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	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing and Rehabilitation 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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews 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 of 1 residents (Resident #1) reviewed for adequate supervision. The facility failed to provide adequate supervision to prevent Resident #1 from falling to the floor and injuring himself during patient care on 01/09/26 and resulted in a laceration to his upper lip which required stitches. This deficiency could expose residents to harm and injury, due to not being adequately monitored. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Immobility Syndrome (Paraplegic), Muscle weakness (generalized), cognitive communication deficit, Hyperlipidemia, Unspecified, Contracture of muscle, unspecified site, Dysphagia, Oral Phase, and Need for assistance with personal care. Review of Resident #1's MDS assessment dated [DATE], section C revealed no BIMS score. Section G regarding the resident's Activities of Daily Living (ADL) Assistance revealed the resident needed supervision and two persons assisting with bed mobility, transferring, and toilet use. It also revealed the resident required two-person assistance with dressing and personal hygiene. Record review of Resident #1's care plan dated 11/12/2025 revealed Resident #1 was care planned for falls. ADL Self-Care Performance Deficit: requiring two-person assist with all ADL except for eating. Record review of CMA-A's signed statement dated 01/09/26 revealed she was providing patient care for Resident #1. The statement read in part, .Resident #1 became agitated. So, I stopped to calm him down, and after he calmed down. I started providing patient care again; however, Resident#1 became agitated again, and as I was wiping him, he fell to the floor, landing face down and on his left side. I observed blood, and I called for help. Record review of Resident #1's hospital record dated 01/09/26 revealed that Resident #1 was diagnosed with a fall, which resulted in a laceration to his upper lip. Resident #1 received stitches to treat his upper lip. Record review of Resident #1's progress note dated 01/09/26 revealed that he returned to the facility at 7:48 p.m. with one stitch to his upper lip due to sustaining a laceration from a fall. Record review of the facility's Provider Investigation Report dated 01/20/2026 and signed by the Administrator revealed, . CMA (CMA A) provided care to Resident (Resident #1) alone when his care plan called for two-person assist. He rolled out of bed on to the floor . Resident (Resident #1) sustained a laceration to his lip during the fall . Order received and carried out to send Resident (Resident #1) to (a local acute care hospital) ER for evaluation and treatment . All staff were trained (In-services on transfers, mechanical lift transfers, bed mobility, and repositioning with return demonstration) and CMA (CMA A) was terminated as it was found she failed to care for him without getting the assistance of a second staff member. Ad-hoc QAPI was held regarding fall . An audit was done on January 9-10 2026 to ensure residents care plans accurately reflected each resident's assessment needs . In an interview on 01/13/26 at 9:45 (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 - Actual harm Residents Affected - Few	a.m., the Administrator stated CMA A was terminated because on 01/09/2026, CMA-A failed to provide appropriate patient care on Resident #1. The Administrator said CMA A should have used a two- person assist for care and because of CMA-A's failure to follow Resident #1's care plan for two-person assist, he fell out of his bed and sustained an injury to his top lip. Resident #1 was taken to the hospital, and his injury required stitches. In an interview with the ADON on 01/13/26, at 9:55 a.m., she stated that CMA A should have checked the Kardex before providing care for Resident #1. She stated the Kardex would have informed her that a two-staff member assist was the safest way to provide care for Resident#1 to prevent injury. An unsuccessful attempt to interview Resident #1 was made on 01/13/2026 at 10:35 a.m. However, observation reflected that Resident #1 did have stitches in his upper lip. In an interview with CNA-A, 10:40 a.m., CNA-B, 10:43 a.m., CMA-B,10:46 a.m., and LVN-A10:50 a.m. on 01/13/26, they stated as a result of Resident #1's incident, they were in-serviced last week on where to look to know if a resident is a two-person assist and if the resident is a Hoyer lift. An unsuccessful attempt was made to contact CMA A on 01/13/2026, at 11:26 a.m. and at 9:30 a.m. on 01/14/2026. In an interview with the MDS Nurse on 1/13/26 at 1:00 p.m., she stated that Resident #1 was a two-person assist with all ADL except eating. In an interview with the Administrator on 01/13/26 at 3:45 p.m., she stated that during her investigation, CMA A told the DON that she did not understand that she was supposed to use two people to assist. The Administrator stated that CMA A was recently in-serviced at the facility on what residents required the Hoyer lift, and where to look in the Kardex to know if a resident is a two-person assist. The Administrator stated that Resident #1 had to be taken to the hospital due to his fall from his bed during patient care with CMA A. The administrator stated that Resident #1 required stitches to his upper lip. Record review of facility in-services revealed all staff were educated on:*Hoyer lift, gait belt, and Kardex check before providing patient care on 01/09/2026.*Transfers and Safe patient handling on 01/09/26.*Abuse and Neglect on 01/09/2026*Abuse/Neglect on 01/09/2026. Record review of facility Safe Handling Policy(not dated) revealed, . The facility has a program to promote and assure safe patient handling for both the resident and the employee. Nurses will identify residents in need of transfer, repositing or movement assistance.Nurses will assess the risks associated with lifting, transferring, repositioning, or movement assistance Nurses will be educated in the identification, assessment, and control of risks of injury to residents and nurses during. Resident will be evaluated on admission and as needed for alternative means of lifting. Transferring, repositing and other movements to minimize risk of injury.patient handling. Nurses will be educated regarding correct safe handling procedures; to report concerns or the inability to perform resident handling or movement that the nurse believes in good faith will expose a resident or nurse to unacceptable risk or injury. 6. Facility staff will report to the supervisor the inability to complete resident lifting, transfer, or repositioning if they feel it will either endanger the resident or cause injury to staff. 7. Nursing will request therapy disciplines to evaluate the resident ability to assist, and the amount of assistance needed with lifting, repositioning, transferring or mobility.