

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/18/2025
NAME OF PROVIDER OR SUPPLIER  Casa Azul Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48605</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 13 of 28 residents</p> <p>(Resident #1, #2, #3, #4, #5, #6, #8, #9, # 10, #11 #12, #13, and #14) reviewed for infection control.</p> <p>The facility failed to ensure residents (Resident #1, #2, #3, #4, #6, #7 #8, #9, # 10, #11, #12, #13, #14) did not acquire Candida auris (Candida auris is a fungal infection that can cause serious illness) infection at the facility.</p> <p>The facility failed to ensure staff (CNA B and LVN M) wash or sanitize hands after providing care to Residents (Resident #2, #3, #4, #5, #6 and #7) rooms.</p> <p>The facility failed to ensure that staff (CNA B and LVN M) implemented appropriate use of PPE and transmission-based precautions prior to enter and exiting residents' (Resident #2, #3, #4, #5, #6 and #7) rooms.</p> <p>The facility failed to ensure that staff (CNA B) clean and disinfect equipment (pulse ox and thermometer) used to obtain residents' (Resident #2, #3, #4, #5, and #6) vitals before and after use.</p> <p>The facility failed to show proof that the facility had established and implemented a surveillance plan for mitigating the spread of Candida auris infection.</p> <p>An Immediate Jeopardy (IJ) situation was identified on 02/15/25. While the IJ was removed on 02/18/25 at 1:30p.m, the facility remained out of compliance at a scope of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures have the potential to affect residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections.</p> <p>Findings include:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 02/02/2025.</p> <p>Record review of Resident #2's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 02/23/2025.</p> <p>Record review of Resident #3's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 12/13/2024.</p> <p>Record review of Resident #4's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 12/11/2024.</p> <p>Record review of Resident #5's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris present on admission.</p> <p>Record review of Resident #6's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 11/18/2024.</p> <p>Record review of Resident #7's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 11/06/2024.</p> <p>Record review of Resident #8's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 01/30/2025.</p> <p>Record review of Resident #9's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], 41 age years old; Resident tested positive for Candida auris dated 07/31/2024.</p> <p>Record review of Resident #10's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 04/08/2024.</p> <p>Record review of Resident #11's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 12/11/2024.</p> <p>Record review of Resident #12's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident tested positive for Candida auris dated 12/04/2024.</p> <p>Record review of Resident #13's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 11/06/2024.</p> <p>Record review of Resident #14's face sheet dated 02/18/2025 revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of Candida auris dated 05/21/2024.</p> <p>Record review of infection control binder provided by IP B revealed the facility was not able to show evidence the facility established/implemented a surveillance plan, for identifying, tracking, monitoring and/or reporting of infections, communicable diseases, and outbreaks.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 02/14/2023 at 11:55am, LVN M verbalized the error of failing to don PPE and wash hands. LVN M stated that Resident #7 was on Contact Precautions due to testing positive for Candida auris. She verbalized an understanding that the transmission of infection can occur when PPE and hand hygiene protocols were not followed. She stated that such error put residents and staff at risk for infection. LVN M mentioned receiving infection control training, some time ago. She stated that contact precaution required her to put wear a glow and gloves and wash or sanitize her hands before and after enter contact isolated rooms. She stated that the facility supplied adequate PPE. She stated that that the facility had not provided training on Candida auris, but she had knowledge of the infection. She did not identify why she failed to implement proper transmission precautions. She stated by failing to don PPE and wash hands she placed residents at risk for being exposed to the infection and the infection could rapidly spread.</p> <p>Interview on 02/14/2025 at 12:10, CNA B expressed uncertainty regarding why proper PPE measures was not utilized, hand hygiene practices were neglected, and disinfectant measures were not implemented. CNA B stated Residents #1, #2, #3, #4, #5, and #6 were on Contact Precautions due to testing positive for Candida auris. CNA B also acknowledged the risk of infection transmission in the absence of proper PPE, hand hygiene and disinfectant measures. CNA B mentioned undergoing training previously but was unable to articulate the specifics or content of the training provided. CNA B stated that she had not received training on caring for Residents with Candida auris.</p> <p>Interview on 02/14/2025 at 12:20 PM, Local Health Department Epidemiologist A stated the health department began working with the facility in April 2024. Epidemiologist A stated the facility initially (April 2024) had approximately 4 residents who tested positive for Candida auris. Epidemiologist A stated she was not aware of the current number of residents who were positive at the facility. She stated a plan of correction along with recommendations was provided by the local health department to the facility in April 2024, in the effort to mitigate the spread of the infection. She stated when visiting the facility monthly, the Local Health Department tested residents who had not been previously tested and identified as positive residents. She stated results were then provided the facility. She stated the facility continued to have positive test results during each visit and there was a continued outbreak at the facility. She stated the Health Department witnessed staff entering and exiting contact precaution rooms with implement PPE and proper hand hygiene. Epidemiologist A stated she had been working with the DON and the Infection Preventionist (IP) for several months. She stated the continued outbreak could be a result of the facility staff not implementing TBPs. She stated not implementing PPE and hand hygiene put all residents at risk of being exposed to the infection.</p> <p>Interview attempt on 02/14/2025 at 12:26 PM, to the DON by telephone was unsuccessful.</p> <p>Interview attempt on 02/14/2025 at 12:40 PM, to IP A by telephone was unsuccessful.</p> <p>Interview conducted on 02/14/2025 at 5:00 PM, the Administrator could not articulate a structured system designed to effectively mitigate the risk of C. auris transmission. He stated the DON was working with the health department and was aware of the health department's recommendation. He could not explain who was monitoring to ensure the plan and recommendations were being followed. The Administrator stated he was not aware of the number of residents effected with C. auris.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview conducted on 02/14/2025 at 5:30 PM, the Regional Corporate Nurse stated staff were expected to follow contact precautions when dealing with residents with Candida auris to prevent its spread. This included using personal protective equipment (PPE) such as gloves and gowns, hand washing, properly disinfecting surfaces, and isolating infected or colonized patients when necessary. He stated when failure to use proper TBP placed other residents at risk for being exposed to the infection.</p> <p>Interview conducted on 02/15/2025 at 10:00 AM, IP B was not able to articulate how staff were monitored for compliance. Infection Preventionist B (IP B) stated the DON resigned after being contacted on 02/14/2025 regarding the health department's recommendation and plan of correction. IP B stated she reached out to the health department's Epidemiologist A to request the plan of correction on 02/14/2025, after the state surveyor requested the information. Infection Preventionist B (IP B) stated she was working with the Regional Corporate Nurse and weekend Supervisor to complete an audit of residents who had acquired the infection at the facility.</p> <p>Interview conducted on 02/15/2025 at 12:00 PM, the Administrator said staff were notified of the Candida auris outbreak when he onboarded in 11/2024. The Administrator could not provide a plan to mitigate the risk at the time of the meeting. The Administrator stated the facility would adhere to infection control policy moving forward. The Administrator did not have knowledge of what the infection control policy indicated. The Administrator stated the DON resigned yesterday, 02/14/2024, after she was notified a state surveyor was in the facility.</p> <p>Interview conducted on 02/15/25 at 1:00 PM with Administrator who stated the facility IP A and IP B were training on transmission-based precautions and were responsible for the tracking and trending of communicable diseases within the facility. He stated he was notified by the DON of concerns related to IP A's performance and ability to maintain the infection control responsibilities, a couple of weeks back (could not recall the specific date). He stated approximately a week ago Infection Preventionist B assumed the role of the facility's Infection Preventionist. He was unable to explain IP A's failures and what action were implemented to correct the failures since identified. He stated the Infection Preventionist role was to prevent and contain the spread of infections. He stated the DON was responsible for overseeing the Infection Preventionist duties and responsibilities were being implemented. The Administrator did not explain his active role of preventing and mitigating the spread of Candida auris and communicable diseases within the facility. The Administrator stated IP A was terminated from the facility this week but could not recall the date. The Administrator stated IP B assumed the role as the Infection Preventionist last week. The Administrator stated the DON was responsible for ensuring the tracking and trending was completed by the Infection Preventionist. He stated the Infection Preventionist and the DON had been working with the local health department epidemiologist, but he was not knowledgeable of the current recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview conducted on 02/15/2025 at 6:00 PM, the DNP (medical provider) stated failure to properly monitor and mitigate the spread of Candida auris could lead to severe adverse outcomes. Initially, infections may cause serious complications, particularly in immunocompromised individuals, leading to increased mortality rates and death. She stated staff were expected to follow contact precautions when dealing with Candida auris to prevent its spread. This included using personal protective equipment such as gloves and gowns, practicing strict hand hygiene. Failure to adhere to these precautions could further exacerbate the outbreak. She stated she was aware of the spread through the facility. She was not able to identify the total number of residents infected. She stated she believed staff implemented the appropriate contact precautions when dealing with resident Candida auris. She stated she could not attest to how often staff washed their hands or entered a contact isolation room without PPE. She could not explain why the facility had such an increase in residents who acquired the infection while admitted at the facility.</p> <p>Record review of local health department plan of correction, 04/2024 read advised to take the corrective actions listed in the recommendations below:</p> <p>1. PPE:</p> <p>a. Patient should be on contact precautions. Staff should be using gowns and gloves upon entering the patients room.</p> <p>b. Clear signage to indicate patients are on TBPs with proper indications for precautions and PPE requirements.</p> <p>c. Follow transmission-based precautions, including the use of personal protective equipment by personnel and prefer single patient- use items.</p> <p>e. Making sure PPE, gowns, and gloves are accessible and used appropriately.</p> <p>2. Handwashing:</p> <p>a. Appropriate hand decontamination following cleaning of C. auris - exposed body fluids/areas.</p> <p>b. Frequent handwashing by staff with soap and water, followed by alcohol-based hand rub.</p> <p>c. Monitor adherence of staff to hand hygiene practices.</p> <p>3. Cleaning:</p> <p>Shared medical equipment should be cleaned and disinfected thoroughly .</p> <p>Thes was determined to be an immediate jeopardy (IJ) on 02/15/23 due to the above failures. The administrator was notified and provided the IJ template on 02/15/23 at 6:45p.m.</p> <p>The immediacy was lowered on Tuesday, 02/18/2025 at 2:05p.m. with the facility Administrator and DON, the facility remained out of compliance at a scope of no actual harm with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview conducted on 02/17/2025 at 11:04 AM, RN E stated a resident with Candida Auris families were called and educated about the disease process. He said the nurses, CNAs, housekeeping, central supply, Respiratory Therapist were educated, about Candida Auris and TBPs. He staff knowledge and understanding was verified by taking and passing a facility provided test competency test.</p> <p>Interview conducted 02/17/2025 at 11:15 AM, the Housekeeping Supervisor stated she worked 6:00 AM to 3:00 PM and as needed. She said she was in-serviced on 02/15/2025 about Candida Auris, how it spread, hand washing, cleaning the equipment's, donning, and doffing PPE's. Identifying residents with Candida Auris with the sign posted. She said the facility had adequate bio-hazard box and bags.</p> <p>Interview conducted on 02/17/2025 at 11:25 AM, LVN M said residents' family were called and educated about Candida Auris disease process, contact isolation for Candida Auris, hand washing, cleaning the equipment's, donning and doffing PPE's and she care planned resident isolation with Candida Auris.</p> <p>Interview conducted on 02/17/2025 at 11:27 AM, revealed RT worked 6:30 AM to 7:00 PM, she had in-services on Candida Auris disease process, contact isolation for Candida Auris, hand washing, cleaning the blood pressure cuff, Accu checks equipment, donning and doffing PPE's.</p> <p>Interview conducted on 02/17/2025 at 11:33 AM, revealed LVN C worked 6:00 AM -2:00 PM for one year, had in-services on Candida Auris disease process, spray, contact isolation for Candida Auris, hand washing, cleaning the blood pressure cuff, Accu checks equipment , donning and doffing PPE's.</p> <p>Interview conducted on 02/17/2025 at 11:47 AM, CNA R stated she worked 6:00 AM to 2:00 PM and had in-services on Candida Auris disease process, spray, contact isolation for Candida Auris, hand washing, donning, doffing PPE's. CNA R was observed to don gloves and a gown to feed Resident #4 on contact isolation.</p> <p>In an interview with the Regional Nurse Consultant and the Facility Administrator on 02/18/2025 at 12:30 PM, the Administrator said the Medical Director was informed of the outbreak.</p> <p>Interview attempt on 02/18/2025 at 1:40 PM with the Medical Director by telephone was unsuccessful.</p> <p>Interview conducted on 02/18/2025 at various times, 9:00am - 5:00pm, with (LVN S, CNA Y, CNA D, CAN S, RT O) revealed they were able to verbalize understanding of all in-services provided on hand hygiene, donning and doffing PPE, contact precaution and transmission-based precautions, and verified knowledge of systems in place as of 02/18/2025.</p> <p>Interview conducted on 02/18/2025 at various time, the Housekeeping Supervisor and Housekeeping staff verbalized TBPs to prevent the spread of Candida auris. All were verbalized knowledge of cleaning schedules for residents affected by Candida auris and the requirement to clean and disinfect twice a day using EPA-approved disinfectants effective against Candida auris per the county health department recommendations.</p> <p>Record review revealed Regional Nurse Consultant provided education on 02/15/2025, 02/16/2025, 02/17/2025, and 02/18/2025 provided to all staff on Candida auris (including background/definition, PPE &amp; isolation protocols (including co-horting), disinfectant protocols, equipment/clothes/linen handling, meal service, and methods to prevent the spread of Candida auris).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/18/2025
NAME OF PROVIDER OR SUPPLIER  Casa Azul Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1480 Katy Flewellen Katy, TX 77494	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review revealed daily cleaning audits logs were being conducted as of 02/17/2025, by Housekeeping Supervisor.</p> <p>Record review of trainings revealed Regional Nurse Consultant provided 1:1 education with the IP B, Weekend RN Supervisor, and Administrator on 2/15/2025 on Candida auris, Infection Prevention Program Policy to include surveillance.</p> <p>Record review of clinical documentation revealed the Regional Nurse randomly selected residents revealed the families was educated on Candida auris and the prevention measures to be used when entering and exiting residents isolation rooms.</p> <p>The Facility Administrator and Regional Nurse Consultant was informed the Immediate Jeopardy was removed on 02/18/2025 at 1:30 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate and a scope of a pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>