STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675423	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Gardens	7210 Northline Dr Houston, TX 77076

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good personal hygiene for 1 (Resident #1) of 5 residents reviewed for quality of life.-The facility failed to ensure Resident #1's brief was changed before becoming full of urine and wetting his bed sheet.This failure could place residents at risk of skin breakdown.The findings included:Record review of Resident #1's admission Record, dated 05/27/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included acute cystitis without hematuria (bladder infection without blood in the urine), deficiency of other vitamins, pain, and quadriplegia, C5-C7 incomplete (spinal cord injury resulting in partial loss of motor function and sensation in all four limbs).Record review of Resident #1's MDS Assessment, dated 05/22/26, revealed a BIMS score of 15, indicating cognition was intact. Further review revealed resident's speech was clear, and he required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene and chair/bed-to-chair transfer. In addition, resident was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding).Record Review of Resident #1's Care Plan, undated, revealed he had an ADL self-care performance deficit r/t limited mobility. Resident required assistance x2 with transferring and was totally dependent upon staff for personal hygiene. Interventions included encouraging discussing his feelings about self-care deficit and using bell to call for assistance. Resident #1 was also at risk for alteration in skin related to incontinence of bowel and bladder.Record review of Resident #1's Progress Notes, effective date: 05/27/26 at 9:14 a.m., revealed a CIC was entered for a change in skin color or condition and PCP recommended barrier cream.Record review of Resident #1's Progress Notes, effective date: 05/27/26 at 10:02 a.m., read in part .resident [#1] complained of burning and redness to testicles. Upon assessment resident was noted to have redness to scrotum area. Resident complained that the burning feeling possibly came from not being changed during the night. Barrier cream applied to area. Notified NP.NP to visit with resident tomorrow. Will continue to monitor.Observation and interview on 05/27/26 at 8:00 a.m. revealed, Resident #1 was lying in bed awake with his call light within reach. He said he was doing okay. He said his brief had not been changed today, 05/27/26, and said staff had not changed his brief since yesterday, 05/26/26. He said he had not used his call light to ask for a brief change.Observation and interview on 05/27/26 at 8:10 a.m., CNA A said she was working 6:00 a.m.-2:00 p.m. today but was late and arrived to work at approximately 7:31 a.m. She said she did not know who was covering her assigned rooms before she arrived. She said she had not yet changed Resident #1's brief. CNA A went to Resident #1's room, checked his brief, and said it was full of urine. She performed a brief change and said resident had a little redness on the cheeks of his butt and got the barrier cream to apply. CNA A said some urine had soaked through resident's brief and onto the bed sheet that was placed under him and said the wet area was about the size of a tennis ball. Observation revealed the brief was full of urine and that his bed sheet had an irregular round shape, about the size of a tennis ball, with a light brownish/yellowish outer edge, and wet center. During a follow-up interview on 05/27/26 at 9:24 a.m., CNA A said she went by Resident #1's room at approximately 7:38 a.m. and he was asleep. She (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she went back by his room at approximately 7:50 a.m. to give him some coffee. She said when she gave Resident #1 coffee, he never asked for a brief change, and she said she never asked him if he needed one. She said leaving a resident in a wet brief for too long could lead to skin damage.During an interview on 05/27/26 at 10:34 a.m., the Staffing Coordinator/Lead CNA said CNA A called her this morning at approximately around 5:40 a.m.-5:50 a.m. to let her know she was going to be late due to car problems. She said she notified Nurse A, CNA B, and CNA C. She said she told the 2 CNAs to watch the call lights and when breakfast was ready to pass out the trays. She said residents should be checked and changed every two hours or when they are hitting their call light.Record review of the facility's policy, Perineal Care, date reviewed/revised: 12/01/2025, revealed .Perineal Care.Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible.