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	11/19/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for 1 of 10 residents (CR #1) reviewed for comprehensive Person-Centered Care Planning. The facility failed to develop a baseline care plan for CR #1 that addressed his communication status/needs, tracheostomy/ventilator status/needs, and his nighttime anxiety. This failure placed newly admitted residents at risk of not receiving the care and services specific to their needs. Findings include: Record review of CR #1's face sheet dated 09/10/2024 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. CR #1 was diagnosed with non-pressure chronic ulcer (a non-healing wound) of the skin, acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and pressure ulcer of the sacral region (the triangular bone that connects the spine to the pelvis and forms the back wall of the pelvis), stage 4 (the most severe type of pressure ulcer and involves full thickness tissue loss with exposed bone, tendon, or muscle). He was discharged to an acute care hospital on 09/10/2024. Record review of CR #1's electronic health record revealed he did not have a completed MDS. Record review of CR #1's Observation Detail List Report dated 09/04/2024 revealed CR #1 could make himself understood, he understood others, and he had no short-term or long-term memory concerns. Record review of CR #1's care plan revised on 09/05/2024 revealed the following care areas: * Baseline Care Plan: will identify my care needs, risks, strengths, and goals for the first 48 hours. Goal included: My initial goal is to have access of services to promote adjustment to my new living environment. Approach included: * Activities and Functional Level for daily Care: I will receive the necessary setup, cueing, support and assistance level for activities of daily living. (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	11/19/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Anticoagulation therapy will be administered as ordered by the physician. * Behavioral need will be evaluated for impact on quality of life, safety, and safety of others. Behavioral management plan will be addressed if needed with physician/NP, IDT, and resident/resident representative. * I will be receiving skilled care and my discharge planning, goals, community referrals, transportation, health knowledge deficits, and follow-up will be discussed and planned with me and as needed with selected representatives. I will remain in place for long-term or hospice care. A comprehensive plan of care will be developed following a complete evaluation of my needs, strengths, and personal preferences. * Infection: Treat any infection upon admission per physician/NP orders. Monitor antibiotics for any signs and symptoms of adverse reactions. Maintain standard precautions or isolation to prevent transmission. * Pressure Ulcer/Injury. Trauma wound to back of head related to immobility. Goal included: Trauma wound to back of head will heal without complications. Approach included: Avoid shearing resident's skin during positioning, transferring, and turning; Conduct systematic skin inspection weekly; Treat area per doctor orders. * Pressure Ulcer/Injury. Stage 4 Pressure injury/ulcer wound to sacrum related to immobility. Goal included: Resident's ulcer will heal without complications. Approach included: Apply dressings per doctor orders; Assess the pressure ulcer for stage, size, granulation tissue, and condition of surrounding skin weekly; Keep resident off load wound; Turn and reposition as needed, and as tolerated. Further review of CR #1's baseline care plan revealed no care areas addressed his communication status (how staff would communicate with CR #1 and how he would call for assistance), tracheostomy/ventilator care (how often staff were to provide tracheostomy care including suctioning), and his tendency to exhibit anxiety during the night shift. Record review of CR #1's Physician's Progress Note dated 09/09/2024 revealed, . [CR #1] is an [AGE] year-old male with no previous medical history whose hospitalization started with a gunshot wound to his right neck in 05/2024. He sustained a transection of right ICA and right vertebral artery with blast injury (physical trauma resulting from direct or indirect exposure to an explosion) of C2 (the second cervical vertebra) and involvement of spinal canal. This has resulted in quadriplegia (a condition that causes a person to lose the ability to move all four limbs and the body from the neck down), tracheostomy placement, and chronic respiratory failure requiring continuous invasive mechanical ventilation. His course was complicated by a pneumothorax (when air leaks into the space between the lungs and chest wall) s/p chest tube placement and removal, multi-drug resistant pneumonia, multi-drug resistant urinary tract infection, and a significant sacral wound requiring I&D (minor surgical procedures to release pus or pressure built up under the skin) on 08/19/2024. He has been treated with multiple antibiotics, however, most recently was placed on Ceftazidime for a 4-week course due to his sacral wound, which per the infectious disease team that was seeing him, should continue until 09/20/2024 . [CR #1] is awake and alert and in no distress . Vital Signs: Pulse - 99 BMP, Blood Pressure - 122/67, O2 Saturation - 99 Room Air, Respiratory Rate - 18 Breaths per minute . Record review of CR #1's Physician's Orders for September 2024 revealed: (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	11/19/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Anti-Anxiety Medication Use - Observe resident closely for significant side effects. Every Shift. Start Date: 09/05/2024. * Respiratory: Suction - Every Shift. Start Date: 09/04/2024. * Respiratory: Suction every two hours or as needed for increased secretions. Every two hours - PRN. Start Date: 09/04/2024. In a telephone interview with CR #1's RP on 09/10/2024 at 11:35 a.m., she stated CR #1 was able to communicate with an eye tracker system on his tablet which allowed him to text (which turned the text to voice) with his eyes since he could not move his limbs. She said the device allowed CR #1 to call phone numbers when he needed help. She said she let the staff know when he was admitted on [DATE] to keep an eye on him because he had problems with his breathing between the hours of 2:00 a.m. - 3:00 a.m. and 6:00 a.m. - 7:00 a.m. Observation and interview with CR #1 on 09/10/2024 at 3:30 p.m. revealed he was in a room in the ER of a local acute care hospital. CR #1 was alert and had a tracheostomy connected to a ventilator. CR #1 also had on a neck brace. CR #1 was sweating heavily. CR #1 did not initially verbalize words. He blinked once for yes answers and twice for no answers. CR #1 said, Help. CR #1 indicated he wanted a nurse. While waiting for a hospital nurse to come, CR #1 said, Ice chips. In an interview with RT B on 09/12/2024 at 3:15 a.m., he stated he worked with CR #1 on Saturday (09/07/2024), Sunday (09/08/2024), and Monday 09/09/2024) (respiratory therapist work 12-hour shifts). He stated CR #1 complained of shortness of breath a few times during his shift, but his oxygen saturation was good at 99% and he was not in distress. He said he thought CR #1 experienced anxiety because his vital signs were fine, he was breathing fine, and it was common for residents with new tracheostomies to have anxiety. RT B said he checked on CR #1 every two hours, and he was called to CR #1's room a lot to suction secretions from his nose and mouth. RT B said CR #1 called his RP and she called them at the facility. He said CR #1 often had a lot of secretions from his nose and mouth. He said as the respiratory therapist, he checked oxygen saturation, respiratory rate, and pulse. He said CR #1 made sounds with his mouth and grimaced, so he suctioned his nose, mouth, and tracheostomy. In a telephone interview with CNA D on 09/12/2024 at 3:30 p.m., she stated she worked the 10:00 p.m. - 6:00 a.m. shift and CR #1 was new to the facility. She said CR #1 could answer yes and no questions when asked if he needed something. She said CR #1 was able to make his needs known and could verbally express when he needed to be suctioned. She said she rounded every two hours. In an interview with LVN F on 09/17/2024, at 2:45 p.m., she stated she was the nurse who admitted CR #1 on 09/04/2024. She stated she did CR #1's head-to-toe assessment and he (CR #1) could communicate verbally. She said sometimes, CR #1 had to repeat his words to be understood, but he could also text his needs on his tablet. She said CR #1 was able to express his needs and wants. (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	11/19/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 10/02/2024 at 2:22 p.m., she stated a baseline care plan should address the needs of the resident which were identified upon admission. She stated if CR #1 was tracheostomy/ventilator dependent, or if he had anxiety, all those conditions should have been added to the baseline care plan within 48-hours of his admission. She said all those things should have been addressed in the baseline care plan including a plan on how staff would care for CR #1 based on the care area. She said CR #1's RP called the facility and informed them about his nighttime anxiety three days after he was admitted (09/07/2024). She said CR #1 had not had a care planning meeting before he discharged on [DATE]. In an interview with LVN G on 10/02/2024 at 2:50 p.m., she stated she was one of the facility's wound care nurses. She stated she assessed all new residents for skin issues upon admission. She stated she only completed skin related care areas on the baseline care plan and the other care areas were initiated by the admitting nurse and the management team, including the DON and the ADON. She stated the baseline care plan was completed based on what each resident needed. She said the baseline care plan would be based on their assessment, observations of the resident, and hospital orders. In an interview with the ADON on 10/04/2024 at 12:10 p.m., she stated one of her duties included completing baseline care plans for new residents. She said the goal of a baseline care plan was to set goals and make sure those goals were achieved. She said baseline care plans were completed within the first 48-hours after admission. She said they looked at each resident, and their needs and medications. She said they completed care plans to let nurses know what plan to follow. She stated for CR #1, safety and pain management were addressed. She said they wanted to see how often CR #1 called for help. She said CR #1 could communicate with his eyes by typing on the screen of his device and by blinking his eyes (for yes and no questions). She said communication would be a part of the baseline care plan, because staff looked for cues with non-verbal residents. She said the methods used to communicate with CR #1 and goals would have been addressed in the baseline care plan. She stated CR #1 could let staff know when he needed to be suctioned. She said staff had to proactively go to his room and anticipate needs, ideally every two hours, since he was not able to move. She stated she would have to review CR #1's care plan to recall why his care areas were not included in the plan. After the ADON reviewed CR #1's baseline care plan, she said the baseline care plan was standard. She said she did not have time to get to know CR #1 better, but checking on him every two hours and anticipating needs would have been a part of his care plan. She said they sometimes updated the care plan as they went but when CR #1 was admitted (Wednesday, 09/04/2024), there was a weekend between that day and when he discharged to the hospital (Tuesday, 09/10/2024), so she did not have time to know him well. She said she, the DON, and the other ADON could update care plans as needs arose. She stated she was never informed of CR #1's nighttime anxiety. Record review of the facility's policy, Care Plans - Baseline revised March 2022 revealed, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation: 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services . 2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed .

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	11/19/2024

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 0684 Level of Harm - Actual harm 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** 26454 Based on observations, interviews, and record reviews, the facility failed to ensure that residents received treatment and care on accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 10 residents (CR #1) reviewed for quality of care. The facility failed to ensure the night shift staff (10:00 p.m. - 6:00 a.m.) recognized and provided clinical interventions when CR #1 experienced a change of condition (shortness of breath, fever of 103.5 degrees Fahrenheit, tachycardia (134 BPM) (when the heart beats faster than normal, usually more than 100 beats per minute while resting), and diaphoresis (sweating profusely), with an oxygen saturation (the percentage of oxygen-saturated hemoglobin in the blood) of 89% (normal range is between 95% and 100 %) on 09/10/2024 after family members attempted to report his concerns by calling the facility approximately 45 times between 1:53 a.m. and 3:47 a.m. This resulted in a delay in CR #1 receiving urgent medical treatment. This failure could place residents at risk of further deterioration of their condition and pain. Findings include: Record review of CR #1's face sheet dated 09/10/2024 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. CR #1 was diagnosed with non-pressure chronic ulcer (a non-healing wound) of the skin, acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and pressure ulcer of the sacral region (the triangular bone that connects the spine to the pelvis and forms the back wall of the pelvis), stage 4 (the most severe type of pressure ulcer and involves full thickness tissue loss with exposed bone, tendon, or muscle). He was discharged to an acute care hospital on 09/10/2024. Record review of CR #1's electronic health record revealed he did not have a completed MDS. Record review of CR #1's Observation Detail List Report dated 09/04/2024 revealed CR #1 could make himself understood, he understood others, and he had no short-term or long-term memory concerns. Record review of CR #1's care plan revised on 09/05/2024 revealed the following care areas: * Baseline Care Plan: will identify my care needs, risks, strengths, and goals for the first 48 hours. Goal included: My initial goal is to have access of services to promote adjustment to my new living environment. Approach included: * Activities and Functional Level for daily Care: I will receive the necessary setup, cueing, support and assistance level for activities of daily living. * Anticoagulation therapy will be administered as ordered by the physician. * Behavioral need will be evaluated for impact on quality of life, safety, and safety of others. (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	* I will be receiving skilled care and my discharge planning, goals, community referrals, transportation, health knowledge deficits, and follow-up will be discussed and planned with me and as needed with selected representatives. I will remain in place for long-term or hospice care. A comprehensive plan of care will be developed following a complete evaluation of my needs, strengths, and personal preferences. * Pressure Ulcer/Injury. Trauma wound to back of head related to immobility. Goal included: Trauma wound to back of head will heal without complications. Approach included: Avoid shearing resident's skin during positioning, transferring, and turning; Conduct systematic skin inspection weekly; Treat area per doctor orders. * Pressure Ulcer/Injury. Stage 4 Pressure injury/ulcer wound to sacrum related to immobility. Goal included: Resident's ulcer will heal without complications. Approach included: Apply dressings per doctor orders; Assess the pressure ulcer for stage, size, granulation tissue (a new connective tissue that forms in a wound during the healing process), and condition of surrounding skin weekly; Keep resident off load wound; Turn and reposition as needed, and as tolerated. Record review of CR #1's undated pre-admission hospital records revealed he was admitted to a specialty hospital on 07/10/2024 and was discharged to the facility on [DATE]. The document revealed CR #1 was diagnosed with the following: *Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, damaging the body's own tissues and organs), *Aspiration pneumonia (a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs), *Leukocytosis (a high level of white blood cells in the blood), *Fever, *Complicated UTI (a UTI that has a higher risk of treatment failure than a simple UTI), *Acute on chronic respiratory failure (when a patient with chronic respiratory insufficiency experiences a sudden decline in health) *s/p tracheostomy, *Peg (a feeding tube) placements with ventilator dependency, *Sacral and posterior head wounds, and *New sepsis of sacral wound (unstageable) with infection/cellulitis (bacterial skin infection). (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Further review read in part, Plan: Presented from an acute care hospital on 07/11/2024 with infiltrates in right upper lobe (lung) and right middle lobe. Began having intermittent fevers on 7/28/2024 (highest temperature seen in records is 102.9 degrees Fahrenheit on 07/31/2024) . Date of Service: 09/03/2024. Subjective Progress Notes: . The patient remains on ventilator with catheter in place . He continues to have intermittent low-grade fevers (a body temperature that is slightly higher than normal, usually between 99.5 and 100.3-degrees Fahrenheit) and remains with leukocytosis . Record review of CR #1's Physician's Progress Note dated 09/09/2024 revealed, . [CR #1] is an [AGE] year-old male with no previous medical history whose hospitalization started with a gunshot wound to his right neck in 05/2024. He sustained a transection of right ICA and right vertebral artery with blast injury (physical trauma resulting from direct or indirect exposure to an explosion) of C2 (the second cervical vertebra) and involvement of spinal canal. This has resulted in quadriplegia (a condition that causes a person to lose the ability to move all four limbs and the body from the neck down), tracheostomy placement, and chronic respiratory failure requiring continuous invasive mechanical ventilation. His course was complicated by a pneumothorax (when air leaks into the space between the lungs and chest wall) s/p chest tube placement and removal, multi-drug resistant pneumonia, multi-drug resistant urinary tract infection, and a significant sacral wound requiring I&D (minor surgical procedures to release pus or pressure built up under the skin) on 08/19/2024. He has been treated with multiple antibiotics, however, most recently was placed on Ceftazidime for a 4-week course due to his sacral wound, which per the infectious disease team that was seeing him, should continue until 09/20/2024 . [CR #1] is awake and alert and in no distress . Vital Signs: Pulse - 99 BMP, Blood Pressure - 122/67, O2 Saturation - 99 degrees Fahrenheit Room Air, Respiratory Rate - 18 Breaths per minute . Record review of CR #1's physician's orders for September 2024 revealed: * Ceftazidime Reconstitution solution (used to treat or prevent a variety of bacterial infections); 1 gram; 1000 mg; Intravenous (within or into a vein). Frequency: Every 8 hours (5:00 a.m., 1:00 p.m., and 9:00 p.m.). Special Instructions: Pneumonia (an infection that inflames air sacs in one or both lungs). Start/End Date: 09/04/2024 - 09/05/2024 (Discontinued date). * Ceftazidime Reconstitution solution; 1 gram; 1000 mg; Intravenous (within or into a vein). Frequency: Every 8 hours (5:00 a.m., 1:00 p.m., and 9:00 p.m.). Special Instructions: Sacral Wound. Start/End Date: 09/05/2024 - 09/20/2024. * Anti-Anxiety Medication Use - Observe resident closely for significant side effects. Every Shift. Start Date: 09/05/2024. * Check vital signs once every shift. Every Shift. Start Date: 09/05/2024. * Respiratory: Suction Every Shift. Start Date: 09/04/2024. * Respiratory: Suction every two hours or as needed for increased secretions. Every two hours - PRN. Start Date: 09/04/2024. * Respiratory: Tracheostomy Care (Even Rooms) Once per day. 7:00 p.m. - 7:00 a.m. Start Date: 09/04/2024. (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #1's MAR for September 2024 revealed Ceftazidime was administered as ordered from 09/05/2024 until 09/09/2024. Record review of CR #1's nursing progress notes for September 2024 revealed: * On 09/09/2024, at 1:45 p.m., LVN C wrote, Resident on day 5 of Ceftazidime 1 gram IV for Pneumonia. Indwelling Catheter intact, patent, and draining . * On 09/11/2024, at 3:17 p.m. (this entry was recorded as a late entry for 09/09/2024 at 11:13 p.m.), LVN A wrote, Resident is alert and oriented x 4 (a medical term that indicates a patient is awake, alert, and oriented to person, place, time, and event), was asked if he needed any PRNs or anything during this nurse first round, resident denied needing anything. Vital signs were taken by nighttime CNAs. IV line was flushed after antibiotic therapy finished. No s/s of distress or pain noted during this round. * On 09/10/2024, at 3:40 a.m., LVN A wrote, 911 showed up to facility for patient by [family member] request. Paramedic suctioned the patient, there was no secretions coming out. He repeatedly kept suctioning and bleeding was observed on the tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck). Vital signs were taken - BP: 114/68, HR: 137, RR: 20, T: 97.9, O2 Sat: 99%. Resident had complained of SOB, RT assessed and O2 Sats were WNL for this patient. Resident is A&O x 4 and requested to be transported to the hospital. Resident will be taken to a local acute care hospital. RP notified of transfer. DON was notified. * On 09/10/2024, at 5:38 a.m., RT B wrote, Lung Sounds: Diminished; Respirations Rhythm/Pattern: Regular/Unlabored. Cough Present? No. Shortness of Breath present? No. Shortness of Breath (dyspnea): None of the above. Oxygen in use? Yes (Liter Flow) 5. Use of vent: Yes . Restlessness present? No. Anxiety present? No . Resident's [family member] called 911 to take resident to the hospital. Resident complaining that he cannot breathe. SPO2 WNL at 99%. Paramedic immediately began suctioning resident's tracheostomy, no secretions noted. Paramedic repeatedly suctioned and bleeding through the tracheostomy started. RT suctioned small amount of secretion through nose and mouth. Resident alert and oriented. No respiratory distress noted. RT has provided respiratory care. EMS left at 4:00 a.m. * On 09/10/2024, at 2:30 p.m., the DON wrote, This writer spoke with RP regarding concerns about phone calls last night. She expressed her concerns. Provided RP with this writer's phone number to call. Explained that new cordless phones are being provided. RP stated she will be bringing [CR #1] back. She stated he has a low fever and will be getting a supra pubic catheter while at the hospital and the return to the facility. * On 09/10/2024, at 3:35 p.m., the Administrator wrote, Spoke to family member and apologized of the phone not being answered timely and gave her my cell phone number to reach out with any questions or concerns . (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #1's EMS record dated 09/10/2024 revealed, . Last known well - 09/10/2024 at 1:00 a. m. Signs and Symptoms: Shortness of Breath (Primary) . Call Received: 3:23 a.m. Dispatched: 3:25 a.m. On Scene: 3:33 a.m. At Patient: 3:36 a.m. Depart Scene: 4:13 a.m. 3:41 a.m. - Pulse: 134, RR: 22, Temperature: 103.5 degrees Fahrenheit . Was dispatched to facility for a breathing problem. We responded emergency traffic and arrived on location without incident or delay. Dispatch advised that the patient's family member called 911 but was not on location. We entered the facility and found the patient lying in bed. Patient contact was made an initial assessment was performed . Patient was A&O x 4. Patient tracheostomy tube was occluded with mucus and was immediately suctioned and cleared. Patient breathing was accelerated with equal chest rise and fall, clear lung sounds, denied any chest pain but was in moderate distress. Patient skin was hot to touch and diaphoretic (sweating profusely), strong and rapid pulses, and no obvious signs of injury or bleeding noted. Further assessment showed patient was running a fever and had increased capnometry (amount of carbon dioxide in exhaled air). Patient family member was contacted at this time. She advised that she had called the facility multiple times since 1:00 a.m. to find out why [CR #1] was having difficulty breathing but eventually called 911 after getting no response. Patient vitals were obtained at this time and are as noted in report. EMS requested additional staff to make location for additional manpower to assist in moving the patient and assisting ventilations during transport . Patient tracheostomy tube was flushed and suctioned . Patient showed sinus tachycardia that would gradually increase in rate during patient care . Record review of CR #1's hospital records revealed on 09/10/2024, at 4:29 a.m. his temperature was 103.5 degrees Fahrenheit, and his heart rate was 158. IV fluids and acetaminophen were ordered. The document read in part, . 09/10/2024, at 9:42 a.m. History and Physical . Today 09/10/2024 brought by EMS with worsening shortness of breath. According to his family member, he has been 'feeling hot' for the past two days, having shortness of breath since last night. According to her, he has been with a lot of respiratory secretions. He reports no symptoms at the time of my interview, only asking for ice chips. He reports no chest pain, no nausea, no vomiting or diarrhea. ED course: Mild hypernatremia (high concentration of sodium in the blood) with slight leukocytosis with mild anemia. Calcium slightly elevated with mild liver enzymes elevation. Chest x-ray was consistent with right lower lobe pneumonia versus atelectasis (complete or partial collapse of a lung). EKG with sinus tachycardia. Patient was treated with IV Meropenem (antibiotic used to treat infection) in the ED and admitted for further evaluation and treatment . Impression and Plan Diagnosis: acute on chronic respiratory failure, acute sepsis, anemia, aspiration pneumonia . (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview with CR #1's RP on 09/10/2024 at 11:35 a.m., she stated EMS told her that CR #1 had a high temperature when he was admitted to the hospital on 09/10/2024. She stated CR #1 was able to communicate with an eye tracker system on his tablet which allowed him to text (which turned the text to voice) with his eyes since he could not move his limbs. She said the device allowed CR #1 to call phone numbers when he needed help. She said she let the staff know when he was admitted on [DATE] to keep an eye on him because he had problems with his breathing between the hours of 2:00 a.m. - 3:00 a.m. and 6:00 a.m. - 7:00 a.m. She said she had not been able to reach the staff by phone during those hours. She said CR #1 was able to tell her he had snot all over his face on the morning of 09/10/2024. She said CR #1 knew when he needed to be repositioned and suctioned and he recalled everything perfectly. She said he was nonverbal now, but he was very aware and alert. She said she had to call 911 on 09/04/2024 because nobody answered the phone and staff only called her to let her know CR #1 was going to the hospital. She said earlier during the night shift, (on 09/09/2024) at 9:31 p.m., CR #1 contacted her and said he had not been repositioned. She said he could not recall what time he was last repositioned, before then, but he said it had been a long time. She said she called the facility at 9:34 p.m. and someone answered the phone and went to assist CR #1. She said on 09/10/2024, the problem started at 1:45 a.m. when CR #1 called another family member and indicated he could not breath, he had mucus coming out of his nose, and he needed to be repositioned. She said that family member called her at 1:53 a.m. She said she called the facility at 1:53 a. m., but nobody ever answered the phone. She said on at 2:38 a.m., she asked CR #1 if anybody came to assist him and he texted No, please call the facility. She said she told CR #1 she was calling right then. She said at 2:40 a.m., she called the facility more times and CR #1 indicated that he was hot, he needed a breathing treatment, and he need to be repositioned. She said at 2:49 a.m., CR #1 indicated nobody came to assist him yet and he had a lot of snot on his face. She said at 2:50 a.m., CR #1 got anxious and texted, Help! She said two other family members got involved and started calling the facility. She said at 3:00 a.m., CR #1 indicated that nobody had come to assist him. She said CR #1 stopped texting at 3:05 a.m., but she was still calling the facility over and over from 3:03 a.m. - 3:19 a.m. She said she called 911 at 3:21 a.m. She said EMS called her from their personal cell phone at 3:47 a.m. and said CR #1 had a face full of snot and needed to be suctioned. She said EMS told her CR #1's other vital signs were fine, but he had a high temperature. She said EMS asked her why they were there (at the facility). She said EMS took CR #1 to the hospital because he wanted to go. She said the facility's staff called her at 4:30 a.m. to let her know CR #1 was being transported to the hospital. She said another family member called the facility 28 times and she called 17 times. She stated she previously told facility staff (she could not recall the names of staff she talked to) that CR #1 experienced anxiety at certain times during the night. Observation and interview with CR #1 on 09/10/2024 at 3:30 p.m. revealed he was in a room in the ER of a local acute care hospital. CR #1 was alert and had a tracheostomy connected to a ventilator. CR #1 also had on a neck brace. CR #1 was sweating heavily. CR #1 did not initially verbalize words. He blinked once for yes answers and twice for no answers. CR #1 indicated no facility staff went to his room early that morning (09/10/2024) until EMS arrived. He indicated he did not know what time facility staff last checked on him. He indicated he felt hot and sick while waiting for staff to reposition him. CR #1 indicated he had trouble breathing and needed to be suctioned that morning. He indicated he was sweating that morning and then he said, Help. CR #1 indicated he wanted a nurse. While waiting for a hospital nurse to come, CR #1 said, Ice chips. CR #1's hospital nurse stated CR #1 was febrile (had a fever) with a temperature of 103.5 when he arrived in the ER, and he was being admitted for sepsis. The nurse took CR #1's temperature and stated it was 99.9. The nurse stated CR #1 was tachycardic upon arrival to the ER at 158 BPM. (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview with RT B on 09/12/2024 at 3:15 a.m., he stated he worked with CR #1 on Saturday (09/07/2024), Sunday (09/08/2024), and Monday 09/09/2024) (respiratory therapist work 12-hour shifts, so RT B was on shift the morning of 09/10/2024). He stated CR #1 complained of shortness of breath a few times during his shift, but his oxygen saturation was good at 99% and he was not in distress. He said he thought CR #1 experienced anxiety because his vital signs were fine, he was breathing fine, and it was common for residents with new tracheostomies to have anxiety. RT B said he checked on CR #1 every two hours, and he was called to CR #1's room a lot to suction secretions from his nose and mouth. RT B said CR #1 called his RP and she called them at the facility. He said CR #1 often had a lot of secretions from his nose and mouth. He said CR #1 was uncomfortable with the secretions, so he suctioned him, but CR #1 was not in an emergency. He said he heard the phone ring a lot on Tuesday morning (09/10/2024) and the nurse (he could not recall which nurse answered the phone) answered a few times. RT B said LVN A told him CR #1's RP wanted them to check him to see if was ok, so they went to check him immediately after his RP called. He said CR #1's vital signs were perfect. He said as the respiratory therapist, he checked oxygen saturation, respiratory rate, and pulse. He said the nurse would have checked CR #1's blood pressure and temperature. He said he went into CR #1's room once with LVN A (when CR #1's RP called), but he went in alone all the other times during his shift. He said LVN A only did a visual check of CR #1 and did not check his temperature when they went into his room together. He said CR #1 made sounds with his mouth and grimaced, so he suctioned his nose, mouth, and tracheostomy. He said CR #1 had some snot (secretions from his nose) on his face, but not a lot. He said LVN A was CR #1's nurse, and she was assigned to work half of two halls, so she was not on CR #1's hall the whole shift. RT B said CR #1 was not sweating when he checked him. He said between 1:45 a.m. and when EMS arrived, he had been in CR #1's room three times. He said he went in when EMS came, so that was his 4th round into CR #1's room. He said he was surprised when he saw EMS in the building, and they immediately suctioned CR #1 because he of SOB. He said nothing came from CR #1's tracheostomy and EMS went in again and again until CR #1 started bleeding. RT B said he told EMS to stop. He said when EMS arrived, CR #1 had a medium amount of nose and mouth secretions. He said he called LVN A to come when EMS arrived because she was on another hall. He said he saw LVN A check CR #1's vital signs, including his temperature when EMS arrived. He said CR #1's heart rate was a little high, but he thought it was from anxiety. RT B said CR #1's temperature was fine at that time and he was not sweating. He said CR #1's RP insisted EMS take him to the hospital. In an interview with the DON on 09/12/2024, at 2:15 p.m., she stated she was familiar with CR #1, and she had just spoken to his RP. She said CR #1's RP said she called the facility multiple times that morning (09/10/2024) and felt CR #1 did not get adequate care. She said the RP said she and other family members called over 50 times. She said a nurse only answered once and went in to help CR #1, but nobody answered the other times. The DON said she investigated, and the nurse verified she went in and checked on CR #1. She said the nurse told her the phone probably did ring that many times, but she was in another room at the time. The DON said that was probably why CR #1's RP called 911. She said since that incident, they have gotten cordless phones for the nurses on each hall. The DON said CR #1 was already gone to the hospital when she arrived on 09/10/2024, so she could not assess him. She stated CNAs, nurses, and respiratory therapists had to go in every two hours and anticipate CR #1's needs because he could not utilize the bells/buzzers as other residents. She said the nurses usually did visual head-to-toe checks and did not check vitals with each round. She said vital signs were taken every shift unless there was a change of condition. The DON said a person's temperature could change fast depending on where they checked it. She said the thermometer the staff used could have been defective. She said if CR #1 did not appear to be abnormal (experiencing a change of condition) and the nurse did not see a need for a hands-on check, she would not have done one. (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview with LVN A on 09/12/2024, at 2:40 p.m., she stated her normal shift was 2:00 p.m. - 10:00 p. m. but she picked up a 10:00 p.m. - 6:00 a.m. shift on Monday 09/09/2024. She stated that was her first time working with CR #1. She said her first encounter with CR #1 was at 10:15 p.m., at the beginning of her shift. She said CR #1 was watching a movie on his tablet and could mouth words. She said CR #1 indicated he was ok. She stated CR #1 did not have any secretions. She said she could not recall what time she saw CR #1 after that initial encounter. She said the second time she checked on CR #1, he indicated he was fine and did not need anything. She said he did not have any secretions. She said she could not recall what time it was, but she flushed IV line and gastrostomy tube (feeding tube) and placed a new feed bottle. She said CR #1 was asleep at that time and he did not have any secretions. She said the next time she saw CR #1 was when EMS arrived. She said she did not take any calls from CR #1's family because she was busy with other residents. She said nobody ever told her CR #1's family called, and she did not know his family called. She said she was the only nurse responding to CR #1 that night and no other nurses helped her with him that night. She said she never observed CR #1 with snot around his nose or face. She said CR #1 did not have any secretions and there were no signs of discomfort. She said she saw CR #1 twice before EMS came into the building. She said when EMS arrived, she went to CR #1's room. She said when EMS tried to suction CR #1, nothing came out. She said after the 3rd or 4th time; a small amount of blood came out. She said there was no snot on CR #1's face when she went in, but RT B was there before her. She said EMS did everything (suctioning and vital signs) and she just printed CR #1's paperwork for his transfer. She said EMS handed her a sheet of paper with CR #1's vital signs that they took. She said the CNAs took residents' vital signs at the beginning of the shift. She said she asked EMS if she could take CR #1's vitals and they said they already took them. She said the only abnormal vital sign she saw on 09/10/2024 was his heart rate at 130-something. She said CR #1's temperature was good, but she could not recall what it was, and she did not keep the paper EMS gave her. She said 103.5 degrees Fahrenheit was not what EMS handed her for CR #1's temperature. She said the vital signs she documented in her progress note on 09/10/2024 were from the beginning of the shift when the CNA checked them. She said when she did her rounds, she had to put her hands on CR #1's skin to flush his IV. She said she had to uncovered CR #1. She said CR #1's face just looked shiny, like he had oil built up. She said CR #1 never expressed that he was not feeling well to her. She said EMS did not really want to talk to her, but she heard him talking to someone on the phone. She said it seemed like the EMT was very upset, but she did not know what he was talking about on the phone. She said she heard the EMT describe the resident to the person on the phone. She said she heard them discuss if they were going to take CR #1 or not. She said the EMT told her they were taking CR #1 because his heart rate was 136. She said EMS asked CR #1 if he wanted to go and he said yes. She said CR #1 was alert and oriented x 4. She said the CNAs checked residents' vitals at the beginning of the shift but if the nurses notice anything usual, they took them again. (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview with CNA D on 09/12/2024 at 3:30 p.m., she stated she worked the 10:00 p.m. - 6:00 a.m. shift and CR #1 was new to the facility. She said CR #1 could answer yes and no questions when asked if he needed something. She said CR #1 was able to make his needs known and could verbally express when he needed to be suctioned. She said her first encounter with CR #1 on 09/09/2024 was between 11:30 p.m. and 12:00 a.m. when she took his vital signs. She said she asked CR #1 if he needed to be repositioned and he said he was ok. She said CR #1's vital signs were normal. She said he was not sweating at that time. She said the next time she checked on CR #1 was around 2:00 a.m. during normal rounds. She said she rounded every two hours. She said she checked to see if CR #1 needed incontinent care or repositioning, but he was ok. She said she asked if he needed anything, and he said he was ok. She said CR #1 did not have any snot around his face or nose at that time. She said she started her next rounds around 3:00 a.m. She said she saw EMS arrive between 3:00 a.m. - 4:00 a.m. She said she did not go into CR #1's room after EMS arrived. She said she was never informed that CR #1's family members were calling the facility and she never observed him sweating. She said she never touched CR #1's skin after checking his vital signs at the beginning of the shift because he had a catheter and CR #1 did not ask for incontinent care. She said she did check to see if CR #1 had a bowel movement and she touched him to check, but his skin was normal. She said she saw CR #1 twice that night. She said CR #1 was alert and oriented. In a follow up interview with the DON on 09/17/2024, at 1:48 p.m., she said a resident's condition could change very quickly. She said they could look fine and then need to go to the hospital fast. She said she had seen quick temperature changes a few times. She said when residents had elevated white blood cells and were being treated with antibiotics, their temperatures could go up and down. She said she could not say that was what happened in CR #1's case, and she could not say what happened that night because she was not there. She stated she expected the nurses to do head to toe assessments when they rounded, including touching the resident. The DON then said she could not say the nurses would physically touch the residents' skin. She said the nurses should go into the room and look to make sure the resident was at baseline, but they would not wake the resident up or be invasive. She said each nurse did their clinical assessments based on what they thought the resident needed. She stated some residents required touch, and some did not. She said she did not know if it was fair to say staff missed CR #1's change of condition. She said if the staff observed CR #1 sweating, it would be considered a change of condition, but it was possible the sweating happened just prior to when EMS arrived. She stated CR #1 had some anxiety between certain hours and started calling his family members at certain times. She said CR #1's family member said she anticipated those calls from CR #1 in the middle of the night. She said she could not speak on what happened, but when nurses saw changes, they responded immediately, and a lot of things could factor that. Record review of the facility's undated job description for LVN's revealed, The primary purpose of this position is to provide skilled nursing care to residents under the medical direction of the residents' attending physician and within the scope of nursing practice for the state. Essential Functions: Observe patients, charting and reporting changes in conditions such as adverse reactions to medication or treatment and takes necessary actions. Answers patients' calls and determines how to assist them. Measures and records patients' vital signs such as height, weight, temperature, blood pressure, pulse, and respiration. Works as part of a health care team to assess patient needs, plans and modifies care, and implements interventions . Provide nursing services to residents in accordance with scope pf practice, facility policies, and professional standards of care. Monitor residents for developments of acute changes of condition including confusion, fever, difficulty breathing, increased pain .; conduct assessments and notify the provider as needed . (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	11/19/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy, Change in a Resident's Condition or Status revised February 2021 revealed, Policy Statement: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status . Policy Interpretation and Implementation . 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 inte [TRUNCATED]

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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, record review, and interview, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities for 4 of 4 halls (100 Hall, 200 Hall, 300 Hall, and 400 Hall) reviewed for call light systems. 1. The facility failed to repair or replace the call light system for the entire building after five months when inclement weather caused the system to fail on 05/02/2024 through 10/09/2024. Resident #2, Resident #3, and Resident #4, who were all physically and cognitively capable of using a call light system had no means to call for staff assistance. 2. The facility failed to have adequate interventions in place for CR #1, who was alert, oriented, and quadriplegic (a condition that causes a person to lose the ability to move all four limbs and the body from the neck down), to call for staff assistance and resulted in family members calling 911 after attempting to call the facility 45 times when CR #1 experienced a change of condition (shortness of breath). EMS noted CR #1 was tachycardic (134 BPM) (when the heart beats faster than normal, usually more than 100 beats per minute while resting), diaphoretic (sweating profusely), and febrile (103 degrees F) (with fever) with an oxygen saturation (the percentage of oxygen-saturated hemoglobin in the blood) of 89% (normal range is between 95% and 100 %) on 09/10/2024. An IJ was identified on 11/14/2024 at 11:49 a.m. The IJ template was provided to the facility on [DATE] at 11:49 a.m. While the IJ was removed on 11/15/2024, the facility remained out of compliance at a scope of pattern with severity level at a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on 11/14/2024. These failures could place residents capable of operating a call light system or adaptive call buttons at risk of experiencing a delay in receiving urgent medical care in emergency situations and delayed assistance with activities of daily living. Findings include: Record review of CR #1's face sheet dated 09/10/2024 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. CR #1 was diagnosed with non-pressure chronic ulcer (a non-healing wound) of the skin, acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and pressure ulcer of the sacral region (the triangular bone that connects the spine to the pelvis and forms the back wall of the pelvis), stage 4 (the most severe type of pressure ulcer and involves full thickness tissue loss with exposed bone, tendon, or muscle). He was discharged to an acute care hospital on 09/10/2024. Record review of CR #1's electronic health record revealed he did not have a completed MDS. Record review of CR #1's Observation Detail List Report dated 09/04/2024 revealed CR #1 could make himself understood, he understood others, and he had no short-term or long-term memory concerns. (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's care plan revised on 09/05/2024 revealed the following care areas: * Baseline Care Plan: will identify my care needs, risks, strengths, and goals for the first 48 hours. Goal included: My initial goal is to have access of services to promote adjustment to my new living environment. Approach included: * Activities and Functional Level for daily Care: I will receive the necessary setup, cueing, support and assistance level for activities of daily living. * Anticoagulation therapy will be administered as ordered by the physician. * Behavioral need will be evaluated for impact on quality of life, safety, and safety of others. * I will be receiving skilled care and my discharge planning, goals, community referrals, transportation, health knowledge deficits, and follow-up will be discussed and planned with me and as needed with selected representatives. I will remain in place for long-term or hospice care. A comprehensive plan of care will be developed following a complete evaluation of my needs, strengths, and personal preferences. * Pressure Ulcer/Injury. Trauma wound to back of head related to immobility. Goal included: Trauma wound to back of head will heal without complications. Approach included: Avoid shearing resident's skin during positioning, transferring, and turning; Conduct systematic skin inspection weekly; Treat area per doctor orders. * Pressure Ulcer/Injury. Stage 4 Pressure injury/ulcer wound to sacrum related to immobility. Goal included: Resident's ulcer will heal without complications. Approach included: Apply dressings per doctor orders; Assess the pressure ulcer for stage, size, granulation tissue (a new connective tissue that forms in a wound during the healing process), and condition of surrounding skin weekly; Keep resident off load wound; Turn and reposition as needed, and as tolerated. Record review of CR #1's Physician's Progress Note dated 09/09/2024 revealed, . [CR #1] is an [AGE] year-old male with no previous medical history whose hospitalization started with a gunshot wound to his right neck in 05/2024. He sustained a transection of right ICA and right vertebral artery with blast injury (physical trauma resulting from direct or indirect exposure to an explosion) of C2 (the second cervical vertebra) and involvement of spinal canal. This has resulted in quadriplegia (a condition that causes a person to lose the ability to move all four limbs and the body from the neck down), tracheostomy placement (a surgical procedure that creates an opening in the neck and into the windpipe, or trachea to provide an airway for breathing), and chronic respiratory failure requiring continuous invasive mechanical ventilation. His course was complicated by a pneumothorax (when air leaks into the space between the lungs and chest wall) s/p chest tube placement and removal, multi-drug resistant pneumonia, multi-drug resistant urinary tract infection, and a significant sacral wound requiring I&D (minor surgical procedures to release pus or pressure built up under the skin) on 08/19/2024. He has been treated with multiple antibiotics, however, most recently was placed on Ceftazidime for a 4-week course due to his sacral wound, which per the infectious disease team that was seeing him, should continue until 09/20/2024 . [CR #1] is awake and alert and in no distress . Vital Signs: Pulse - 99 BMP, Blood Pressure - 122/67, O2 Saturation - 99 Room Air, Respiratory Rate - 18 Breaths per minute . (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's nursing progress notes for September 2024 revealed: * On 09/09/2024, at 1:45 p.m., LVN C wrote, Resident on day 5 of Ceftazidime 1 gram IV for Pneumonia. Indwelling Catheter intact, patent (open and functioning properly, with minimal blockage), and draining . * On 09/11/2024, at 3:17 p.m. (this entry was recorded as a late entry for 09/09/2024 at 11:13 p.m.), LVN A wrote, Resident is alert and oriented x 4 (a medical term that indicates a patient is awake, alert, and oriented to person, place, time, and event), was asked if he needed any PRNs or anything during this nurse first round, resident denied needing anything. Vital signs were taken by nighttime CNAs. IV line was flushed after antibiotic therapy finished. No s/s of distress or pain noted during this round. * On 09/10/2024, at 3:40 a.m., LVN A wrote, 911 showed up to facility for patient by [family member] request. Paramedic suctioned the patient, there was no secretions coming out. He repeatedly kept suctioning and bleeding was observed on the tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck). Vital signs were taken - BP: 114/68, HR: 137, RR: 20, T: 97.9 [degrees Fahrenheit], O2 Sat: 99%. Resident had complained of SOB, RT assessed and O2 Sats were WNL for this patient. Resident is A&O x 4 and requested to be transported to the hospital. Resident will be taken to a local acute care hospital. RP notified of transfer. DON was notified. * On 09/10/2024, at 5:38 a.m., RT B wrote, Lung Sounds: Diminished; Respirations Rhythm/Pattern: Regular/Unlabored. Cough Present? No. Shortness of Breath present? No. Shortness of Breath (dyspnea): None of the above. Oxygen in use? Yes (Liter Flow) 5. Use of vent: Yes . Restlessness present? No. Anxiety present? No . Resident's [family member] called 911 to take resident to the hospital. Resident complaining that he cannot breathe. SPO2 WNL at 99%. Paramedic immediately began suctioning resident's tracheostomy, no secretions noted. Paramedic repeatedly suctioned and bleeding through the tracheostomy started. RT suctioned small amount of secretion through nose and mouth. Resident alert and oriented. No respiratory distress noted. RT has provided respiratory care. EMS left at 4:00 a.m. * On 09/10/2024, at 2:30 p.m., the DON wrote, This writer spoke with RP regarding concerns about phone calls last night. She expressed her concerns. Provided RP with this writer's phone number to call. Explained that new cordless phones are being provided. RP stated she will be bringing [CR #1] back. She stated he has a low fever and will be getting a supra pubic catheter while at the hospital and the return to the facility. * On 09/10/2024, at 3:35 p.m., the Administrator wrote, Spoke to family member and apologized of the phone not being answered timely and gave her my cell phone number to reach out with any questions or concerns . (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's EMS record dated 09/10/2024 revealed, . Last known well - 09/10/2024 at 1:00 a. m. Signs and Symptoms: Shortness of Breath (Primary) . Call Received: 3:23 a.m. Dispatched: 3:25 a.m. On Scene: 3:33 a.m. At Patient: 3:36 a.m. Depart Scene: 4:13 a.m. 3:41 a.m. - Pulse: 134, RR: 22, Temperature: 103.5 [degrees Fahrenheit] . Was dispatched to facility for a breathing problem. We responded emergency traffic and arrived on location without incident or delay. Dispatch advised that the patient's family member called 911 but was not on location. We entered the facility and found the patient lying in bed. Patient contact was made an initial assessment was performed . Patient was A&O x 4. Patient tracheostomy tube was occluded with mucus and was immediately suctioned and cleared. Patient breathing was accelerated with equal chest rise and fall, clear lung sounds, denied any chest pain but was in moderate distress. Patient skin was hot to touch and diaphoretic (sweating profusely), strong and rapid pulses, and no obvious signs of injury or bleeding noted. Further assessment showed patient was running a fever and had increased capnometry (amount of carbon dioxide in exhaled air). Patient family member was contacted at this time. She advised that she had called the facility multiple times since 1:00 a.m. to find out why [CR #1] was having difficulty breathing but eventually called 911 after getting no response. Patient vitals were obtained at this time and are as noted in report. EMS requested additional staff to make location for additional manpower to assist in moving the patient and assisting ventilations during transport . Patient tracheostomy tube was flushed and suctioned . Patient showed sinus tachycardia that would gradually increase in rate during patient care . Record review of CR #1's hospital records revealed on 09/10/2024, at 4:29 a.m. his temperature was 103.5 degrees Fahrenheit, and his heart rate was 158. IV fluids and acetaminophen were ordered. The document read in part, . 09/10/2024, at 9:42 a.m. History and Physical . Today 09/10/2024 brought by EMS with worsening shortness of breath. According to his family member, he has been 'feeling hot' for the past two days, having shortness of breath since last night. According to her, he has been with a lot of respiratory secretions. He reports no symptoms at the time of my interview, only asking for ice chips. He reports no chest pain, no nausea, no vomiting, or diarrhea. ED course: Mild hypernatremia (high concentration of sodium in the blood) with slight leukocytosis (high white blood cell count) with mild anemia. Calcium slightly elevated with mild liver enzymes elevation. Chest x-ray was consistent with right lower lobe pneumonia versus atelectasis (complete or partial collapse of a lung). EKG with sinus tachycardia. Patient was treated with IV Meropenem (antibiotic used to treat infection) in the ED and admitted for further evaluation and treatment . Impression and Plan Diagnosis: acute on chronic respiratory failure, acute sepsis (a life-threatening complication of an infection), anemia, aspiration pneumonia (a lung infection due to a relatively large amount of material from the stomach or mouth entering the lungs) . Record review of Resident #2's face sheet dated 09/17/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with acute respiratory failure with hypoxia, cerebral palsy (a congenital disorder of movement, muscle tone, or posture), chronic obstructive pulmonary disease (a group of lung diseases that make it hard to breathe), history of tracheostomy, and dependence on respirator. Record review of Resident #2's MDS dated [DATE] revealed he could make himself understood; he had a BIMS score of 15 (cognitively intact); and he required extensive assistance from one staff member with bed mobility, transfers, eating, and toilet use. Record review of Resident #2's care plan revised 06/20/2024 revealed the following care areas: (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* Resident is at risk for falls due to weakness. Goal included: Resident will be free of falls. Approaches included: Implement exercise program that targets strength, gait, and balance. Place call light/ call bell within reach all the time and respond to call light/ call bell promptly. * Resident has a chronic established contractures of bilateral (both sides) upper extremities due to cerebral palsy (upon admission). Goal included: Resident will receive measures to correct or prevent further progression of current contractures from developing to allow for proper positioning and adequate hygiene of extremities. Approach included: PT/OT to establish most appropriate contracture management program and work on compensatory strategies to improve independence with functional tasks. * Resident able to communicate well with the staff: alert and oriented x 3-4 (3: person is alert and oriented to person, place, and time, but not what is happening to them. 4: fully alert), verbal, speaks and understands English, understood and able to understand other. Goal included: Resident needs will be communicated to the staff and will ensure that they are met. Approaches included: Allow resident time to speak. Avoid interrupting. Encourage verbalization. Record review of Resident #3's face sheet dated 09/17/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with metabolic encephalopathy (a group of neurological disorders that occur when the brain is affected by chemical imbalance in the blood), cognitive communication deficit (difficulty with communication that is caused by a disruption in cognition) , aphonia (loss of voice), dysphagia (difficulty swallowing), tracheostomy status, and dependence on a respirator, acute and chronic respiratory failure, cerebral infarction (when blood flow to the brain is blocked, resulting in brain tissue death), and end-stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids). Record review of Resident #3's MDS dated [DATE] revealed he was usually understood by others; he had a BIMS score of 15 (cognitively intact); and he required substantial/maximal assistance from staff with eating, oral hygiene, and toileting. Record review of Resident #3's care plan revised 10/03/2024 revealed the following care areas: * Resident has impaired communication related to unclear speech and aphonia (loss of voice). Resident is usually understood and understands other. Goal included: Resident will be able to make basic needs known daily. Approaches included: Allow adequate time to respond, repeat as necessary. Anticipate and meet needs. Ensure/provide a safe environment: call light in reach, adequate low glare light. * Resident is at risk for falls due to muscle weakness, decreased coordination, and impaired physical and functional mobility. Goal included: Resident will be free from minor/major fall related injuries. Approaches included: Implement exercise program that targets strength, gait, and balance. Keep call light/call bell within easy reach. Ensure prompt staff response. (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's face sheet dated 11/19/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with acute and chronic respiratory failure with hypoxia, anemia (when the blood does not have enough healthy red blood cells and hemoglobin to carry oxygen all through the body), pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus), dysphagia, history of transient ischemic attack (a brief stroke-like attack) and cerebral infarction, aphonia, cognitive communication deficit, and history of tracheostomy. Record review of Resident #4's quarterly MDS dated [DATE] revealed she understood others and made herself understood; she had a BIMS of 8 (moderate cognitive impairment); and she was dependent on staff for eating, hygiene and bathing. Record review of Resident #4's care plan revised 10/23/2024 revealed the following care area: * Resident is at risk for falls due to weakness. Goal included: Resident will be free of falls. Approaches included: Increased staff supervision with intensity based on resident need. Place call light/call bell within reach all the time and respond to call light/call bell promptly. Observation of all four of the facility's halls (100 Hall, 200 Hall, 300 Halls, and 400 Hall) and random rooms on all four halls inside the facility (101, 103 - 100 Hall, 204 - 200 Hall, 306 - 300 Hall, and 402, 413, 414 - 400 Hall) on 09/10/2024, starting at 12:45 p.m. until 3:15 p.m. revealed residents had cowbells (a hand percussion instrument), squeeze toys, and buzzers to use at beside and in bathrooms when they needed staff assistance. Further observation of the facility during this timeframe revealed there were multiple bedside tables placed haphazardly on each hall with chairs. Facility staff were observed sitting in the chairs at random times. Observation and interview of Resident #2 in room [ROOM NUMBER] (on the 100 Hall) on 09/10/2024, at 1:16 p.m. revealed he was alert and oriented. He stated his family supplied him with a buzzer which played a musical sound to use when he needed staff assistance. He stated because of his hands, he would not be able to operate a regular call button and would require an adaptive call button. The sound from the buzzer was loud inside the resident's room and could be heard from outside the resident's room. The sound of the buzzer became more and more faint further down the hall. Resident #2 stated he pushed the buzzer multiple times, depending on the urgency of what he needed. He stated staff responded timely most of the time, but sometimes, staff took longer to respond, just as they did when the call light system was in working order. He said he had not experienced any negative outcomes because of the broken call light system. (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview with CR #1 on 09/10/2024 at 3:30 p.m. revealed he was in a room in the ER of a local acute care hospital. CR #1 was alert and had a tracheostomy connected to a ventilator. CR #1 also had on a neck brace. CR #1 was sweating heavily. CR #1 did not initially verbalize words. He blinked once for yes answers and twice for no answers. CR #1 indicated no facility staff went to his room early that morning (09/10/2024) until EMS arrived. He indicated he did not know what time facility staff last checked on him. He indicated he felt hot and sick while waiting for staff to reposition him. CR #1 indicated he had trouble breathing and needed to be suctioned that morning, but he did not have a way to call the staff directly for help. He indicated he was sweating that morning and then he said, Help. CR #1 indicated he wanted a nurse. While waiting for a hospital nurse to come, CR #1 said, Ice chips. CR #1's hospital nurse stated CR #1 was febrile (had a fever) with a temperature of 103.5 degrees Fahrenheit when he arrived in the ER, and he was being admitted for sepsis. The nurse took CR #1's temperature and stated it was 99.9 degrees Fahrenheit. The nurse stated CR #1 was tachycardic upon arrival to the ER at 158 BPM. Observation and interview of Resident #3 in room [ROOM NUMBER] (on the 400 Hall) on 09/17/2024 at 1:18 p.m. revealed he was alert but had a tracheostomy connected to a ventilator and could not communicate verbally. There was a red cowbell on a bedside table in the space between Resident #3 and his roommate's bed. The bell was not within reach of Resident #3. Resident #3 could answer questions with gestures and head nods. He indicated he did not have a bell to ring if he needed help from staff because the call light system did not work. He indicated the red bell on the table was not his. He indicated he was new to the facility, and nobody ever gave him a bell or device to use when he needed help from staff. He indicated he could move both of his hands and arms. Observation of Resident #3, at that time, revealed he could move both arms and hands. He shrugged his shoulders to indicate he did not know how he would let staff know he needed help. At that time, RT E was in the hallway outside of Resident #3's room. RT E stated Resident #3 was alert and oriented. RT E stated the red bell on the table belonged to Resident #3 because his roommate was unable to operate the bell. Resident #3 indicated nobody ever told him the red bell was his to ring when he needed help from staff. RT E asked Resident #3 to demonstrate his ability to ring the bell. Resident #3 placed his hand around the bell and attempted to ring it, but the sound was slightly muffled. RT E provided Resident #3 with a buzzer, and he demonstrated he could operate it successfully. Observation and interview with a Resident #4 in room [ROOM NUMBER] (100 Hall) on 09/17/2024 1:40 p.m. revealed she was alert with a tracheostomy and could not communicate verbally. Observation of Resident #4's room revealed she did not have a bell or other device to operate if she needed help from staff. She could answer questions with gestures and head nods. She indicated she did not know where her bell was, and she did not know how long it had been missing. Observation of Resident #4 at that time revealed she could move her arms and hands. She indicated she did have a bell at one time, but she had not seen it in a while. She indicated she had not had the bell for at least multiple days. She shrugged her shoulders to indicate she did not know how she would alert staff if she needed help. (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with CR #1's RP on 09/10/2024 at 11:35 a.m., she stated EMS told her that CR #1 had a high temperature when he was admitted to the hospital on 09/10/2024. She stated CR #1 was able to communicate with an eye tracker system on his tablet which allowed him to text (which turned the text to voice) with his eyes since he could not move his limbs and the facility did not have a call light he could use. She said the device allowed CR #1 to call phone numbers when he needed help. She said she let the staff know when he was admitted on [DATE] to keep an eye on him because he had problems with his breathing between the hours of 2:00 a.m. - 3:00 a.m. and 6:00 a.m. - 7:00 a.m. She said she had not been able to reach the staff by phone during those hours. She said CR #1 was able to tell her he had snot all over his face on the morning of 09/10/2024. She said CR #1 knew when he needed to be repositioned and suctioned and he recalled everything perfectly. She said he was nonverbal now, but he was very aware and alert. She said she had to call 911 on 09/10/2024 because nobody answered the phone and staff only called her to let her know CR #1 was going to the hospital. She said earlier during the night shift, (on 09/09/2024) at 9:31 p.m., CR #1 contacted her and said he had not been repositioned. She said he could not recall what time he was last repositioned, before then, but he said it had been a long time. She said she called the facility at 9:34 p. m. and someone answered the phone and went to assist CR #1. She said on 09/10/2024, the problem started at 1:45 a.m. when CR #1 called another family member and indicated he could not breath, he had mucus coming out of his nose, and he needed to be repositioned. She said that family member called her at 1:53 a.m. She said she called the facility at 1:53 a.m., but nobody ever answered the phone. She said on at 2:38 a.m., she asked CR #1 if anybody came to assist him and he texted No, please call the facility. She said she told CR #1 she was calling right then. She said at 2:40 a.m., she called the facility more times and CR #1 indicated that he was hot, he needed a breathing treatment, and he need to be repositioned. She said at 2:49 a.m., CR #1 indicated nobody came to assist him yet and he had a lot of snot on his face. She said at 2:50 a.m., CR #1 got anxious and texted, Help! She said two other family members got involved and started calling the facility. She said at 3:00 a.m., CR #1 indicated that nobody had went to assist him. She said CR #1 stopped texting at 3:05 a.m., but she was still calling the facility over and over from 3:03 a.m. - 3:19 a.m. She said she called 911 at 3:21 a.m. She said EMS called her from their personal cell phone at 3:47 a.m. and said CR #1 had a face full of snot and needed to be suctioned. She said EMS told her CR #1's other vital signs were fine, but he had a high temperature. She said EMS took CR #1 to the hospital because he wanted to go. She said the facility's staff called her at 4:30 a.m. to let her know CR #1 was being transported to the hospital. She said another family member called the facility 28 times and she called 17 times. She stated she previously told facility staff (she could not recall the names of staff she talked to) that CR #1 experienced anxiety at certain times during the night. (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with RT B on 09/12/2024 at 3:15 a.m., he stated he worked with CR #1 on Saturday (09/07/2024), Sunday (09/08/2024), and Monday 09/09/2024) (respiratory therapists work 12-hour shifts, so RT B was on shift the morning of 09/10/2024). He stated CR #1 complained of shortness of breath a few times during his shift, but his oxygen saturation was good at 99% and he was not in distress. He said he thought CR #1 experienced anxiety because his vital signs were fine, he was breathing fine, and it was common for residents with new tracheostomies to have anxiety. RT B said he checked on CR #1 every two hours, and he was called to CR #1's room a lot to suction secretions from his nose and mouth. RT B said CR #1 always called his RP and she called them at the facility. He said CR #1 often had a lot of secretions from his nose and mouth. He said CR #1 was uncomfortable with the secretions, so he suctioned him, but CR #1 was not in an emergency. He said he heard the phone ring a lot on Tuesday morning (09/10/2024) and the nurse (he could not recall which nurse answered the phone) answered a few times. RT B said LVN A told him CR #1's RP wanted them to check him to see if was ok, so they went to check him immediately after his RP called. He said CR #1's vital signs were perfect. He said CR #1 made sounds with his mouth and grimaced, so he suctioned his nose, mouth, and tracheostomy. He said CR #1 had some snot (secretions from his nose) on his face, but not a lot. He said LVN A was CR #1's nurse, and she was assigned to work half of two halls, so she was not on CR #1's hall the whole shift. RT B said CR #1 was not sweating when he checked him. He said between 1:45 a.m. and when EMS arrived, he had been in CR #1's room three times. He said he went in when EMS came, so that was his 4th round into CR #1's room. He said he was surprised when he saw EMS in the building, and they immediately suctioned CR #1 because of SOB. He said nothing came from CR #1's tracheostomy and EMS went in again and again until CR #1 started bleeding. RT B said he told EMS to stop. He said when EMS arrived, CR #1 had a medium amount of nose and mouth secretions. He said he called LVN A to come when EMS arrived because she was on another hall. He said he saw LVN A check CR #1's vital signs, including his temperature when EMS arrived. He said CR #1's heart rate was a little high, but he thought it was from anxiety. RT B said CR #1's temperature was fine at that time and he was not sweating. He said CR #1's RP insisted EMS take him to the hospital. In an interview with the Administrator on 09/12/2024, at 12:45 p.m., she stated the call light system was still broken and had been broken for several months since a thunderstorm caused it to go out in April 2024, or May 2024. She stated lightning struck the whole panel during the storm and the system could not be fixed. She stated she went out and bought bells and squeeze toys because the bells were too heavy for some residents to use. She said they also placed tables and chairs for nursing staff to sit out on each hall and check residents more frequently. She said she also implemented the use of walkie-talkies, so if an RT needed a nurse quickly, they could call on the walkie-talkie. She said contractors tried to replace the system and said they would come back when they were paid. She stated she did not know when the contractors would be paid by corporate. She said residents asked for updates every month during resident council meetings, but she had to tell them she did not have answers. She said she heard residents say it took too long for staff to come when they rang the bells/buzzers, but some residents also had that complaint before the call light system broke. (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	11/19/2024

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 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on 09/12/2024, at 2:15 p.m., she stated she was familiar with CR #1, and she had just spoken to his RP. She said CR #1's RP said she called the facility multiple times that morning (09/10/2024) and felt CR #1 did not get adequate care. She said the RP said she and other family members called over 50 times. She said a nurse only answered once and went in to help CR #1, but nobody answered the other times. The DON said she investigated, and the nurse (LVN A) verified she went in and checked on CR #1. She said the nurse told her the phone probably did ring that many times, but she was in another room at the time. The DON said that was probably why CR #1's RP called 911. She said since that incident, they had gotten cordless phones for the nurses on each hall. The DON said CR #1 was already gone to the hospital when she arrived on 09/10/2024, so she could not assess him. She stated CNAs, nurses, and respiratory therapists had to go in every two hours and anticipate CR #1's needs because he could not utilize the bells/buzzers as other residents. She said the nurses usually did visual head-to-toe checks and did not check vitals with each round. In an interview with LVN A on 09/12/2024, at 2:40 p.m., she stated her normal shift was 2:00 p.m. - 10:00 p. m. but she picked up a 10:00 p.m. - 6:00 a.m. shift on Monday 09/09/2024. She stated that was her first time working with CR #1. She said her first encounter with CR #1 was at 10:15 p.m., at the beginning of her shift. She said CR #1 was watching a movie on his tablet and could mouth words. She said CR #1 indicated he was ok. She state [TRUNCATED]