STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 out of 1 resident (Resident #2) reviewed for adequate supervision. The facility failed to provide adequate supervision to prevent Resident #2 from eloping from the facility at 2:05 a. m. on 5/6/25 .The noncompliance was identified as Past Non-Compliance. The IJ began on 5/6/25 and ended on 6/6/25 . The facility had corrected the noncompliance before the survey began. The failure placed residents with wander guards at risk of serious harm or death. Findings included:Record review of Resident #2's face sheet dated 7/9/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Unspecified Dementia (group of symptoms affecting memory, thinking and social abilities), Muscle Wasting and Atrophy (decrease in size), and Other Abnormalities of Gait (a person's manner of walking) and Mobility. Record review of Resident #2's annual MDS dated [DATE], section C revealed a BIMS score of 6 that indicated severe cognitive impairment. Section E revealed Resident #2 had exhibited wandering daily but did not place him at significant risk of getting to a potentially dangerous place or significantly intrude on the privacy or activities of others. Section GG regarding Resident #2's Functional Abilities revealed he needed partial/moderate assistance for oral hygiene, toileting hygiene, showering/bathing, dressing, putting on/taking off footwear and substantial/maximal assistance for personal hygiene. Section V regarding Care Area Assessments revealed Resident #2 was reviewed for risks in the following areas: Cognitive Loss/Dementia (dated 4/11/2025), Communication (dated 4/11/2025), ADL Functional/Rehabilitation Potential (dated 4/11/2025), Urinary Incontinence and Indwelling Catheter (dated 4/11/2025), Behavioral Symptoms with care plan ongoing, Falls (dated 4/11/2025), and Psychotropic Drug Use (dated 4/11/2025). Record review revealed Resident #2 had an Elopement Risk Assessment completed on 2/27/25 that indicated Resident #2 was at risk of elopement. Record review of Resident #2's Care Plan revealed Resident #2 was care planned for being at risk for elopement related to wandering with date of initiation on 4/2/24. Resident #2 was also care planned regarding being noncompliant with wearing the wander guard and removing the wander guard after being applied. Interventions included wander guard with initiation date of 4/2/24with placement and function to be assessed every shift. Interventions added after the incident included Resident #2's family looking at 2 secure facilities due to noncompliance with wander guard with initiation date of 5/6/25 , and 1:1 (continuous observation) close monitoring with initiation date of 5/6/25 . Record review of Resident #2's MAR and TAR for May 2025 revealed from 5/1-5/6/25 that his wander guard was checked every shift with no documentation for night shift of 5/1/25 and sleeping was documented for night shift from 10 p.m. to 6 a.m. of 5/5/25 and 5/6/25 with no specific time documented . Wander guard was checked every four hours from 5/13/25 at 4 p.m. through 5/31/25 at 8 p.m. with no documentation for 5/21/25 at 12 p.m., 5/26 at 12 p.m. and 5/29/25 at 8 p.m. Wander guard was checked every night from 5/14-5/31/25. Safety checks were also documented every 30 minutes from 5/7-5/31/25. Record review of Resident #2's nursing progress note dated 5/6/25 at 12:01 a.m. by LVN B revealed, Resident observed not in bed during rounds. After searching around the unit and the neighborhood without finding resident. Facility management notified hence elopement protocol activated. Resident Responsible party notified. 911 called with police response. Physician also notified.Record review of statement written by CNA G on 5/6/25 revealed CNA G saw Resident #2 between 11:00 p.m. to 11:30 p.m. when CNA G took a snack to Resident #2, and he was asleep in his bed at that time and was not seen during the rest of CNA G's shift. Record review of statement written by LVN B on 5/6/25 revealed during shift report at 10:00 p.m. on 5/5/25 they were advised the door alarm in the Magnolia room (large sitting room) was going off. LVN B stated that about 12 midnight they made rounds on the unit and Resident #2 was not in his bed. LVN B stated that when they made rounds and Resident #2 was not in the center, they checked the Magnolia door, and it showed a green light (the door was operational) , and the door was secured and locked but could not recall the exact time this occurred. LVN B stated they notified CNA G at 12:15 a.m. to help look for Resident #2 and notified the other units to help search as well. Then 1 a.m. after still not being able to find Resident #2, LVN B drove to the nearby streets and neighborhood to search for him. LVN B returned to the facility at 1:45 a.m. and notified the administrator around 2 a.m. that Resident #2 was missing. LVN B notified the local Police Department and Resident #2's Responsible Party at 3:33 a.m.Record review of written statement, RN C revealed on 5/6/25