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	04/04/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 6 (Resient #1) reviewed for supervision in that: -The facility failed to ensure CNA A did not improperly reposition Resident #1 by pulling his arm on 03/24/25. This failure could place residents at risk of being injured, bruised, or have fractured limbs . Findings Include: Record review of Resident #1's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included acute and chronic respiratory failure (when the lungs cannot properly exchange gases, causing abnormal levels of oxygen and carbon dioxide in the blood), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), tracheostomy (a surgical procedure where an opening is created in the neck to allow air to enter), essential hypertension (a chronic disease that cause abnormal high blood pressure) and malignant neoplasm of larynx (develops when cancerous cells form in the larynx or voice box). Record review of Resident #1's admission MDS, dated [DATE], revealed: Section C0500- BIM coded as 99, which indicated the interview was unable to be completes. Section GG-Functional Abilities and Goals Eating was coded as 88 (not attempted due to medical condition) Oral Hygiene, toileting, shower, upper and lower body dressing, putting on/taking off footwear, personal hygiene were all coded as (1), which indicated the resident was Dependent and a helper does all of the effort. Section GG0170- Safety and Quality performance Roll left and right, sit to lying, lying to sitting on side of bed were coded as (2), which indicated Substantial/max assist (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H0300- Urinary Incontinence and H0400-Bowel incontinence were coded as (3), which indicated Always incontinent. Section O- Special treatment: C. Oxygen therapy D. Suctioning E. Tracheostomy F1. Invasive Mechanical Ventilator all had X for while a resident treatment used at the facility. O0110- Dialysis had a X for while a resident O0400- Speech-language Pathology - 183 minutes, start date 2/21/2025 Occupational Therapy 187 minutes, started 2/21/2025 Physical therapy 198 minutes, started on 2/21/2025 Record review of Resident#1's care plan revealed: Focus- Resident #1 will continue to maintain current ADL functions, date initiated 3/21/2025, Interventions: Assist with ADLs as needed, give medications per order, monitor for abnormal bleeding, bruising, weakness, and report to MD. Observation of video #GNTI_9001_2025_03-24T09_52_20.mp4 on 4/4/2025 at 12:32 PM, it revealed on 3/24/2025 at 9:52 AM, Resident #1 was observed lying in the bed sideways with his head hanging off the bed. CNA A arrived in the room first and went on the right side of his bed, then the left side at a slow pace. She grabbed Resident #1 by his left arm and pulled him to the center of the bed. CNA B walked into the room and stood by while CNA A adjusted Resident #1's head. During an interview with Resident #1 's FM on 4/3/2025 at 5:41 PM, she stated Resident #1 was pulled by his arm and CNA A was very rough on March 24, 2025 . She said she believed it was done purposely. She said she had a video of the incident as she had a camera placed in Resident #1's room when he was admitted back to the facility in February of this year. She said she did not recall any bruising from staff pulling his arm. She said he was not capable of moving himself back into the bed. She admitted it appeared he was falling out of the bed. She said he had no history of falls. She said she called to speak with the DON and learned someone new had been selected. She said there were other issues that were discussed with the Administrator, but she had not shown him the video of this incident . She said she did not want this to happen to other residents that may not have family visiting or watching on cameras to be mistreated. She said she would send the video to Investigator via email . An interview via Interpreter translation on 4/4/2025 at 1:38 PM, revealed CNA B stated it was her on the video. She said at that moment Resident #1 was about to fall out the bed. She said he was feeling ill or something. She said she thought he was about to fall. She said this incident was about 2 weeks ago. She stated what she viewed on the video was not appropriate re-positioning. She said it was not appropriate, but CNA A probably had to act quickly. She said they were nervous. She provided the name of CNA A. She said she came in the room to help CNAA because it was an emergency to keep him from falling. She said she did not exactly see her handling him rough when she was in the room her back was turned, but looking at the video it did look like her re-positioning was inappropriate but was rushing she thought. She said she would tell the DON, Charge nurse and Administrator if she believed a resident was being mistreated or abused. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with CNA A ,via Interpreter translation, on 4/4/2025 at 2:07 PM, employed at the facility since June 2024, shift she normally worked (6-2pm), Hall 300, she said it was her in the video. She said she got scared the resident was going to fall to the floor. She said this was not the way residents should be re-positioned. She said it was not her intention to harm him just to move him quickly, so he did not fall. She stated she was taught to reposition when getting her CNA certificate , so she knew that it was not the way, two people were to reposition him, this was her reaction to seeing him hanging off the bed and his trach in the air. She said she was aware Resident #1 had cameras in his room. She said she had not had any training on re-positioning recently. She said the DON did not speak with her about this incident as this was her first time seeing the video. An interview with the Regional Nurse(RDON)and the Administrator on 4/4/2025 at 2:33 PM, revealed after reviewing the video, Nurse consultant stated it was an emergency and therefore staff were attempting to move Resident #1 quickly so he was not injured from a fall. He said to his knowledge the family had not shared this concern with the facility staff. He stated the re-positioning was not correctly done, but CNA B was moving quickly to ensure he did not fall from the bed. The Administrator added he would speak with the CNAs about this video. He said, No, that was not the way we want to handle residents, but, let him speak with the family about this incident on 3/24/2025. An interview with the DON on 4/4/2025 at 5:40 PM, the DON said she had been employed for 7 years, but she was the weekend supervisor. She stated she had been the DON for about two weeks. She stated Resident #1's family member was very involved in his care . She stated she was not informed about the incident with CNA B. She was shown the video from 3/24/ 2025 at 9:52 AM. After viewing the video, she stated she would conduct a training on proper repositioning transfer (refresher) for all CNA's. She said CNA B could have injured his arm or shoulder . She said after viewing the video, she said she would have reported to the State agency, because the CNA was not repositioning Resident #1 correctly . She said as a new DON she would read the regulations and she would have to do an investigation into this matter. She said while they were doing the investigation CNA B would have to be suspended. She said she would have to check with the Administrator and Nursing Consultant to find out if they started an in-service. A record review of the facility's turning and repositioning policy, revised on 6/2019, revealed: Policy: It is the policy of this facility that all residents identified at risk for skin breakdown will be placed on a turning/repositioning program. Procedures: 1. The turning/repositioning programs should be individualized to the resident. It should be organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs. 2. The expected repositioning times and positions should be defined by the facility team to ensure that the care providers have a clear understanding of the resident's individualized turning/repositioning program. 3. Completion of turning/repositioning should be documented, at a minimum, every shift by the CNA or licensed nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Documentation should be performed in Point Click Care.