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	10/27/2025

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on , interview and record review the facility failed to ensure the resident had the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law for 1 of 13 residents (Resident #7) reviewed for resident rights. The facility failed to establish if Resident #7 wished to designate a Responsible Party at the time of his admission on [DATE] when he was alert and oriented and able to make his wishes known. This failure could place residents at risk for a diminished quality of life, loss of dignity and loss of self-worth. Findings include: Record review of Resident #7's face sheet, dated 10/23/2025, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #7 had a principal diagnosis of Total retinal detachment, bilateral(the retina in both eyes has fully detached from the back of the eye). He was designated to be his own responsible party. Record review of Resident #7's care plan, dated 09/01/2025, reflected:Focus: Resident #7 is his own responsible party. Date Initiated: 10/16/2025Goal: Resident #7 will manage his own personal affairs such as making medical appointments, outings in the community, choice of insurance, etc. Date Initiated: 10/16/2025Interventions: Resident #7 allows 2 friends to assist him with making personal decisions regarding his medical care. Date Initiated: 10/16/2025. Focus: Resident #7 has impaired visual function r/t bilateral retinal detachment Transfer: Supervision set-up x1 with cane/walking stick.Goal: Resident #7 will have no indications of acute eye problems through the review date. Interventions: Arrange consultation with eye care practitioner as required. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Tell the resident where you are placing their items. Be consistent. Record review of Resident #7's admission progress note, dated 02/20/2025, reflected he was alert and oriented times 4 at the time of his admission. Record review of Resident #7's admission MDS assessment, dated 03/19/2025, and last quarterly MDS assessment, dated 09/11/2025, reflected he had a BIMS score of 15 to indicate his cognition was intact. Record review of Resident #7's 72-hour care plan meeting progress note, dated 02/21/2025, reflected the meeting was held with Resident #7, with no information about designating a responsible party. Record review of a grievance, dated 10/03/2025, to involve Resident #7, reflected the resident was upset because his insurance was changed to PPHP and a pending appointment would be missed on 10/03/2025. The grievance was resolved after it was confirmed with PPHP the RP authorized the insurance change, although the RP denied changing the insurance. The grievance was resolved with Resident #7 being named his own responsible party, he disenrolled in PPHP insurance, re-enrolled with previous insurance provider, and his procedure was rescheduled for 11/5/2025. In an interview on 10/14/2025 at 11:48 AM, Resident #7 said he had been at the facility since February of 2025. He stated he was legally blind. He said he found out from an insurance agent with PPHP his insurance had been changed by Former RP. He said the Former RP could not have signed to change his insurance because he resided out of state. He said he called the Former RP in the presence of Administrator A and the Former RP denied signing any paperwork to change his insurance provider. In a phone interview on 10/21/2025 at 12:28pm with the previous RP, he said he always made it clear he was not Resident #7's responsible party and he was only next of kin. He said it was his understanding he would be contacted in the event of an emergency. He said Resident #7's health was not good at the time of admission but he had enough mental capacity to make his own decision then and now. He said someone called him about a special problem that would not be a charge to Resident #7, that would provide him with snacks and do his nails, but he told the person they would need to contact Resident #7 at the facility. He denied he authorized a change in Resident #7's insurance. In an interview on 10/22/2025 at 10:25 AM, Resident #7 said he was legally blind and his previous health insurance plan covered for him to have eye surgery, but when his insurance plan was changed the physician doing the surgery was no longer in network. He said the Former RP denied he changed the insurance, and he never told anyone at the facility the Former RP could make his decisions a RP. He said he was now his own RP at the facility he switched his insurance back and he was scheduled to have his eye surgery in November of 2025. He said the eye surgery was to help him regain some of not all his eyesight. He said his surgery was delayed for about one month. In an interview on 10/23/2025 at 12:12 PM with the Social Worker, he said Resident #7 filed a grievance after he went to a pre-operation appointment with an eye surgeon to discover the physician was no longer in network with his

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Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 13 residents (Resident#2) reviewed for resident rights. 1. The facility failed to notify Resident #2's Physician when they failed to administer IV antibiotic, Zosyn, as ordered from admission on [DATE] through 10/04/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities. 2. The facility failed to notify Resident #2's Physician when she was unable to receive Hemodialysis treatment as ordered on 10/03/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities. 3. The facility failed to notify Resident #2's Physician when Resident # 2 had not received all ordered treatments for all of her 14 wounds from 09/30/2025 through 10/02/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities. 4. The facility failed to notify Resident #2's Physician when the orders given on 10/02/2025 for wound care had not been entered into Resident #2's electronic medical records or implemented from 10/02/2025 through 10/04/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities. 5. The facility failed to notify Resident #2's Physician when Resident #2 had only as needed, over the counter regular strength Tylenol ordered for pain medications, had not received any pain medication prior to any of the wound care treatments, or had not had pain assessments prior to wound treatments for her 14 wounds. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities. An Immediate Jeopardy (IJ) was identified on 10/11/2025. The IJ template was provided to the facility on [DATE] at 12:02 PM. While the IJ was removed on 10/19/2025, the facility remained out of compliance scoped at pattern with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could place residents at risk of delays in treatment, worsening of condition, hospitalization, and death. Findings include: Record review of Resident#2's facesheet dated 10/09/2025, reflected she was a [AGE] year-old female, who admitted to the facility on [DATE] with a principal diagnosis of cerebral infarction, unspecified (stroke), admitting diagnosis of sepsis due to Escherichia Coli (E.Coli a bacteria) and serve sepsis with septic shock (a life-threatening condition that occurs when an infection leads to dangerously low blood pressure and organ failure, and secondary diagnosis of End Stage Renal Disease(ESRD the final stage of chronic kidney disease, where the kidneys can no longer function adequately to sustain life without treatment) pressure ulcer of sacral region, unstable, and UTI, site not specified. Secondary diagnosis dated 10/03/2025 for pressure ulcers of right buttock stage 4, left buttock stage 4,right ankle unstageable, left ankle unstageable, left heel unstageable, and other site unstageable. Secondary diagnosis dated 10/03/2025 for non-pressure chronic ulcer of right heel and midfoot, right foot, and left foot with fat layer exposed. Record review of Resident#2's admission assessment dated [DATE] reflected a BIMS(Brief Interview for Mental Status) was not available as the resident rarely /never understood with severely impaired cognitive skills for daily decision making in Section C. In Section I for active diagnosis, she was triggered for ERSD, Pneumonia, Septicemia, and UTI. In Section M for skin, she was triggered to have 2 stage 4 pressure ulcers, 6 unstageable pressure ulcers, and 5 venous and arterial ulcers present upon admission. In section M she was triggered to have infection of the foot (e.g., cellulitis, purulent drainage.) In Section N for Medications, she was triggered to have antibiotics. In Section O for Special Treatments, Procedures, and Programs, she triggered to have IV medication and hemodialysis. Record review of Resident#2's comprehensive care dated 10/06/2025 reflected:Focus: Resident#2 needs hemodialysis MWF(Monday, Wednesday, and Friday) r/t(related to) renal failure.Goal: The resident will have immediate intervention should any s/sx(sign and symptoms) of complications from dialysis occur through the review date. Intervention: Encourage resident to go for the scheduled dialysis appointments. Resident receives

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment for 2 of 4 halls; Hall 300 and Hall 400 reviewed for homelike environment.Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment for 2 of 4 halls; Hall 300 and Hall 400 reviewed for homelike environment. The facility failed to ensure Hall 300 was free of odors. The facility failed to deodorize Resident #21 and Resident #31's room resulting in foul orders filling the 300 Hallway and other residents rooms on the 300 hall resulting in complaints from other residents and family members. The facility failed to ensure construction-renovations were completed in Hall 400 resulting in 2 residents (Resident #11 and Resident #22) not getting wound care and living in an unpleasant and uncomfortable environment for the residents. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, uncomfortable, and unsafe. The findings included: Record review of Resident #21's Electronic Health Record revealed a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including Pressure Ulcer of Sacral Region, Stage 4 (a deep wound with full-thickness tissue loss that has damaged muscle, tendon, or bone), Pressure Ulcer of Left Lower back, stage 3 (a full-thickness skin and tissue loss injury that has damaged the skin and fat layer, creating deep crater, but has not yet exposed muscle, bone, or tendon), Pressure Ulcer of Right hip, Stage 4 (a severe, full thickness wound that extends through the skin and fat to expose underlying muscle, tendon, or bone), Pressure Ulcer of Left Ankle, Unstageable, Pressure Ulcer of other site (full thickness tissue loss, but the depth cannot be determined because it is covered by eschar (dead tissue) or other slough (dead or dying tissue)), Major Depressive Disorder(a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), Generalized Anxiety disorder (a common mental health condition characterized by excessive, persistent, and uncontrollable worry and anxiety about various aspects of life), and Benign Prostatic Hyperplasia without Lower Urinary Tract symptoms (a condition where the prostate gland enlarges but does not cause any noticeable urinary problems) and Colostomy Status (refers to the condition of having a surgical procedure called colostomy). Record review of the Resident #21's Quarterly MDS revealed a BIMS score of 14, which indicates cognitively intact. Section GG of the MDS revealed the resident did use a mobility device (wheelchair) and he required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and oral hygiene. Resident #21 required partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts or holds trunk or limbs but provides less than half the effort) for rolling left to right. Resident #21 required substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self, upper body dressing, personal hygiene, sit to lying, and lying to sitting on side of bed. Record review of Resident #21's care plan dated 09/17/25 revealed the following in part: Focus: I am Non-Complaint daily to care and refuse care (Peri-care-wound care-ADL Care) has a preference to not wear briefs, refuses nail care, shaving, haircut, showers, and grooming and wound care.Goal: Prevent New Wounds and Heal Current Wounds- I will be free of Pain or Discomfort Focus: The resident has a behavior problem refusing medications, wound care, ADL care, grooming, no sheet on bed and meals Goal: The resident will have fewer episodes of refusing medications by review date Record review of Resident #31's Electronic Health Record revealed a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including Unspecified Dementia (a diagnosis used when a person exhibits symptoms of dementia by the specific underlying cause cannot be determined), Local Infection of the skin and subcutaneous tissue (an infection that affects the layers of skin and underlying fat), Chronic Venous Hypertension with Ulcer of Right Lower Extremity (there is high blood pressure in the veins of the right leg, which has caused an open sore (ulcer) to form due to poor circulation), Chronic Venous Hypertension with Ulcer of Left Lower Extremity (high blood pressure in the veins of the left leg has caused a non-healing sore (ulcer) to form due to poor blood flow), Schizophrenia, Unspecified (a diagnostic category used in psychiatry when a person exhibits symptoms of schizophrenia but does not meet the full criteria for any specific subtypes of schizophrenia), Pressure Ulcer of Sacral Region, Stage 4 (a severe form of pressure injury where there is full-thickness tissue loss with exposed bone, muscle, or

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to be free from neglect for 2 of 13 residents (CR#1 and Resident #2) reviewed for neglect.1. The facility failed to treat the wound of CR#1's buttock from admission on [DATE]-[DATE].2. The facility failed to notify Resident #2's Physician when they failed to administer IV antibiotic, Zosyn, as ordered from admission on [DATE] through 10/04/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities.3. The facility failed to notify Resident #2's Physician when she was unable to receive Hemodialysis treatment as ordered on 10/03/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities.4. The facility failed to notify Resident #2's Physician when Resident # 2 had not received all ordered treatments for all of her 14 wounds from 09/30/2025 through 10/02/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities.5. The facility failed to notify Resident #2's Physician when the orders given on 10/02/2025 for wound care had not been entered into Resident #2's electronic medical records or implemented from 10/02/2025 through 10/04/2025. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities. 6. The facility failed to notify Resident #2's Physician when Resident #2 had only as needed, over the counter regular strength Tylenol ordered for pain medications, had not received any pain medication prior to any of the wound care treatments, or had not had pain assessments prior to wound treatments for her 14 wounds. Resident#2 was transferred to a local hospital on [DATE] with elevated WBC, diagnosed with sepsis, treated with IV antibiotics, and had a bilateral AKA due to lack of blood flow and necrotic tissue to both extremities. An Immediate Jeopardy (IJ) was identified on 10/13/2025. The IJ template was provided to the facility on [DATE] at 12:13 PM. While the IJ was removed on 10/20/2025, the facility remained out of compliance scoped at pattern with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could place residents at risk for delayed treatment, worsening of condition, increased pain, hospitalization, and death Findings include:1. Record review of CR#1's face sheet, dated 09/30/2025, reflected a [AGE] year-old male, who admitted to the facility on [DATE]. CR#1 had a diagnosis which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness resulting from a stroke). CR#1 was transferred to a local hospital on [DATE] related to a percutaneous gastrostomy endoscopic (PEG) tube replacement (feeding tube replacement). Record review of CR#1's admission MDS assessment, dated 06/03/2025, reflected a BIMS was not available as the resident rarely /never understood with severely impaired cognitive skills for daily decision making. In Section M for skin, he was triggered to have 1 stage 2 pressure ulcer upon admission. Record review of CR#1's comprehensive care, dated 09/26/2025, reflected:Focus: CR#1 has a pressure ulcer to the sacrum, back (2), left ankle, left foot, left heel, Right lower legand right heel related to limited mobility, incontinence, end stage skin failure.Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date.Intervention: Administer treatments as ordered and monitor for effectiveness. Record review of CR#1's hospital clinical record, dated 05/27/2025, reflected a pressure ulcer located to the buttock on 05/26/2025, with no orders identified for continued treatment upon discharge. Record review of CR#1's progress notes, dated 05/28/2025 at 9:56 PM by ADON B, read in part, . [CR#1] has dressing to sacral area and has a peg tube. No other skin issues observed to resident. Record review of CR#1's total body skin assessment, dated 05/29/2025, reflected 1 wound with no documentation of the wounds stage or size. Record review of CR#1's MAR for the month of May of 2025 reflected no wound care treatment. Record review of CR#1's May 2025 order summary reflected no orders for wound treatment or wound consult. Record review of CR#1's physician order, dated 06/03/2025, read in part, wound (1) pressure stage 2 coccyx (tailbone). Cleanse with normal saline or wound wash, pat dry, apply comfort foam border 2x (times) weekly and PRN (as needed) if soiled or dislodged. Record review of CR#1's MAR for the month of June of 2025 reflected wound care treatment for a stage 2 coccyx an initial documentation on

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, a residents with pressure ulcers received necessary treatments and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 13 residents (CR #1 and Resident #2) reviewed for pressure ulcers. -The facility failed to treat the wound of CR#1's buttock from admission on [DATE]-[DATE]/2025. 2.--The facility failed to identify and treat the wounds of Resident #2 from admission on [DATE]-[DATE]. An Immediate Jeopardy (IJ) situation was identified on 10/11/2025. While the IJ was removed on 10/20/2025, the facility remained out of compliance, at a scope of pattern with a potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for delayed treatment, worsening of condition, hospitalization, and death. Resident #2 was admitted to the hospital on [DATE] with a critically elevated white blood cell count (WBC), sepsis and had an above the knee amputation of both legs due to gangrene. Findings include: 1. Record review of CR#1's face sheet dated 09/30/2025, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE] with a principal diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness resulting from a stroke). CR#1 was transferred to a local hospital on [DATE] related to a percutaneous gastrostomy endoscopic (PEG) tube replacement (feeding tube replacement). Record review of CR#1's admission MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS (Brief Interview for Mental Status) was not available as the resident rarely /never understood with severely impaired cognitive skills for daily decision making. In Section M for skin, he was triggered to have 1 stage 2 pressure ulcer upon admission. Record review of CR#1's comprehensive care dated 09/26/2025 reflected: Focus: CR#1 has a pressure ulcer to sacrum, back (2), left ankle, left foot, left heel, Right lower leg and right heel related to limited mobility, incontinence, end stage skin failure. Goal: The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date. Intervention: Administer treatments as ordered and monitor for effectiveness. Record review of CR#1's hospital clinical record dated 05/27/2025 reflected a pressure ulcer located to the buttock on 05/26/2025. Record review of CR#1's progress notes dated 05/28/2025 9:56pm by ADON B, read in part, .CR#1 has dressing to sacral area and has a peg tube. No other skin issues observed to resident. Record review of CR#1's total body skin assessment dated [DATE] reflected 1 wound. Record review of CR#1's Medication Administration Record (MAR) for the month of May of 2025 reflected no wound care treatment. Record review of CR#1's May 2025 order summary reflected no orders for wound treatment or wound consult. Record review of CR#1's physician order dated 06/03/2025 read in part, wound(1) pressure stage 2 coccyx(tailbone). Cleanse with normal saline or wound wash, pat dry, apply comfort foam border 2x(times) weekly and PRN (as needed) if soiled or dislodged. Record review of CR#1's MAR for the month of June of 2025 reflected wound care treatment for a stage 2 coccyx an initial documentation on 06/04/2025. Record review of Resident #2's admission Record dated 10/22/2025 revealed she was a [AGE] year old female who admitted to the facility on [DATE] from another state with diagnoses that included: cerebral infarction (a condition that occurs when blood flow to the brain is interrupted, causing brain cells to die), sepsis due to Escherichia Coli (a life-threatening infection, where bacteria from the intestine spreads to the blood stream and triggers a systemic inflammatory response in the body), severe sepsis with septic shock (an infection that leads to life threatening organ dysfunction and failure), pressure ulcer of sacral region (a skin and soft tissue injury that develops over the sacrum (the bone at the base of the spine) due to prolonged pressure, friction or shear which causes the tissue to breakdown and form an open wound), dependence on renal dialysis (a lifelong, and life sustaining therapy involving regular treatments that perform the function of the kidneys to filter waste and remove excess fluid from the blood for people with severe or permanent kidney failure), and gastrostomy status (an opening in the abdomen with insertion of a tube directly into the stomach that allows for nutrition, medication and fluids to be administered to a person unable to eat or drink anything by mouth). Record review of Resident #2's admission Minimum Data Set (MDS) dated [DATE] revealed she had a SAMS (Staff Assessment for Mental Status) completed and was coded as being severely impaired in cognitive skills for daily living decision making. Resident #2 was also coded as having upper and lower extremity impairments on one side of her body and was totally dependent on at least one staff member to provide all ADL (Activities

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	455682	A. Building B. Wing	10/27/2025

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 13 residents (Resident #2) reviewed for pain. -The facility failed to ensure that pain management was provided for Resident #2, who was crying in pain, during the treatment of her 14 individual wounds. -The facility failed to assess Resident #2 accurately and appropriately, for pain prior to Resident #2 receiving wound care treatments for 14 separate wounds. -The facility failed to provide timely medication interventions for Resident #2's pain management for daily wound care treatments of her 14 individual wounds. An immediate Jeopardy (IJ) was identified on 10/10/2025. The IJ template was provided to the facility on [DATE] at 6:39 PM. While the Immediacy was removed on 10/19/2025 at 5:44 PM, the facility remained out of compliance scoped at pattern with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures placed residents at risk of increased or unmanaged pain and actual harm. Findings Include: Resident #2 Record review of Resident #2's admission Record dated 10/22/2025 revealed she was a [AGE] year old female who admitted to the facility on [DATE] from another state with diagnoses that included: cerebral infarction (a condition that occurs when blood flow to the brain is interrupted, causing brain cells to die), sepsis due to Escherichia Coli (a life-threatening infection, where bacteria from the intestine spreads to the blood stream and triggers a systemic inflammatory response in the body), severe sepsis with septic shock (an infection that leads to life threatening organ dysfunction and failure), pressure ulcer of sacral region (a skin and soft tissue injury that develops over the sacrum (the bone at the base of the spine) due to prolonged pressure, friction or shear which causes the tissue to breakdown and form an open wound), dependence on renal dialysis (a lifelong, and life sustaining therapy involving regular treatments that perform the function of the kidneys to filter waste and remove excess fluid from the blood for people with severe or permanent kidney failure), and gastrostomy status (an opening in the abdomen with insertion of a tube directly into the stomach that allows for nutrition, medication and fluids to be administered to a person unable to eat or drink anything by mouth). Record review of Resident #2's admission Minimum Data Set (MDS) dated [DATE] revealed she had a SAMS (Staff Assessment for Mental Status) completed and was coded as being severely impaired in cognitive skills for daily living decision making. Resident #2 was also coded as having upper and lower extremity impairments on one side of her body and was totally dependent on at least one staff member to provide all ADL (Activities of Daily Living) care. Continued record review revealed Resident #2 was coded in Section M related to Skin Conditions as having two stage four pressure ulcers upon admission. Six unstageable wounds upon admission, and five venous or arterial ulcers. Resident #2 was also coded under Section M as having an infection of the foot. Record review of Section V of the MDS related to Resident #2's Care Area Assessment Summary (CAA) had no care area triggers for pain and had no care planning decision made for pain. Record review of Resident #2's comprehensive care plan review with a review completed date of 10/06/2025 revealed no care plan for pain. Record review of Resident #2's out of state hospital records dated 09/29/2025 revealed she had the following as needed (prn) orders for pain: Acetaminophen 650 mg tablet Q 6 hours prn mild pain. Acetaminophen 650 mg tablet Q 6 hours prn pain or temperature 100.4 or greater which Resident #2 was documented as having received on 9/28/25 at 5:28 PM. Hydromorphone PF Dilaudid 0.5mg IV Q 4 hours prn for severe pain which Resident #2 was documented as having received on 9/28/25 at 12:36 PM. Record review of Resident #2's facility Order Recap dated September 2025 revealed an order for Acetaminophen oral tablet 325 MG Give 2 tablets by mouth every 6 hours as needed for pain. Continued record review revealed the order was for an oral/by mouth administration and Resident #2 was a gastrostomy status resident. Record review of Resident #2's Medication Administration Record (MAR) dated September 1, 2025, through September 30,2025 revealed Resident #2 did not receive any Acetaminophen during the month of September. Record review of Resident #2's MAR dated October 1, 2025, through October 31, 2025, revealed the following order: Acetaminophen oral tablet 325 MG Give 2 tablets by mouth every 6 hours as needed for pain. D/C Date 10/10/2025. Resident #2 did not receive this medication. Observation on 10/09/2025 of Resident #2's wound care treatment at 10:57am performed by ADON A and assisted by CNA A. ADON A was asked prior to the start of Resident #2's treatment if Resident #2 had been

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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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice for 1 of 4 residents (Resident #2). The facility to ensure that Resident #2 received hemodialysis as ordered on 10/03/2025, which resulted in her not receiving any hemodialysis for a total of four days. An immediate Jeopardy (IJ) was identified on 10/10/2025. The IJ template was provided to the facility on [DATE] at 8:11 PM. While the Immediacy was removed on 10/16/2025 at 7:43 PM, the facility remained out of compliance scoped at pattern with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. This failure placed residents at risk for delayed treatments, and actual harm. Findings Include: Resident #2 Record review of Resident #2's admission Record dated 10/22/25 revealed she was a [AGE] year old female who admitted to the facility on [DATE] from another state with diagnoses that included: cerebral infarction (a condition that occurs when blood flow to the brain is interrupted, causing brain cells to die), sepsis due to Escherichia Coli (a life-threatening infection, where bacteria from the intestine spreads to the blood stream and triggers a systemic inflammatory response in the body), severe sepsis with septic shock (an infection that leads to life threatening organ dysfunction and failure), pressure ulcer of sacral region (a skin and soft tissue injury that develops over the sacrum (the bone at the base of the spine) due to prolonged pressure, friction or shear which causes the tissue to breakdown and form an open wound), dependence on renal dialysis (a lifelong, and life sustaining therapy involving regular treatments that perform the function of the kidneys to filter waste and remove excess fluid from the blood for people with severe or permanent kidney failure), and gastrostomy status (an opening in the abdomen with insertion of a tube directly into the stomach that allows for nutrition, medication and fluids to be administered to a person unable to eat or drink anything by mouth). Record review of Resident #2's admission Minimum Data Set (MDS) dated [DATE] revealed she had a SAMS (Staff Assessment for Mental Status) completed and was coded as being severely impaired in cognitive skills for daily living decision making. Resident #2 was also coded as having upper and lower extremity impairments on one side of her body and was totally dependent on at least one staff member to provide all ADL (Activities of Daily Living) care. Continued record review revealed Resident #2 was coded in Section I for an active diagnosis of Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD). Record review of Section O of the MDS for Special Treatments, Procedures, and Programs was coded for Dialysis while a resident. Record review of Resident #2's comprehensive care plan review with a last care plan review completed date of 10/06/2025 revealed in part: .Focus.Resident #2 needs hemodialysis MWF r/t renal failure.Goal.The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date.Target Date: 10/12/2025.Interventions/Tasks.obtain vital signs and weight per protocol. Report significant changes in pulse, respiration, and B/P immediately. Record review of Resident #2's out of state hospital records dated 09/29/2025 revealed the following entry: Assessment and Plan.1. ESRD on HD.Resident #2 has been getting HD TTS.Resident #2 pending DC to skilled nursing (out of state).However, unable to DC today because she needs to leave early enough to arrive there before 2pm so she can be admitted to the facility. Tomorrow will be her dialysis today and she will most likely not be able to DC in time if we do dialysis tomorrow. I will run her dialysis today and that way she will not need dialysis tomorrow.I have discussed with dialysis nurse that the patient will have dialysis orders for today to help facilitate her discharge in the morning. [sic] Continued record review revealed Resident #2 had a Dialysis Central Line Catheter Tunneled Right Subclavian dialysis access site. (A long flexible, hollow tube that is inserted into the large subclavian vein (a large deep vein located on each side of the body) beneath the right collar bone and then tunneled under the skin to an exit port, typically on the chest wall). Record review of Resident #2's progress note dated 10/03/2025 and created by RN A at 6:27 am revealed the following entry: .Observed in bed resting comfortably this morning. Vital signs are Temp:97.6, RR: 20, Pulse 106, B/P: 126/66, POX % is 98% on room air. No distress noted. NP A [sic]notified this morning about the situation/and the change. Resident RP. was called and notified also. Continued record review at the bottom of the entry for .Show on Shift Report, show on 24 Hour Report, Show on MD/Nursing Communication Report were unchecked and remained blank. Record review on 10/09/2025 at 11:48am of Resident #2's progress notes revealed she received in-house hemodialysis as prescribed on 10/01/2025 Record review on 10/09/2025 at 11:55 am of Resident

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (Resident #2) - The facility failed to administer Resident#2's IV antibiotic as ordered from her admission on [DATE]-[DATE]. An immediate Jeopardy (IJ) was identified on 10/10/2025. The IJ template was provided to the facility on [DATE] at 8:11 pm. While the Immediacy was removed on 10/19/2025 at 5:44 pm, the facility remained out of compliance scoped at pattern with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. This failure had the potential to place residents at risk for delayed treatment, and worsening infections which can lead to actual harm. Resident #2 was admitted to the hospital with critically elevated white blood cell count, sepsis and had an above the knee amputation of both of her legs. Findings Included: Resident #2 Record review of Resident #2's admission Record dated 10/22/25 revealed she was a [AGE] year old female who admitted to the facility on [DATE] from another state with diagnoses that included: cerebral infarction (a condition that occurs when blood flow to the brain is interrupted, causing brain cells to die), sepsis due to Escherichia Coli (a life-threatening infection, where bacteria from the intestine spreads to the blood stream and triggers a systemic inflammatory response in the body), severe sepsis with septic shock (an infection that leads to life threatening organ dysfunction and failure), pressure ulcer of sacral region (a skin and soft tissue injury that develops over the sacrum (the bone at the base of the spine) due to prolonged pressure, friction or shear which causes the tissue to breakdown and form an open wound), dependence on renal dialysis (a lifelong, and life sustaining therapy involving regular treatments that perform the function of the kidneys to filter waste and remove excess fluid from the blood for people with severe or permanent kidney failure), and gastrostomy status (an opening in the abdomen with insertion of a tube directly into the stomach that allows for nutrition, medication and fluids to be administered to a person unable to eat or drink anything by mouth). Record review of Resident #2's admission Minimum Data Set (MDS) dated [DATE] revealed she had a SAMS (Staff Assessment for Mental Status) completed and was coded as being severely impaired in cognitive skills for daily living decision making. Resident #2 was also coded as having upper and lower extremity impairments on one side of her body and was totally dependent on at least one staff member to provide all ADL (Activities of Daily Living) care. Continued record review revealed Resident #2 was coded in Section M related to Skin Conditions as having two stage four pressure ulcers upon admission. Six unstageable wounds upon admission, and five venous or arterial ulcers. Resident #2 was also coded under Section M as having an infection of the foot. In Section N of the MDS for Medications she was coded as having received antibiotics within the last 7 days. Record review of Resident #2's comprehensive care plan review with a review completed date of 10/06/2025 revealed in part: Focus.Resident #2 is on antibiotic therapy r/t sepsis, r/t wounds, UTI and aspiration PNA. Goal.The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Target Date: 10/12/2025.Interventions.Administer medications as ordered. Record review of Resident #2's out of state hospital records dated 09/29/2025 revealed she had the following order: Piperacillin Tazobactam (Zosyn) 4.5 g in Sodium Chloride 0.9% 100 ml IVPB Dose: 4.5 g.Freq: every 12 hours.Route: IV.Indications of use: Cellulitis. Record review of Resident #2's physician order dated 9/30/25 at 7:15 pm revealed the following order: Piperacillin Sod-Tazobactam So Intravenous Solution Reconstituted 4.5 (4-0.5) GM (Piperacillin Sodium Tazobactam Sodium) Use 100 gram intravenous every 12 hours for wound infection for 14 days, and was confirmed by LVN B. Record review of Resident #2's MAR dated September 1, 2025, through September 30, 2025, revealed Resident #2 did not receive Piperacillin Sod-Tazobactam So Intravenous Solution Reconstituted 4.5 (4-0.5) GM (Piperacillin Sodium Tazobactam Sodium) Use 100 gram intravenous every 12 hours for wound infection for 14 days, as ordered. Continued record review revealed Resident #2 did not receive the medication on 9/30/25 and the order was discontinued on 10/01/25. Record review of Resident #2's Medication Administration Record (MAR) dated October 1, 2025, through October 31,2025 revealed the following: Zosyn Intravenous solution 4-0.5 GM/100 ML Piperacillin Sodium-Tazobactam Sodium in Dextrose (sugar water) Use 100 ml intravenously every 12 hours for Sepsis r/t E. Coli Continue until 10/16/2025.D/C Date: 10/04/2025 at 5:25pm. There was no administration of the medication documented on 10/01/25 for the 06:00 am dose or the 5:00pm dose. There was no documentation on 10/02/25 for the 06:00am dose and the 9=other/see nurse notes, was documented

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	455682	A. Building B. Wing	10/27/2025

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Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to maintain a safe, functional, sanitary, and comfortable environment for 2 of 4 halls; Hall 300 and Hall 400 reviewed for physical environment. Based on observation, interviews, and record review, the facility failed to maintain a safe, functional, sanitary, and comfortable environment for 2 of 4 halls; Hall 300 and Hall 400 reviewed for physical environment. The facility failed to ensure Hall 300 was free of odors. The facility failed to deodorize Resident #21 and Resident #31's room resulting in foul orders filling the 300 Hallway and other residents rooms on the 300 hall resulting in complaints from other residents and family members. The facility failed to ensure construction-renovations were completed in Hall 400 resulting in 2 residents (Resident #11 and Resident #22) not getting wound care, unpleasant and uncomfortable environment for the residents. The facility failed to keep the dining room door closed by propping it open with a zip tie. These failures could place residents at risk of living in an unsafe, uncomfortable environment and decreased quality of life. The findings included: Record review of Resident #21's Electronic Health Record revealed a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including Pressure Ulcer of Sacral Region, Stage 4 (a deep wound with full-thickness tissue loss that has damaged muscle, tendon, or bone), Pressure Ulcer of Left Lower back, stage 3 (a full-thickness skin and tissue loss injury that has damaged the skin and fat layer, creating deep crater, but has not yet exposed muscle, bone, or tendon), Pressure Ulcer of Right hip, Stage 4 (a severe, full thickness wound that extends through the skin and fat to expose underlying muscle, tendon, or bone), Pressure Ulcer of Left Ankle, Unstageable, Pressure Ulcer of other site (full thickness tissue loss, but the depth cannot be determined because it is covered by eschar (dead tissue) or other slough (dead or dying tissue)), Major Depressive Disorder(a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), Generalized Anxiety disorder (a common mental health condition characterized by excessive, persistent, and uncontrollable worry and anxiety about various aspects of life), and Benign Prostatic Hyperplasia without Lower Urinary Tract symptoms (a condition where the prostate gland enlarges but does not cause any noticeable urinary problems) and Colostomy Status (refers to the condition of having a surgical procedure called colostomy). Record review of the Resident #21's Quarterly MDS revealed a BIMS score of 14, which indicates cognitively intact. Section GG of the MDS revealed the resident did use a mobility device (wheelchair) and he required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and oral hygiene. Resident #21 required partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts or holds trunk or limbs but provides less than half the effort) for roll left to right. Resident #21 required substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self, upper body dressing, personal hygiene, sit to lying, and lying to sitting on side of bed. Record review of Resident #21's care plan dated 09/17/25 revealed the following in part: Focus: I am Non-Complaint daily to care and refuse care (Peri-care-wound care-ADL Care) has a preference to not wear briefs, refuses nail care, shaving, haircut, showers, and grooming and wound care.Goal: Prevent New Wounds and Heal Current Wounds- I will be free of Pain or Discomfort Focus: The resident has a behavior problem refusing medications, wound care, ADL care, grooming, no sheet on bed and meals Goal: The resident will have fever episodes of refusing medications by review date Record review of Resident #31's Electronic Health Record revealed a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including Unspecified Dementia (a diagnosis used when a person exhibits symptoms of dementia by the specific underlying cause cannot be determined), Local Infection of the skin and subcutaneous tissue (an infection that affects the layers of skin and underlying fat), Chronic Venous Hypertension with Ulcer of Right Lower Extremity (there is high blood pressure in the veins of the right leg, which has caused an open sore (ulcer) to form due to poor circulation), Chronic Venous Hypertension with Ulcer of Left Lower Extremity (high blood pressure in the veins of the left leg has caused a non-healing sore (ulcer) to form due to poor blood flow), Schizophrenia, Unspecified (a diagnostic category used in psychiatry when a person exhibits symptoms of schizophrenia but does not meet the full criteria for any specific subtypes of schizophrenia), Pressure Ulcer of Sacral Region, Stage 4 (a severe form of pressure injury where there is full-thickness tissue loss with exposed bone, muscle, or

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for 1 of 4 hallways, (Hall 300) and Resident #21's and Resident #31's room. The facility had live flies in areas of the facility including Halls 300, and Resident #21 and Resident #31's room. This failure could place residents at risk for decreased health, safety and quality of life. Findings included: Record review of Resident #21's Electronic Health Record revealed a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including Pressure Ulcer of Sacral Region, Stage 4 (a deep wound with full-thickness tissue loss that has damaged muscle, tendon, or bone), Pressure Ulcer of Left Lower back, stage 3 (a full-thickness skin and tissue loss injury that has damaged the skin and fat layer, creating deep crater, but has not yet exposed muscle, bone, or tendon), Pressure Ulcer of Right hip, Stage 4 (a severe, full thickness wound that extends through the skin and fat to expose underlying muscle, tendon, or bone), Pressure Ulcer of Left Ankle, Unstageable, Pressure Ulcer of other site (full thickness tissue loss, but the depth cannot be determined because it is covered by eschar (dead tissue) or other slough (dead or dying tissue)), Major Depressive Disorder(a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), Generalized Anxiety disorder (a common mental health condition characterized by excessive, persistent, and uncontrollable worry and anxiety about various aspects of life), and Benign Prostatic Hyperplasia without Lower Urinary Tract symptoms (a condition where the prostate gland enlarges but does not cause any noticeable urinary problems) and Colostomy Status (refers to the condition of having a surgical procedure called colostomy). Record review of the Resident #21's Quarterly MDS revealed a BIMS score of 14, which indicates cognitively intact. Section GG of the MDS revealed the resident did use a mobility device (wheelchair) and he required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and oral hygiene. Resident #21 required partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts or holds trunk or limbs but provides less than half the effort) for rolling left to right. Resident #21 required substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self, upper body dressing, personal hygiene, sit to lying, and lying to sitting on side of bed. Record review of Resident #31's Electronic Health Record revealed a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including Unspecified Dementia (a diagnosis used when a person exhibits symptoms of dementia by the specific underlying cause cannot be determined), Local Infection of the skin and subcutaneous tissue (an infection that affects the layers of skin and underlying fat), Chronic Venous Hypertension with Ulcer of Right Lower Extremity (there is high blood pressure in the veins of the right leg, which has caused an open sore (ulcer) to form due to poor circulation), Chronic Venous Hypertension with Ulcer of Left Lower Extremity (high blood pressure in the veins of the left leg has caused a non-healing sore (ulcer) to form due to poor blood flow), Schizophrenia, Unspecified (a diagnostic category used in psychiatry when a person exhibits symptoms of schizophrenia but does not meet the full criteria for any specific subtypes of schizophrenia), Pressure Ulcer of Sacral Region, Stage 4 (a severe form of pressure injury where there is full-thickness tissue loss with exposed bone, muscle, or tendons), Pressure Ulcer of Right Heel, Stage 4 (the most severe type of pressure injury, involving deep-tissue damage with full-thickness tissue loss that exposes muscle, tendon, or bone), and Cognitive Communication Deficit (a communication challenge caused by problems with thinking abilities like attention, memory, and executive function, rather than a language or speech problem). Record review of the Resident #31's Quarterly MDS revealed a BIMS score of 11, which indicates moderately impaired cognition. Section GG of the MDS revealed the resident did use a mobility device (wheelchair) and he required supervision or touching assistance (Helper provides verbal cues and/or ouching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and oral hygiene. Resident #31 required partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts or holds trunk or limbs but provides less than half the effort) for rolling left to right. Resident #31 required substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathe self, upper body dressing