STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	05/01/2025

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #19) of 4 residents reviewed for resident rights. - The facility failed to place Resident #19's foley catheter bag inside of a privacy bag. This failure could affect the residents who require assistance with their ADLs from facility staff by placing them at risk for social isolation, loss of dignity, and self-worth. The findings include: Record of Resident #19's Facesheet dated 04/30/2025 reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included but were not limited to functional quadriplegia (complete inability to move due to sever disability or medical condition), benign prostatic hyperplasia (enlarged prostate (male gland below the bladder responsible for reproduction and fluid flow including urine) causing frequent urination) without lower urinary tract symptoms, dementia (group of symptoms affecting memory, thinking and social abilities), without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, bipolar disorder (extreme high/low mood swings), gastro-esophageal reflux disease without esophagitis (stomach acid backing up into the esophagus (muscle tube that connects throat to the stomach) causing visible damage to the esophageal (tube that connects the throat to the stomach) lining), gastrostomy status (presence of a surgical opening into the stomach for nutritional support or gastric decompression), and tracheostomy status (surgical hole in the windpipe that helps with breathing when the usual way is blocked or reduced). Record review of Resident #19's Minimum Data Set (MDS) dated [DATE] revealed that the resident had no Brief Interview for Mental Status (BIMS) indicating he was not able to answer or respond to the BIMS questions. Section H: Bladder and bowel: Resident noted to have an indwelling catheter (including suprapubic catheter and nephrostomy tube). Record review of Resident #19's Nursing Progress Notes dated 04/26/2025 at 03:13 p.m. reflected, Licensed Vocation Nurse (LVN) A provided foley catheter care and noted: dark yellow urine recorded a.m. shift. Incontinent care provided. No acute distress noted this far. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 04/27/2025 at 03:10 p.m., Resident #19 laid in his room bed. Resident's foley catheter bag was exposed, and urine within was visible. The resident did not arouse to sound or voice. In an interview on 04/27/2025 at 03:13 p.m., LVN A stated that Resident #19's foley catheter bag was not to have been exposed and should have been placed into a privacy bag for his dignity. She stated that catheters were changed twice a month, and the foley once a month and after those changes, his privacy cover must have been thrown away and not replaced. She stated it had been her responsibility to ensure that the resident's catheter bag was in a privacy bag. She stated that the staff received in-services on foley catheter care monthly. In an interview on 04/27/2025 at 05:35 p.m., Registered Nurse (RN) A stated that it was everyone's responsibility to ensure that resident's catheters were within privacy bags to preserve a resident's privacy. He stated that if he had seen a foley bag without a privacy bag he would cover it immediately with a new privacy bag cover. He stated that they received in-service on foley catheter care monthly. In an interview on 04/28/2025 at 01:56 p.m., LVN C stated that the Director of Nursing (DON) performed in-services on foley catheter care routinely. She stated that the Certified Nursing Assistants (CNA) were responsible for emptying resident's foley catheters and reporting any changes in a resident's condition to the charge nurses immediately, including notifying them if a foley bag had not been within a privacy bag. She stated it had been the responsibility of the nurses to change foley catheters and ensure that foley bags were covered in a privacy bag. In an interview on 04/28/2025 at 02:47 p.m., the DON stated that residents with a foley bag should have a privacy cover over the bag to preserve dignity. She stated it had been the responsibility of the CNAs and the nursing staff to ensure that the foley bag was covered with a privacy bag. She stated she performed in-services all the time on foley care to include placing the bag in a privacy bag. Record review of facility Education In-service Attendance Record dated 02/01/2025 and titled . Foley Catheter . Summary of Training: Date and cover urine foley catheter bag, check proper placement of foley, drain by gravity, and below the bladder. Presented by DON and signed by LVN A and other nursing staff. Record review of facility policy revised dated: 02/2024 and titled: Policy Policies and Procedures. Catheter Care Policy . Catheter Management: Privacy: Store the catheter bag in a privacy bag to maintain dignity.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #34) reviewed. -The facility failed to ensure that Resident #34's status of oxygen was a focus area in the resident's comprehensive care plan and no intervention was in place. This deficient practice could affect residents by contributing to inadequate care. The findings included: Resident #34 Record review of Resident #34's facility admission record dated 4/28/25 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included sepsis (sepsis is a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to organ damage) and heart failure (a condition where the heart muscle is unable to pump blood effectively enough to meet the body's needs. This results in the accumulation of fluid in the lungs and other parts of the body, leading to symptoms such as shortness of breath, fatigue, and swelling). Record review of Resident #34's Admission Minimum MDS dated [DATE] revealed Resident #34 had a BIM score of 15 out of 15 indicating she was cognitively intact. Resident #34 required substantial/maximal assistance with ADL's. She was occasionally incontinent of bladder bowel. Record review of section O (special treatments) revealed that she used oxygen. Record review of Resident #34's comprehensive care plan revealed there were no care plans to address oxygen use. Interview and record review on 4/29/25 at time unknown, with the MDS Coordinator, said she is the one that performs the care plans and confirmed no comprehensive care plan for Resident# 34 in either EMR systems, she also said that the care plan for oxygen was added on 4/28/25. She said that the RAI manual was used to complete assessments. During an interview on 4/30/25 at 10:22 a.m. with the DON, she said that Comprehensive care plans and MDS assessments were important because they all addressed goals and interventions, helped carry orders correctly and safely. The risk of not having them in place was that staff could make a mistake in performing duties correctly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure entitled Care Planning dated revised 6/2019 read in part . It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident .Procedure: A comprehensive care plan is developed within seven (7) days of completion of the comprehensive assessment .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 3 of 4 residents (Resident #33and Resident #56, and Resident #15) reviewed for ADLs. - The facility failed to ensure Resident #33, and Resident #56 were provided incontinent care in a timely manner by facility staff. - The facility failed to ensure Resident #15 was provided personal grooming (cut resident long classified toenails) by facility staff. These failures placed residents a risk for skin break down, offensive odors, and decrease in quality of life. Findings included: Resident #33 Record review of Resident #33's face sheet dated 04/30/25 revealed a [AGE] year-old male was admitted the facility on 10/24/24. Resident #33 diagnosis included: dependence on respirator (ventilator: a device for maintaining artificial respiration), hypertension (force of blood against the walls of the arteries is consistently too high), and gastrostomy (a surgical procedure used to insert a tube, often through the abdomen and into the stomach) Record review of Resident #33's quarterly assessment dated [DATE] revealed on section C0700 Resident #33 had memory problem. Further review revealed Resident #33 dependent on staff for ADL care with one to two staff assist and the resident was incontinent of bowel and bladder. Record review of Resident #33's care plan initiated 01/29/25 revealed Resident #33 had ADL self-care deficits and is at risk for further decline in ADL functioning and injury AEB weakness. Intervention: Provide (Extensive/) assistance of (1 of support persons) for toileting/incontinent care. During an observation on 04/27/24 at 3:30 p.m., the incontinent care for Resident #33 provided by CNA E revealed that the incontinent brief was saturated with urine, the inside of the brief was dark brown, and the cotton stuffing was broken apart. Resident #33's room has a very strong ammonia odor. The draw sheet under Resident #33 was saturated with urine and it had brown defined bordered line. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/27/25 at 3:43 p.m., RN S said she came to work at 6:00 a.m. today. RN S said she did not notice Resident #33 was wet when she saw CNA E in Resident #33's room at 11:00 a.m. She said the aides and the nurses were supposed to make rounds every two hours for incontinent care. RN S said the aide and the nurse should check the resident's brief during the round because the resident could not talk. She said she did not check the brief. RN S said Resident #3 skin would start to break down if Resident #33 was left on a wet incontinent for extended time. RN S said she had skills check-off, which included incontinent care and rounding. She said the staff must make rounds every two hours and change the resident. She said the nurses monitored the aides throughout the shift. RN S said the nurse managers monitors the nurse during rounding. During an interview on 04/27/25 at 3:58 p.m., CNA E said she came to work at 6:00 a.m. and changed Resident #33 around 6:30 a.m. CNA E said that she had not changed the resident before now because she was working alone and had to change other residents. CNA E said Resident #33's incontinent brief was soaked with urine and the draw sheet was also soaked with urine and had brown ring. CNA E said she was supposed to make rounds every 2 to 3 hours and change the resident, but she did not today because she had a lot of residents (12). CNA E said Resident #33 could develop blister and skin break down when Resident #33 was left on a wet incontinent brief. CNA E said that she had a skill check-off and in-service on rounding and providing incontinent care, and the trainer educated the aides to check on the resident every two hours. She said he did not check on the resident every two hours because she got busy, had to feed other residents, and had to go on break, too. She said the nurse monitored the aides throughout the shift. During an interview on 04/28/25 at 1:54 p.m., the Unit Manager said the aides should make rounds every two hours and as needed. She said if the resident could not make needs known, the aides had to check the resident's brief. The Unit Manager said the aides have skills check-off on ADL with another staff before the aide would work on the floor by herself, and they also have in-services. She stated the DON taught the aides to make rounds every two hours, see if the resident was wet, and check skin condition. The Unit Manager said Resident #33 could develop a skin breakdown if CNA E had not provided incontinent care for #33 promptly. She said the charge nurse and the lead CNA monitor the aide throughout the shift. Resident #56 Record review of Resident #56's face sheet dated 04/30/25 revealed a [AGE] year-old female was admitted to the facility on [DATE]. Resident #56 diagnosis included: malignant neoplasm of colon (cancerous growth in the colon), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and cognitive communication deficit (someone has difficulty communicating because their thinking processes, like memory, attention, and reasoning). Record review of Resident #56's admission assessment dated [DATE] revealed on BIMS of 13 indicating intact cognition. Further review revealed Resident #56 required substantiation assistance with ADL care with one to two staff assist. Record review of Resident #56's care plan dated 04/09/25 revealed Resident #56 had incontinent of bowel and bladder. Interventions: perform routine rounding to include incontinence care and brief changes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/2/25 at 4:38 p.m., Resident #56 said CNA V changed her last around 11:00 a.m., and she is wet now and needs to be changed. Resident #56 said the staff had not come to ask if she needed to be changed. Resident#56 said she felt neglected, bad, and dirty. Then she stated What could she do but endure because she could not care for herself Then, she lowered her head and would not talk again. During an interview on 04/27/25 at 4:46 p.m., CNA V said she had changed Resident #56 around 11:00 a.m. or 12:00 p.m., since she came to work at 6:15 a.m. CNA C said she has a lot of residents, and she was doing the best she could. During an observation on 04/27/25 at 5:00 p.m., incontinent care for Resident #56 provided by CNA V and CNA E revealed the resident's incontinence brief was saturated with urine and bowel movement from the resident's lower back up to the resident's pubic area. The draw sheet under Resident #56 was soaked with urine and stained with bowel movement. The draw sheet was also had dry brown ring. During an interview on 04/27/25 at 5:16 p.m., CNA V said Resident #56's incontinent brief was dirty and saturated with urine and bowel movement and the bowel movement was inside Resident #56's private area. CNA V said the pad on Resident #56's bead was soaked with urine and bowel movement, and it had brown ring which meant Resident #56 had been wet for more than two hours. During an interview on 04/28/25 at 12:01 p.m., the Medical Director said if CNA V did not change Resident #56's incontinent brief timely, the resident's skin could become macerated. During an interview on 04/28/25 at 3:05 p.m., the DON said staff should make rounds every 2 hours as needed. She said the aides should check the incontinent brief and see if it was wet. The DON said Resident #56 would be at risk for skin breakdown if CNA V did not change Resident #56 promptly. The DON said the lead CNA and nurse check if the aides provide care to the resident, and the nurse managers monitor the nurses during random rounds. The DON said the aides are trained upon hire and in services are provided on intervals throughout the year. The DON said the aides are told to make round for incontinent every two to three hours during in -service. Resident #15 Record review of Resident #15's face sheet dated 04/30/25 revealed a [AGE] year-old female was initial admitted to the facility on [DATE]and readmitted on [DATE]. Resident #15 diagnosis included: dependence on respirator (ventilator: a device for maintaining artificial respiration), tracheostomy(an opening surgically created through the neck into the trachea(windpipe) to allow air to fill the lungs), hypotension (force of blood against the walls of the arteries is consistently too low), and cognitive communication deficit (someone has difficulty communicating because their thinking processes, like memory, attention, and reasoning) Record review of Resident #15's quarterly assessment dated [DATE] revealed on section C0700 Resident #15 had memory problem. Further review revealed Resident #1 dependent on staff for ADL care with one to two staff assist. Record review of Resident #15's care plan initiated on 02/02/25 revealed Resident #1 had ADL self - care deficit and is at risk for further deficits in ADL and injury. Interventions: Provide (Total) assistance of (# of support persons) for personal hygiene/grooming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's physician ordered for April 2025 revealed don not resuscitate, do not hospitalize, no labs, hospice care dated 04/25/25. Record review of Resident #15's physician ordered for April 2025 revealed the resident was admitted to hospice care on 04/28/25. During an observation and interview on04/27/25 at 5:25 p.m., Resident #15's long toenails were observed. CNA V said Resident #15 had 10 long and classified toenails, and she told the nurse 3 weeks ago about Resident #15's toenails. She said the nurse, or the podiatrist, cuts the resident's toenails. During an observation and interview on 04/27/25 at 5:29 p.m., RN S said she saw Resident #15's toenails were long and needed to be cut down. She said the aides are responsible for cutting the residents toenails but if the resident were diabetic then the podiatrist would cut the resident toenails. She said Resident #15's toenails were long on Saturday and Sunday, but did not tell the DON. RN S said the nurses monitored the aides throughout the shift, and the nurse managers monitored the nurses during random rounds. RN S said Resident #15's long toenails could cut Resident #15's skin or get infected. During an Interview on 04/28/25 at 2:23 p.m., the Unit Manager said the aides were responsible for cutting the resident toenails and if the resident had diabetes, then the podiatrist cuts the resident toenails. The Unit Manager said the nurse would tell her, and she would put in the order, and the social worker would contact the podiatrist. She said if Resident #15 had long toenails, she could cut her skin open, and it could lead to gangrene. During an interview on 04/28/25 at 2:34 p.m., SW said the podiatrist emails the list of residents he would see when he made rounds to her, and the residents are from the referrals she sent to the podiatrist. SW said the podiatrist saw the residents on 04/16/25. SW said Resident #15 was put on hospice on Friday (04/25/25) when Resident #15 came back from the hospital, and her family member told her she did not want Resident #15 on any services. Still, she did not document what family member told her. During an interview on 04/28/25 at 3:18 p.m., the DON said Resident #15, who was on hospice, should still have her toenails cut. She said she was told yesterday (04/27/25) by RN S after the surveyor showered Resident #15's toenails to RN S. The DON said she told the Unit Manager to call hospice and did not know if she had called hospice. The DON said Resident #15's skin could break down, and she could develop an infection under her toenails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/29/25 at 5:00 p.m., the ADON said she was unaware Resident #15 had long toenails and was unsure if Resident #15 was admitted to hospice. She said if the resident were on hospice, they would call the hospice nurse and let the nurse know that the resident had long toenails, then the facility would wait for the hospice nurse to respond before contacting the podiatrist. She said if the resident did not have diabetes, the aides would cut the resident's toenails. The DON said If the resident had diabetes the nurses would cut it and also use nursing judgment to determine if Resident #15 was at risk and if Resident #15 was at risk, then the SW would call the podiatrist would be called. The ADON said she did not know what was done about Resident #15's long toenails. She said Resident #15, who had long, calcified toenails, could be injured if her nails got caught on the sheets and even infected. The DON said the aides and the nurse went to school and should know how to provide toenail care. The ADON said she did not know the facility's policy on toenail care and would check and get back to the surveyor. The ADON said the nurses monitored the aides throughout the shift, and the nurse managers monitored the nurse nurses during random rounding. Record review of the facility on activities of daily living revised 3/2019 read in part . the facility is responsible to provide necessary care to all residents who are not able to carry out activities of daily living on their own to ensure they maintain proper . grooming and hygiene .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on observation, interviews, and record review the facility failed to provide, based on the preferences of each resident, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 5 of 5 confidential residents reviewed for activities. The facility failed to provide activities to meet the residents' interests on Saturdays and Sundays for 5 confidential residents. These failures placed residents at risk for decline in quality of life, social and mental psychosocial wellbeing. Findings Include: Observation on Sunday, 04/27/2025 from 01:00 p.m. to 06:00 p.m. revealed there were no activities visible provided for residents in the activity area. Later observation on 04/28/2025 from 8:00 a.m. to 1:00 p.m. revealed there were no activities visible provided for residents in the activity area. Interview on 04/27/2025 at 02:38 p.m. with the Activity Director, she said that she would arrange Resident Council tomorrow 04/48/2025 at 10:30 a.m. During a confidential group interview on 04/28/2025 at 10:30 a.m., with 5 confidential residents, all residents stated that there were no weekend activities. 3 of 5 said that the Activity Director came in on Sunday's and would sit in her office, and they were on their own. While displaying a printed calendar for April 2025, they all agreed that the calendars were not really for the residents, but for others (visitors) to see. All said that they have never done a lot of the activities printed on the calendar. 3 out of 5 saying, and all agreeing that this makes us feel tired, like banging our heads against the wall. 3 out of 5 said that they Never even had coffee and a donut for an activity. 2 said, all agreed that watching tv in your room was not an activity and that one resident was so bored that he used to watch cars passing by and count them, so they (The facility) put in on the calendar as an activity for bird watching. Interview on 04/28/2025 at 01:21 p.m. with the Activity Director, w [NAME] reviewing the Activities calendar for April 2025, she said that the residents attend about 90 % of the activities on the calendar. When informed that no activities on the calendar were observed or done since the survey began on 04/27/2025, she said many times she would go and check the residents to see if they had taken medication, were drowsy, in pain or if they wanted to attend an activity and a lot of residents said no, they did not want to attend. She said that she would have worksheets, coloring books and other items sitting out if the residents chose to do any activity at times if the activity staff were not there on the weekend. The Activity Director said activities posted were not done because residents refused to go. During an interview on 04/29/2025 at 06:07 pm with the Administrator he said that not having activities could cause the resident to get bored and have a negative impact on the resident's quality of life. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/30/2025 at 10:22 a.m. with the DON, she said that residents not having activities could cause psychological and mental health could develop. She said that the responsibility of the activity program was the Activity Director's and they all worked together as a team. During an interview on 05/01/2025 at 11:19 a.m. with the Activity Director Assistant, she said she had been the Activity Director Assistant for about a year, she said that activities were important to residents because they could feel isolated or become depressed and affect their quality of life. Record Review of the Activities Calendar for April 2025, the following Saturday dates 04/12/25, 04/26/2025 had family visits, individual Activity Sheets, and watching tv. On the following Sunday dates 04/06/2025, 04/13/2025, 4/20/2025, and 04/27/2025 had 009:30 a.m. Bible Study Rounds, 01:30 p.m. Puzzles and Coloring Sheets and 02:30 p.m. watching tv. Record review of the policy and procedure entitled Activities dated revised 5/24 read in part .The Facility's activity program shall provide meaningful, person-centered activities to meet each resident's physical, mental, and psychosocial well-being, per their comprehensive care plan .offer a variety of activities that promote engagement and meet the diverse needs of the resident population, including: Group and individual activities .physical, intellectual, spiritual, emotional, and social activities.

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Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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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** 48923 Based on observation, interview and record review, the facility failed to ensure that resident environment remains as free of accident hazards as is possible for 1 of 6 (Resident #13) resident rooms observed for accident hazards. -Resident #13's room had two bottles of hair products on their dresser not stored in a safe manner on 4/27/2025. This failure could place residents at risk of injury due to unnecessary access to potentially harmful substances. Findings included: Record review of Resident #13's face sheet captured 04/27/2025, she was a [AGE] year-old female originally admitted to the facility on [DATE]. Her medical diagnoses included Type 2 Diabetes Mellitus (high blood sugar), Dementia, Dysphagia, Traumatic Subdural hemorrhage with loss of Consciousness of Unspecified Duration (brain bleed) and Tracheostomy. Record review of Resident #13's Quarterly MDS dated [DATE] revealed, she did not have a BIMS completed and did not have a mood interview done due to her being rarely or never understood. She was totally dependent on staff for ADLs, including toileting, oral and personal hygiene, dressing and showering/bathing self. Record review of Resident #13's care plan last updated 02/12/2025 revealed, she had ADL self-care deficits and required total assistance for bathing, personal hygiene/grooming. and toileting/incontinent care. Record review of the facility's census revealed, the facility marked five residents as being ambulatory, meaning they were able to independently move around the facility. Observation on 4/27/2025 at 3:25pm in Resident #13's room, Resident #13 was resting in bed and appeared well-groomed, comfortable with no grimacing. She was unresponsive to questions. There were two bottles of hair product on top of the resident's dresser. The first was a 300 mL quarter-full clear shampoo bottle. On the back, the bottle read in part, Safety Tip: Keep out of reach of children. The second was a 778 mL purple opaque conditioner bottle. Both bottles had names of other residents who were no longer at the facility. Interview on 4/27/2025 at 3:25pm with LVN B, he said the two bottles should not have been there, it could have been cross-contamination between resident personal items. He called the aide into the room and told him to remove the bottles. Interview on 4/27/2025 at 3:30pm with CNA B, he said he was the aide on the hall, and he did not know the bottles were there or who put it there. He put gloves on and said he was going to remove the bottles. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/28/2025 at 2:43pm with CNA E, she said that toiletries should be ziplocked and put away in residents' drawers. They should be sealed and labelled to avoid infection control issues from using other residents' items. Wandering residents could be at risk if they have access to these items. CNA E said she was the one responsible for checking resident rooms for making sure items were ziplocked and put away once a week. Interview with the DON on 4/28/25 at 2:42pm, she said that personal hygiene products should be labelled with the resident's name and placed in a bag or placed inside a drawer so that residents were not using someone else's items. A risk to residents would also be infection control and could be a risk to wandering residents. The DON said that CNA E was responsible for checking resident rooms once a week to ensure personal hygiene products were ziplocked and put away in residents' drawers. Record review of the facility's Resident Rights policy last revised 04/2024, it read it part, The facility provides a clean, safe, comfortable and home-like environment .Resident rights may be restricted only to the extent necessary to protect the resident and others. Request for an Accident/Hazards policy was made on 4/29/2025 at 10:34am to the DON and Administrator, the DON later stated they did not have a specific policy on that.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #56) reviewed for incontinent care. The facility failed to ensure CNA V properly cleaned Resident #56 during incontinent care when CNA V did not separate Resident #56's labia on 04/27/2025. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #56's face sheet dated 04/30/25 revealed a [AGE] year-old female was admitted to the facility on [DATE]. Resident #56 diagnosis included: malignant neoplasm of colon (cancerous growth in the colon), hypertension (force of blood against the walls of the arteries is consistently too high), atrial fibrillation (an irregular heartbeat) and cognitive communication deficit (someone has difficulty communicating because their thinking processes, like memory, attention, and reasoning). During an observation on 04/27/25 at 5:00 p.m., CNA V did not separate Resident #65's labia during incontinent care for Resident #3. The surveyor intervened when CNA V was about to close the strips on the clean incontinent brief. CNA V reseparated the resident's labia and wiped the resident's labia four additional times, and from the labia area exposed feces on the wipes, and on the fifth wiping/wipe the area appeared to be cleaned. Record review of Resident #56's admission assessment dated [DATE] revealed on BIMS of 13 indicating intact cognition. Further review revealed Resident #56 required substantiation assistance with ADL care with one to two staff assist. Record review of Resident #56's care plan dated 04/09/25 revealed Resident #56 had incontinent bowel and bladder. Interventions: perform routine rounding to include incontinence care and brief changes. During an interview on 04/27/25 at 5:16 p.m., CNA V said if the surveyor did not intervene, she would not have separated Resident #56's labia and cleaned the labia well before applying the clean incontinent brief. CNA V said if she did not clean Resident #56 well, she could develop an infection (UTI). CNA V said she had skills check off and in service on ADL, including rounding and incontinent care. She stated that the nurse monitored the aide throughout the shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/28/25 at 2:02 p.m., the Unit Manager said CNA V should have separated Resident #56's labia and cleaned side, side and middle to ensure the resident was clean properly to prevent Resident #56 from getting UTI. She said the aide had training on providing incontinent care before they started to work on the floor. The Unit Manager said the aides were tough to wipe from front to back to prevent infection. She said the nurse and lead CNA monitor the aides throughout the shift, and the nurse manager monitors the nurses during random rounds. During an interview on 04/28/25 at 3:16 p.m., the DON said CNA V should have cleaned Resident #56 from front to back and should have separated Resident #56's labia and cleaned three times, side, side, and middle each time with a different wipe. The DON said the resident's labia are separated and cleaned to avoid redness or the development of infection. She stated that the nurses and lead CNA monitored the aides throughout the shift, and the nurse managers monitored the nurses during random rounds. She said the aides should have a skilled check-off before working on the floor. They also had in-service on ADL rounding and incontinent care. Record review of the facility's policy on perineal care revised 12/23 read in part . the facility will provide perineal care in a manner that . reduce the risk of infection, and promotes skin integrity .procedure: . cleaning . for female residents, separate the labia and clean from front to back using a clean wipe for each stroke .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #11) of 7 residents reviewed for enteral nutrition. The facility failed to follow physician orders for Resident #11 enteral feeding tube to be administer 55ml (milliliters) high-protein tube-feeding formula 1.5 calories (cal) every hour (hr). This failure could place residents who had gastrostomy tube at risk for fluid overload. Findings included: Record of Resident #11's Facesheet dated 05/05/2025 revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included but were not limited to acute and chronic respiratory failure (lungs are unable to adequately exchange oxygen and carbon dioxide), moderate protein- calorie malnutrition (deficiency in both protein and calories, leading to a weight loss or a lack of weight gain), and encounter for attention to gastrostomy (a surgical procedure that creates an opening in the stomach through the abdominal wall for receiving nutrition), and dehydration (body losing too much fluid). Record review of Resident #11's Comprehensive MDS dated [DATE] revealed that the resident had no BIMS indicating he was not able to answer or respond to the BIMS questions. Section K: Swallowing/Nutritional Status. Feeding tube (e.g., nasogastric or abdominal (PEG). The percent (%) Intake by Artificial Route: The proportion of total calories the resident received through parenteral, or tube feeding was 51% or more. The average fluid intake per day by IV or tube feeding 501 cc (cubic centimeter)/day or more. Record review of Resident #11's undated Care Plan reflected FOCUS: FEEDING TUBE: Resident required the use of a feeding tube for nutrition and was at risk for aspiration, unplanned weight loss, dehydration and nutritional complications. GOAL: Resident's feeding tube would remain patent and resident would receive nutrition as ordered without evidence of aspiration, dehydration, or nutritional compromise through the review date. INTERVENTIONS: Follow Physician orders for feedings. Record review of Resident #11's Physician Order dated 02/26/2025, reflected, Enteral Feeding- Order: High-protein tube-feeding formula 1.5 cal 55ml/hr . preposition (via) gastrostomy tube (G-tube) continuously times (x) 22 hours. 22 hours accounts for activities of daily living (ADL) Care. Every shift for feeding. Record review of Resident #11's 04/29/2025 at 04:53 p.m. Medication Administration Record (MAR) dated 04/01/2025 to 04/29/2025 reflected, on 04/26/2025 into 04/27/2025 RN A administered the resident's enteral feeding - order high-protein tube-feeding formula 1 .5 cal. at 06:00 a.m., 55ml/hr . via G-tube continuously x 22 hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/27/2025 at 02:29 p.m., reflected Resident #11 laid in bed and had not aroused to voice or sound. Feeding machine reflected, high-protein tube-feeding formula 1.5 cal at a continuous rate of 56 ml/hr. Total feed 1385 ml. Interview on 04/28/2025 at 02:47 p.m., DON stated that not following Resident #11's high-protein tube-feeding formula of 55ml/hr rather that the feeding machines setting of 56 ml/hr could result in an overload of weight gain for the resident resulting in an undesired maintains of weight. She stated that nursing staff were responsible for verifying each order, every shift, every time the resident's feeding was administered. Interview on 04/29/2025 at 06:01 p.m., the Administrator (ADM) stated that Resident #11 feeding order should be followed and received as ordered. He stated that the resident receiving 56mls verse 55mls of high protein feeding formula would result in overfeeding and unplanned and undesired weight gain. Interview on 05/01/2025 at 09:30 a.m., RN A stated he had been responsible MAR for Resident #11's high-protein tube-feeding formula at 55ml/hr on 04/26/2025 into 04/27/2025. He stated he was not aware that Resident #11's feeding entered at 56ml/hr verses the physician ordered 55ml/hr. He stated that the CNAs start and stop the feeding machines to provide incontinence care and maybe the feeding was changed inadvertently during the stopping and starting. He stated that CNAs were not to stop and start the machine and it was ultimately his responsibility as the resident's nurse to ensure that the amount of formula was correctly administered per hr by confirming with the actual order each time the formula was administered. He stated that the consequences of residents receiving too much feeding could result in side effects such as weakness, abdominal distention, shortness breath and cause pulmonary destress, and circulatory overload. He stated he received his training on how to administer feeding in college as a student. He stated he also received 3-days of training on how to enter and follow physician orders from LVN B and LVN C when he began working with the facility nearly a year ago. He stated that the facility provides in-services on how to stop and start the feeding machines routinely. Record review of facility policy dated title: Policy Policies and Procedures Physician Orders Policy All physician orders must be accurate, timely, and documented in the resident's medical record. Only authorized individuals (e.g., physicians, nurse practitioners, or physician assistants) may write or verbally provide orders. Verbal orders must be promptly documented, signed, and authenticated by the prescribing practitioner within the timeframe. The facility staff must ensure that all orders are obtained, clarified, and carried out promptly, with documentation . Following Physician Orders 1. Facility staff are responsible for: Reviewing the order promptly. Ensuring that all orders are correctly implemented within the timeframe specified. Communicating any barriers to implementation to the prescribing practitioner. 2. Documentation of implementation must include: Date and time the order was carried out. Name and credentials of the staff member completing the task. Any resident responses or outcomes, as applicable. 3. If clarification is required, the staff member must: Contact the prescribing practitioner for clarification. Document the clarification conversation and any modifications in the medical record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48923 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 6 residents (Resident #71) reviewed for pharmacy services. -Resident #71 had Ipratropium .02% solution with 22 plastic vials (respiratory treatment), Ipratropium .02% nebulizer solution with 15 plastic vials, and Budesonide inhalation (respiratory treatment for Crohn's and asthma) suspension of .5mg/ml in medication cart A, even though Resident #71 had discharged from the facility. The failure of not disposing of discharged residents' medications could potentially cause a decline in their health condition and further injury if they were accidentally administered another resident's medication. Findings included: Observation on 5/1/2025 at 11:49 am of LVN G on Cart A, revealed Resident #71 had medications labelled Ipratropium .02% solution with 22 plastic vials, Ipratropium .02% nebulizer solution with 15 plastic vials, and Budesonide inhalation suspension of .5mg/ml. In an interview with LVN G on 5/1/2025 at 12:00pm, LVN G said Resident #71 was discharged and if residents get discharged or go to the hospital, their medications should have been taken off the cart to avoid administering them to another resident. In an interview with the DON on 5/1/2025 at 12:12pm, the DON said nurses could leave medications on the cart within 24 hours if they knew the resident would return. If residents do not come back, nurses should dispose of it. The DON said the rationale of pulling discharged residents' medication would be to avoid medication error. Record review of the facility's policy on controlled substances revised on 08-2020, it read in part, Medications included in the Drug Enforcement Administration classification as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt and recordkeeping requirements in the facility, elements of the prescription which includes, name of medication, strength of medication, dosage form and quantity prescribed .Controlled substances are dispensed by the provider pharmacy in readily accountable quantities and containers designed for easy counting of contents. Record review of the facility's policy on storage of controlled substances revised on 08-2020 read in part, Any discrepancy in controlled substance counts is reported to the Director of Nursing immediately and/or in accordance with facility policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy on discontinued medications revised on 08-2020 read in part, When medications are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are marked as discontinued and stored in a secure and separate area from the active medications until destroyed per facility policy .Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48923 Based on observation, interview and record review, the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 carts (Cart B) reviewed for medication labelling. - LVN V's cart (cart B) had one undated Lidocaine vial (used to treat pain) with injection marks in the seal. These failures could cause medications to be given past their expiration date, potentially leading to ineffective therapeutic effect. Findings included: Observation of LVN V's medication cart B on 5/1/25 at 11:27am, revealed there was one bottle labelled Lidocaine Hydrochloride injection 88 1/0 with injection marks on the seal with no date on it. In an interview with LVN V on 5/1/2025 at 11:27am, she said if she had opened and used the Lidocaine vial she would have taken it out from the cardboard box, and written the date on the side before using it. She was not the person who opened it. In an interview on 5/1/2025 at 11:34pm with the DON and the Corporate Nurse, the DON said the Lidocaine vial should have been dated to ensure the medication's shelf life. Record review of the facility's policy on vials and ampules of injectable medications last revised on 08/2020, it read in part, Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to record on multi-dose vials. At minimum, the date opened must be reported. These labels are not required on single-use vials or ampules.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48923 Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 facility dumpsters observed for proper garbage disposal -Dumpster A's side door was observed open with trash inside on 4/27/2025. This failure could place residents at risk of contact with pests and associated diseases. Findings included: Observation on 4/27/2025 at 1:04pm, revealed the left-side sliding door Dumpster A was open. The dumpster appeared half-full of trash inside. In an interview on 4/27/2025 at 1:04pm with the DS, she saw the side door was open and slid it closed. She said it should have been closed. She said all the departments used that dumpster. If it was left open, animals and pests could get into it. In an interview on 4/27/2025 at 3:04pm with the DM, she said the dumpster should not be left open. A potential risk to the facility and residents from leaving the dumpster door open would be in attracting rodents from overflow, or people can get in it. In an interview on 4/28/2025 at 4:10pm with the HK Supervisor, she said housekeeping staff uses the dumpster. The HK Supervisor stated it should be kept closed in case residents or others get in it and would be a risk if there was no one around to see or assist. The dumpster should also be closed to prevent rain or animals from getting into it. In an interview on 4/29/2025 at 6:03pm with the Administrator, he said the dumpster should be closed and having it open would be an infection control issue. Record review of the facility's policy on waste disposal last revised 06-2019 read in part, Waste will be disposed of in a manner to prevent transmission of disease, nuisance or breeding place for insects and feeding places for rodents and other mammals .5. Cover waste containers and close dumpsters at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #19 and Resident #13) of 14 residents reviewed for infection control. - The facility failed to ensure Resident #19 foley catheter tubing was off the floor. - The facility failed to ensure Resident #19's floor mat was free from his foley catheter tubing. - - Resident #13's room had two bottles of hair products with other resident's names on them on the dresser on [DATE]. These failures placed residents, staff and visitors at risk for cross contamination, unwanted infections, and decease in quality of life. Findings: Resident #19: Record of Resident #19's Facesheet revealed he was a [AGE] year-old male who readmitted on [DATE] with diagnosis that included but were not limited to functional quadriplegia (complete inability to move due to sever disability or medical condition), gastrostomy status (presence of a surgical opening into the stomach for nutritional support or gastric decompression), and tracheostomy status (surgical hole in the windpipe that helps with breathing when the usual way is blocked or reduced). Record review of Resident #19's MDS dated [DATE] revealed that the resident had no BIMS indicating he was not able to answer or respond to the BIMS questions. Section H: Bladder and bowel: Resident noted to have an indwelling catheter (including suprapubic catheter and nephrostomy tube). Record review of Resident #19's Nursing Progress Notes dated [DATE] at 03:13 p.m. reflected LVN A provided Resident #19 with foley catheter care. In an observation on [DATE] at 03:10 p.m., Resident #19's foley catheter tubing was resting on the resident's fall mat. The resident did not respond to sound or voice. In an interview on [DATE] at 03:13 p.m., LVN A stated that she was responsible for ensuring that Resident #19's foley catheter was properly in position. She stated that the because the resident's bed had to be in its lowest position, it was difficult to keep the resident's catheter tubing off the floor. She stated that the catheter tubing should not be on the floor and not on the resident's fall mat to follow and prevent infection control protocols. She stated that they received in-services on foley catheter care monthly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	05/01/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 05:35 p.m., Registered Nurse (RN) A stated that it had been everyone's responsibility to ensure that resident's foley catheters were hanging to allow gravity to drain the urine and off to be off the floor to keep the tubing free from infection control issues. He stated that they received in-service on foley catheter care monthly. In an interview on [DATE] at 01:56 p.m., LVN C stated that the Director of Nursing (DON) had performed in-services on foley catheter care often and that Certified Nursing Assistants (CNA) were responsible for emptying resident's foley catheters and ensuring that they were in the correction position to allow gravity to drain the urine and free from the floor to follow infection control protocols. In an interview on [DATE] at 02:47 p.m., the DON stated that staff were responsible for ensuring that resident's foley bags were properly hung to allow gravity to drain the urine and be free from sitting on the floor or other items including residents fall mats. She stated the catheter tubing resting on the floor or resident's fall mats could cause infection control issues. She stated that Resident #19's bed was low to the ground making and made it easy for his tubing to rest on his fall mat. He stated that when LVN A changed the tubing and saw that it had been resting on the floor or the resident's fall mat, LVN A should have placed a basin under neither and allowed the tubing to rest within. She stated she performed in-services all the time on foley care that included ensuring tubing was property hanging and off the floor. Record review of facility Education In-service Attendance Record dated [DATE] and titled . Foley Catheter . Summary of Training: Date and cover urine foley catheter bag, check proper placement of foley, drain by gravity, and below the bladder. Presented by DON and signed by LVN A and other nursing staff. Resident #13: Record review of Resident #13's face sheet reflected she was a [AGE] year-old female originally admitted to the facility on [DATE]. Her medical diagnoses included Type 2 Diabetes Mellitus (high blood sugar), Dementia, Dysphagia, Traumatic Subdural hemorrhage with loss of Consciousness of Unspecified Duration (brain bleed) and Tracheostomy. Record review of Resident #13's Quarterly MDS dated [DATE], reflected she did not have a BIMS completed and did not have a mood interview done due to her being rarely or never understood. She was totally dependent on staff for ADLs, including toileting, oral and personal hygiene, dressing and showering/bathing self. Record review of Resident #13's care plan last updated [DATE], reflected she had ADL self-care deficits and required total assistance for bathing, personal hygiene/grooming. and toileting/incontinent care. Observation on [DATE] at 3:25pm in Resident #13's room, Resident #13 was resting in bed and appeared well-groomed, comfortable with no grimacing. She was unresponsive to questions. There were two bottles of hair product on top of the resident's dresser. The first was a 300 mL quarter-full clear shampoo bottle. The second was a 778 mL purple opaque conditioner bottle. Both bottles had names of other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 3:25pm with LVN B, he said the two bottles should not have been there, and it could have been cross-contamination between resident's personal items. He called the aide into the room and told him to remove the bottles. In an interview on [DATE] at 3:30pm with CNA B, he said he was the aide on the hall, and he did not know the bottles were there or who put them there. He put gloves on and said he was going to remove the bottles. In an interview on [DATE] at 2:43pm with CNA D, she said that toiletries should be ziplocked and put away in residents' drawers. They should be sealed and labelled to avoid infection control issues from using other residents' items. Wandering residents could be at risk. In an interview with the DON on [DATE] at 2:42pm, she said that personal hygiene products should be labelled with the resident's name and placed in a bag or placed inside a drawer so that residents were not using someone else's items. A risk to residents would also be infection control and could be a risk to wandering residents. Record review of facility policy revised dated: ,d+[DATE] and titled: Policy Policies and Procedures. Catheter Care Policy reflected, . To ensure proper hygiene . Record review of facility policy revised dated: Revised:,d+[DATE] and titled: Policies and Procedures. Infection Control Program Policy, reflected . The Facility will establish a comprehensive infection control program encompassing essential elements to safeguard the health and safety of residents, staff, and visitors. The Facility is dedicated to maintaining a safe and healthy environment by implementing an effective infection control program that adheres to state and federal regulations and follows evidence-based practices recommended by the CDC. Program Objectives: o The program's objectives encompass key infection control ideologies: prevention, identification, reporting, investigation, and control of infections and communicable diseases among residents, employees, and visitors. o The Facility promotes awareness and adherence to infection control practices through the Infection Control Committee. o The Facility will continually monitor and evaluate the effectiveness of infection control practices through the Quality Assurance and Performance Improvement (QAPI) process.