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	11/21/2025

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

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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 interviews and record review the facility failed to ensure the resident environment remained free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (CR #1's) reviewed for adequate supervision. -The facility failed to provide adequate supervision to prevent CR #1 from eloping from the facility at an unknown time on 9/21/25. This deficiency exposed residents living in the facility to potential harm, injury, or death due to not being adequately monitored. An Immediate Jeopardy (IJ) was identified on 11/18/25. The IJ template was provided to the facility on [DATE] at 4:41 pm. While the IJ was removed on 11/19/25, the facility remained out of compliance at a scope of with a severity of no actual harm with potential for more than minimal harm that was not an immediate jeopardy and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective system. Findings included: Record review of CR#1's face sheet dated 11/18/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. CR #1 discharged on 10/07/25. His diagnosis of Parkinson's Disease with Dyskinesia (experiencing involuntary, uncontrolled movements), Cognitive Communication, Dementia with Agitation (restlessness, pacing, verbal aggression like yelling, and physical aggression such as kicking or biting). Traumatic brain injury (resulting from an external force), which may impact cognition, behavior, or functional status. Record review of CR #1's admission MDS assessment, dated 9/11/25, revealed the BIMS score was six out of fifteen, indicating he had significant cognitive impairment. Further review of MDS revealed CR #1 needs moderate assistance with supervision with one staff assistance. Record review of CR #1's care plan dated 06/16/22 revealed CR #1 has a short attention span wandering in and out of activities. Further review of the care plan revealed CR #1 was an elopement risk/wander dated 11/08/23. care plan reviewed and had interventions for risk of elopement due to wandering that included a wander guard in place that was to monitor per shift and alert staff of CR #1 attempts to leave the facility unattended. Monitor location per shift. Observing the wandering behavior and attempted the diversional interventions in behavior log. Revision dated 01/31/24. During an interview on 11/17/25 at 10:30 am, the video was requested by the ADM but the video for the incident on 9/21/25 was not provided. Record review of email on 11/17/25 at 12:31 pm. surveyor requested a video of the incident from the Regional Corporate Compliance Nurse. During interview on 11/17/15 at 2:06 p.m. Dietary-aide A, said he observed CR #1 enter the lobby, sit down, and then stand and begin pacing back and forth. He said when he left the lobby, CR #1 remained in the lobby area pacing up and down. During an interview on 11/17/25 at 2:42 pm. ADON said that CR #1 walked out with church members, but she was not present and did not know who could have opened the door. She said someone would have to unlock the door for CR #1 to be able to leave. She said whoever unlocked the door had a visual of whoever was leaving the facility. She said she did not know why the staff had not identified CR #1 before he walked out the front door. She said CR #1 was at risk and could have experienced death, been hit by a car, or been picked up by someone. During a telephone interview on 11/17/25 at 3:14 pm. RN B said LVN C came from station 3 and told her CR #1 was on the street. She said she did not know how CR #1 left the facility. She said CR #1 could have had a fall or hit by a car. During an interview on 11/17/25 at 3:33 p.m. , the Social Worker said he was the manager on the day of the incident. Staff told SW that CR#1 was out of the facility. SW said he was close to the facility and was going to drive to CR #1 location. SW said the police officer was walking with CR #1. SW said he identified himself, and CR #1 recognized him and said he was ready to go home. SW said CR #1 immediately got into his car. SW said none of the staff knew which door CR #1 went out of. He said CR #1 did not have a wander guard on. He said the risk to CR #1 getting out of the facility was CR #1 could become lost and could have gotten hurt. During an interview on 11/17/25 at 4:31 pm. Regional Corporate Compliance Nurse, said CR#1 had gone out with the church group because there was a church group that morning. He said a staff member should have let the church group out and had a visual of who they were letting out of the facility. He could not give a time of how long CR#1 was out of the facility. He said they should have observed CR#1 was among the church group. He said CR#1 could have been injured, had a fall, been hit by a car, and/ or received other negative outcomes. During an interview on 11/18/25 at 8:56 am. CMA D said she saw CR #1 while she was in an Uber and called CR #1 by name. She said she exited the vehicle and called the facility and spoke with LVN C to inform her that CR #1 was no longer in the facility. She said she got out of the car and repeatedly called CR #1 by name, but CR #1