for LVN A. In an interview with Regional Nurse Consultant B on 05/29/24 at 12:58 PM, she said if a resident changed their own inner cannula, there was a risk for infection, and ultimately death if the resident had any airway issues arise. Record review of the facility's Tracheostomy Care policy, revised October 2023, reflected the following: . Clean the Removable Inner Cannula 1. Open tracheostomy cleaning kit. 2. Set up supplies on sterile field. 3. Maintaining sterile field, pour normal saline in two compartments of opened kit. 4. Open 8eith 4x4 gauze pads and saturate with sterile saline. 5. Open two 4x4 gauze pads; keep them dry. 6. Put on sterile gloves. 7. Secure the outer neck plate with non-dominant gloved hand. 8. Unlock inner cannula with gloved dominant hand. 9. Gently remove the inner cannula, rotating counterclockwise while lifting away from the resident. 10. Place the cannula in one of the saline compartments. 11. Clean with brush. 12. Rinse with saline in second compartment and pat dry with pipe cleaners. 13. Remove and discard gloves into appropriate receptacle. 14. Perform hand hygiene and apply fresh gloves. 15. Replace the cannula carefully and lock in place. 16. Remove gloves and perform hand hygiene. 17. Ensure there is an emergency tracheostomy set up at resident's bedside .Documentation 1. Document the following in the resident's record. a. The procedure. b. The condition of the stoma and surrounding skin. c. The resident's tolerance of the procedure. d. Any provider notification of unexpected or abnormal findings.

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47358 Based on observation, interview and record review the facility failed to ensure that residents who required dialysis received such services, consistent with the professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of four residents (CR # 1) reviewed for dialysis. The facility failed to ensure CR # 1 received hemodialysis treatments as ordered by his physician. CR # 1 exhibited symptoms of fluid overload and required emergency medical care. In addition, Resident #1's dialysis access port malfunctioned, and Resident # 1 did not receive dialysis for 4 days.CR # 2 missed dialysys treatments on [DATE] and [DATE]. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 2:50 pm. While the IJ was removed on [DATE] at 11:41 am, the facility remained out of compliance at scope of isolated with the potential of more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of missing vital treatment, serious health side effects and death. Finding include: Record review of CR # 1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. CR # 1 had diagnoses which included Acute and chronic respiratory failure with hypoxia (absence of oxygen in the tissue to sustain bodily functions), Hypokalemia (low potassium), End stage renal disease (the kidney can no longer function properly) , and Hypertensive heart disease without heart failure (a condition that happens when chronic blood pressure causes changes in the heart left ventricle, left atrium, and coronary arteries. Record review of CR #1's orders, start date [DATE], reflected dialysis catheter dressing change to be done by dialysis nurse only (Monday, Wednesday and Friday (start date [DATE]), Dialysis: Monday, Wednesday, and Friday (once a day at 6:00 am) (start date [DATE]), If the dialysis center is unable to perform hemodialysis as scheduled transfer resident to nearest hospital. As needed (prn1, prn2, and prn 3), monitor catheter site for s/s infection (every shift). Notify MD/NP. Record review of CR#1's MDS, dated [DATE], reflected no BIMS (severe cognitive impairment), partial/moderate assistance with eating, oral hygiene, showering /bath, and personal hygiene and he required dialysis. Record review of Resident # 1's Care plan, start date [DATE], reflected Resident #1 had a risk of falling related to weakness and impaired mobility. Record review of CR#1's Treatment Details Report from the dialysis center, dated [DATE], reflected Treatment Type: In-Center Hemodialysis Treatment. No data available for the following: machine setup nurse prescription verification pre-treatment verification, pre-treatment fluid calculation treatment nurse assessment, access, labs, Intradialytic/vitals stat line. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's Treatment Details Report from dialysis center, dated [DATE] reflected, Treatment Type: In-Center Hemodialysis Treatment). Pre-Treatment Vitals on [DATE] at 6:04 AM-(1) Comments (Pre) Patient has new CVC placed faint blood noted to CVC exit site. No s/s trauma or infection present. Patient denies pain CVC dressing changed prior to treatment initiation. Comments (Post) Staff will receive Cathflo this evening and indwelling it for next treatment. No time notated. (2) Comments (Pre) Patient received alert and in stable condition. Patient denies pain or discomfort. Comments (Post) Patient treatment was not performed because of catheter malfunction. The MD would like for to have Cathflo instilled into the catheter over the weekend. The staff will go pick up over the weekend and come back to instill it. (3) Comment-Arterial lumen (allows for the free flow of oxygenated blood from the heart to the veins and capillaries) is not pushing on pulling. MD is aware he orders Cathflo but there is not in the Den. Attempting to get Cathflo from SNF. Record review of CR#1's Treatment Detail Report from dialysis center, dated [DATE], reflected Treatment Nurse Assessment: Time: Pre-6:42 AM and Post: 10:31 AM-Comment: Patient Treatment terminated early due to problematic. Record review of CR#1's progress notes, dated [DATE] at 12:06 PM, reflected CR#1 was found unresponsive at 11:25 AM. Nurse called out to resident, no response, sternal rub performed, no response. Pulse checked, undetected. Nurse immediately called code blue and began ambu(a bag valve mask used to provide respiratory support) bagging resident. When RT Aide walked in to assist with bagging, nurse began compressions. No blood pressure reading obtained due to condition, blood glucose 215 at time on first round of compressions. 11:30 AM AED pads placed on resident no shock advised. 911 was called and CPR continued until arrival of EMS. Multiple rounds of CPR done, when EMS arrived monitor placed, and no pulse detected. EMS called of death 11:45 AM. Dialysis nurse verbalized concerns for fluid overload due to inability to perform dialysis Saturday and today [DATE]. CR#1 received orders to be sent out to the ER to restores function to port and receive dialysis in hospital. Transport scheduled to pick up resident with 2 hours. Resident in bed resting, no distress noted at this time vs WNL, no c/o pain or discomfort at this time. CVC. MD notified. Record review of CR#1's dialysis center patient notes, dated [DATE], reflected, CR#1 returned from hospital unable to treat on scheduled day due to watery stool noticed in den at treatment time. Per hospital discharge documents patient tested positive for C. diff and is receiving PO ABX. In addition, the patient was admitted due to malfunction of gastrostomy tube diarrhea, and GI/PEG tube exchange. At the time of exchange the patient was also noted to have an ileus (inability of the intestine to contract normally and move waste out of the body). The dialysis MD updated about pa record review of CR#1's dialysis center patient notes, dated [DATE], reflected, Resident #1 patient status and ok with schedule adjustment. Record review of CR#1's dialysis center patient notes, dated [DATE], reflected, [CR#1] treatment terminated early due to problematic access. Patient had 118 minutes remaining at the time of treatment was discontinued. Notified Dialysis MD, ordered the patient be sent out to the hospital to treat and evaluate catheter. Venous pressure continuously high causing the machine to alarm often Cathflo was previously tried prior to being sent out. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's orders form SNF dialysis, dated [DATE], reflected Please place Cathflo in Arterial Lumen for 45 minutes. Today DX: Dysfunction/clotted Lumen. If patient cannot receive Cathflo today, he will have to wait until Monday for treatment when Cathflo is available. Record review of CR#1's orders form SNF dialysis, dated [DATE], reflected Please send patient out to the hospital to dialyze. Unable to treat due to problematic CVC, Venous pressure continuously elevated. Record review of CR#1's dialysis SNF Services Communication form, dated [DATE], reflected Pre-Treatment Report Nurse-isolation reason: C. Diff, fall precaution - yes, Mental status- alert, pain assessment-none, VS: BP ,d+[DATE], Pulse 78, R 20, Temperature 97.2, Fo2 Sat 99%, O,d+[DATE]/Vent- time vital and weight obtained 5:38 AM. Dialysis Access Notes problematic, alarmed throughout treatment, catheter problematic treatment terminated early. MD notified There were no dialysis SNF Services Communication form for [DATE] and [DATE]. During an interview on [DATE] at 1:00 PM Dialysis RN A she stated CR#1 had a CVC catheter (central venous catheter). CR#1' was sent out to the hospital on [DATE] because he had a loose stool, peg tube malfunction, vomiting. CR#1 returned to the facility last Wednesday ([DATE]) or Thursday ([DATE]). She stated on [DATE] she was not aware Resident # 1 returned to the facility. She stated the SNF staff did not inform the dialysis center CR#1 returned. She stated after realizing CR#1 returned she stayed late for him to dialyzed. She stated when she attempted to get CR#1's weight she noticed he had loose stool on him. He tested positive for C-DIFF (loose stool and you have to use bleach). She stated she contacted the MD and informed him as to the situation. She stated the MD gave approval for CR#1 to receive dialysis on [DATE]. She stated Dialysis RN B attempted to dialyze CR#1 on [DATE]. CR#1was not dialyzed on [DATE] because CR#1's catheter did not work. She stated Dialysis notified the Dialysis MD. The Dialysis MD gave an order to put Activase in the catheter. She stated Activase breaks up the clot and allow the blood to flow. She stated CR#1's port continued to malfunction. She stated the Dialysis MD gave an order to have the resident dialyzed on Monday. She stated on [DATE] CR#1 received dialysis. She stated he was unable to complete dialysis due the malfunction of CR # 1's port. She stated he received dialysis for 3 hours and 30 minutes, however, he only received 1 hour and 30 minutes of treatment. She stated the dialysis machine kept beeping. She stated CR#1 received a new catheter, and the catheter was not working. She contacted the Dialysis MD and was informed to have the resident transferred to the hospital. Dialysis RN B stated CR#1 was taken back to the SNF. She stated she informed CR#1's Nurse the resident needed to be transferred to the hospital to have his catheter assessed and dialysis RN A stated she was going to call an ambulance to have the resident transferred. She stated this occurred around 8:30 AM. She stated hours later she heard a code blue (code that indicates a patient needs immediate medical attention). She stated if an ESRD patient went without dialysis for three to four days they could have confusion, fluid overload, and septic. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Dialysis RN B on [DATE] at 2:30 PM, she stated on [DATE] CR#1 came to the den for dialysis treatment. She stated CR # 1's arterial was not pushing and pulling. She stated the reversed the venous pressure and it was high, and it kept alarming. She stated it would start at two hundred and the dialysis machine kept cutting off. She stated she contacted the Dialysis MD, and she told him CR#1 had a new catheter from the hospital. The Dialysis MD asked if the facility had any Cathflo and they did not. She stated later that day she went to the clinic and got Cathflo. She stated she returned to the facility. She stated Cathflo was administered to CR#1. She stated once the Cathflo was administered there was a 45-minute wait. She stated she informed the Dialysis MD, and she was given an order that CR#1 could be dialyzed on Monday. During a telephone interview on [DATE] at 3:00 PM with RN A, she stated CR#1 was on Dialysis. She stated protocol for resident's who received in-house dialysis was the resident's vital signs were taken prior to being transported to dialysis. She stated the resident was transported the in-house dialysis center with the Nurse, RT, CNA, and Transporter. She stated the SNF and Dialysis communicated verbally. She stated there was a communication form which consisted of pre and post dialysis information. She stated that when she arrived CR#1 was in dialysis. She stated on [DATE] around 8:30 am the Dialysis RN A stated CR#1 could not be dialyzed, and CR# 1 needed to be sent to the hospital. She stated Dialysis RN A informed her that CR#1's port was malfunctioning, and CR#1 had fluid overload. She stated she scheduled non-emergency transport for CR#1 to be transported to the hospital. She stated the transport service informed her that it would be 2 hours before the transport would arrive. She stated she did not call 911. She stated she assessed CR#1 to include checking blood pressure and pulse rate and there were signs of distress. She stated CR#1 verbalized he was tired which was a common side effect after dialysis. She stated she checked on CR #1 at 11:15 AM and went to check on CR#1 and he was unresponsive. She stated she called a code blue. She stated they began CPR and EMS arrived, and CR# 1 was pronounced deceased at 11:45 AM. She stated if a resident did not have dialysis for three to four day they could have fluid overload, septic, and other serious injuries to include death. Record Review of The National Kidney Foundation website, undated, reflected if you miss your dialysis treatment, you may feel the effects of fluid overload, which include shortness of breath due to fluid in your lungs. If this happens, you may need to go to your hospital's emergency department for dialysis. During an interview with the DON on [DATE] at 9:55 AM, she stated CR#1 received dialysis on Monday, Wednesday and Friday. She stated CR#1 was in the hospital from [DATE]-[DATE]. She stated she did not why the Dialysis nurse did not know CR#1 returned to the facility. She stated Dialysis had access to the Matrix. She stated CR#1 staff was aware his port was not working. She stated Resident #1 had C-DIFF, however, this would not prevent him or any resident from having dialysis. She stated when a resident had C-DIFF the stool was continuous. She stated if a resident's port was clogged the resident would be scheduled to go out and looked at by a vascular doctor. She stated a clogged port was not a reason to send a resident out to the hospital by 911. She stated CR#1 was assessed by RN A and there were no signs of distress, therefore, the contracted ambulance service was contacted and not 911. . (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:50 AM, RN C stated when a resident was on dialysis they must be placed on the dialysis schedule. She stated when a resident returned from dialysis the nurse should assess the resident to include vital signs. She stated if a resident's dialysis port was malfunctioning, she would call the doctor. She stated that if the MD ordered the resident be transferred to the hospital, she would call 911. She stated because the resident had not had dialysis for days she would call 911. She stated when a resident was not dialyzed the resident was prone to fluid overload, electrolytes would not be good, the resident would be confused and the level of consciousness would be affected. Record review of the facility's Abnormal Findings Job Aid policy, dated [DATE], reflected any abnormal findings or findings outside of any patient specific physician ordered parameters discovered pre, intra or post treatment data collection will be discontinued and immediately reported to the licensure nurse. An assessment by the nurse prior to initiation of dialysis, during dialysis, and/or prior to discharge will be triggered by an abnormal finding. The medical record should indicate the finding, the intervention, physician notification, physician orders and the patient response. Record review of the facility's Hemodialysis policies and procedures, dated [DATE], reflected the following: patient data the nursing assessment, patient identity, prescription and machine settings, Pre-treatment data collection/ assessment, Intradialytic data collection assessment, post treatment data collection/assessment and abnormal findings. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 2:50 PM. The Administrator was notified. The Administrator was provided the IJ template on [DATE] at 2:50 PM. The following Plan of Removal submitted by the facility was accepted on [DATE] at 2:23 PM: PLAN OF REMOVAL Name of facility: Date: [DATE] The Texas Department of Health and Human Services entered the facility on [DATE] for a P1 Complaint Survey. During the survey process an IJ (Immediate Jeopardy) was cited on [DATE] regarding - F698 and F684 as stated below: F698 Dialysis Services CR#1 Passed away on [DATE] Immediate action: On [DATE] DON under the guidance of the Regional Nurse Consultant initiated an in-service with all direct care staff training will be completed by [DATE]. (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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Notifying Physician and Family of Resident Change of Condition/or have not receive their full dialysis. The physician should be notified as soon as possible after identifying a change of condition/or have not received their full dialysis, assessed resident needs, and provided necessary services. If the physician is unable to be reached, the DON and/or designee should be notified and the Medical Director contacted for treatment plan. o Recognizing and Reporting Acute Changes of Condition. Changes of condition include, but are not limited to SOB, vital signs, mental status changes, functional decline, desaturation, etc. o Symptoms include the need for emergency ambulance services. o Documentation of events (Change of Condition), SBAR and Stop & Watch. o Change of Condition and policy was reviewed, no changes were made. Staff in-service on current policy. o Staff in-service to pre-dialysis assessment and post assessment documentation in Matrix. o Communications between dialysis and nursing will be documented in Matrix. o Continue weekly core team meetings with dialysis. o Location where dialysis schedule is at. o Nurses will review dialysis schedules with transport daily. o How codes should be run. o Location where the AED is at. o Shift report will go over admits and discharges. o Review all new orders daily by management. o [DATE] In-service on dialysis policy to all direct care staff and completion date [DATE]. o 100% audit on all residents to ensure anyone who was unable to do dialysis has been identified and MD notified completion date [DATE]. On going dialysis audit will be done in IDT morning clinical meeting. o DON/Designee will audit all residents who have dialysis in IDT morning clinical meeting to make sure they have received their dialysis or if unable to do dialysis then MD/DON was notified. Facility Plan to ensure compliance quickly: o All nursing staff will be in-service on the above-listed topics prior to beginning their next scheduled work shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o The DON and/or designee will conduct audits of the 24-hour report to include review of progress notes to ensure that all changes of conditions/ or have not fully received dialysis will be identified and physician notification has been made. This audit began [DATE]. Demonstration of and acknowledgement that all licensed nurses are aware of the above: o The DON/ADON and/or designee will contact all licensed nurse staff and get a verbal acknowledgement as a return demonstration of understanding that: o A physician is to be notified immediately of changes of condition or have not received dialysis. o This in-service began [DATE] and will be completed by [DATE]. On [DATE] The facility Administrator, ADON, and Regional Nurse Consultant held an ad hoc QAPI meeting with the Medical Director, via phone, to discuss: o F698 - Dialysis Services - IJ Cited o Plan of Removal and actions taken to ensure continued compliance. QAPI: o The above actions will be reviewed monthly in QAPI to ensure continued compliance. Monitoring of the plan of removal included: During interviews on [DATE] from 10:30 AM - 4:00 PM - three CNA's, five RN's, four LVN's and six RT's stated they were in-serviced before their shifts in: Change of Condition, Recognizing and Reporting Acute Change of Condition, Symptoms included for the need for emergency ambulance services, Documentation of events (Change of Conditions), SBAR and Stop and Watch, Staff in-service to pre and post dialysis assessment documentation, communications between dialysis and nursing will be documented in Matrix, Nurses will review dialysis schedule with transport daily, shift reports will go over admits and discharges. Staff stated they were competent in all trainings. Record review of General In-Service for All Direct Care Staff and RT, dated [DATE], reflected the following in-services: Change of Condition, Recognizing and Reporting Acute Change of Condition, Symptoms included for the need for emergency ambulance services, Documentation of events (Change of Conditions), SBAR and Stop and Watch, Staff in-service to pre and post dialysis assessment documentation, communications between dialysis and nursing will be documented in Matrix, Nurses will review dialysis schedule with transport daily, shift reports will go over admits and discharges, MD/NP/DON or designee will determine if resident needs to go by 911 or non-emergency transport and will be documented in resident chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of In-services for DON, dated [DATE], reflected: Change of Condition, Recognizing and Reporting Acute Changes of Condition, Symptoms include the need of emergency ambulance services, Documentation of events (change of condition, SBAR, and Stop & Watch, Pre and Post dialysis assessment documentation in Matrix, Communication between dialysis and nursing , continue weekly core team meetings with dialysis, nurses will review dialysis schedules with transport daily, shift reports will go over admits and discharges, review all orders daily by management, Education provided to 100% nursing staff on monitoring of residents who experience change in condition while waiting on emergency services, and MD/NP/DON or designee will determine if resident needs to go by 911 or non-emergency transport and will be documented in resident chart. The Administrator was informed the Immediate Jeopardy (IJ) was removed on [DATE] at 11:41 AM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal arm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place that is not immediate.