

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Autumn Leaves Nursing and Rehab Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Kilgore Drive Henderson, TX 75652	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 of 19 (Resident #64, Resident #74 and Resident #76) residents reviewed for call lights.</p> <p>The facility failed to ensure call lights were within reach while Resident #64, Resident #74 and Resident #76 were in bed.</p> <p>This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity.</p> <p>Findings included:</p> <p>1. Record review of Resident 64's face sheet dated 03/18/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #64 had diagnoses which included hemiplegia (paralysis of one side of the body), hemiparesis (weakness on one side of the body, affecting muscles and motor function), acquired absence of left leg above the knee, and depression.</p> <p>Record review of Resident #64's quarterly MDS assessment dated [DATE], indicated he had a BIMS score of 10, which indicated she had moderate cognitive impairment. Resident #64 was totally dependent on staff for most ADLs. The MDS indicated Resident #64 was totally dependent for chair/bed-to-chair transfers. The MDS indicated Resident #64 was always incontinent of bowel and bladder.</p> <p>Record review of Resident #64's Care Plan last revised 02/10/25 reflected the resident had an ADL self-care performance deficit with an intervention to encourage the resident to use bell to call for assistance.</p> <p>During an observation and interview on 03/17/25 at 9:48 a.m., Resident #64 said he did not have a call button. He said he had to holler when he did not have his call bell. Resident #64's call light draped over the foot of the bed. He said he was unable reach it. He said, once it is down there it is gone.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #74's face sheet dated 03/18/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #74 had diagnoses which included anxiety, depression, stroke and hemiplegia (paralysis of one side of the body), and hemiparesis (weakness on one side of the body, affecting muscles and motor function).</p> <p>Record review of Resident #74's a quarterly MDS assessment dated [DATE], indicated he had a BIMs score of 11, which indicated he had moderate cognitive impairment. Resident #74 required substantial/maximal assistance for with ADLs. The MDS indicated Resident #74 was always incontinent of bladder and bowel. The MDS indicated Resident #74 required substantial/maximal assistance with chair/bed-to-chair transfers.</p> <p>Record review of Resident #74's Care Plan last revised 02/21/25 reflected the resident had an ADL self-care performance deficit with an intervention to encourage the resident to use bell to call for assistance. The care plan indicated Resident #74 was at risk for falls.</p> <p>During an observation and interview on 03/17/25 at 10:32 a.m., Resident #74's call light was draped over head of bed. He said he could not reach the call light. He said, I have to holler nurse, but they don't like that.</p> <p>During an observation on 03/18/25 at 8:24 a.m., Resident #74 was asleep in the bed. The call light was on the floor under the edge of the head of the bed.</p> <p>3. Record review of Resident #76's face sheet dated 03/18/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #76 had diagnoses which included morbid obesity, diabetes, stroke and hemiplegia (paralysis of one side of the body), and hemiparesis (weakness on one side of the body, affecting muscles and motor function).</p> <p>Record review of Resident #76's quarterly MDS assessment dated [DATE], indicated he had a BIMs score of 10, which indicated he had moderate cognitive impairment. Resident #76 required substantial/maximal for most ADLs including chair/bed-to-chair transfers. The MDS indicated Resident #76 was always incontinent of bladder and bowel.</p> <p>Record review of Resident #76's Care Plan last updated 01/29/25 reflected Resident #76 had an ADL self-care performance deficit with an intervention to encourage the resident to use bell to call for assistance. The care plan reflected Resident #76 was at risk for falls.</p> <p>During an observation and interview on 03/17/25 at 10:12 a.m., Resident #76's call light was on floor under the side of the bed. She said she could reach the call light. She said sometimes she had to holler and sometimes she tried to sit up to get it.</p> <p>During an observation and interview on 03/19/25 at 8:15 a.m., Resident #76 was in bed eating breakfast. Her call light was draped over the foot of her bed. She said she could not reach the call light if she needed it.</p> <p>During an interview on 03/19/25 at 10:03 a.m., CNA B said call lights should been to where residents could always reach them. She said all care givers were responsible for making sure residents have their call lights. She said not having a call light could lead to a fall risk or the resident might have an emergency.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/19/25 at 10:23 a.m., LVN M said everybody was responsible for making sure residents had their call lights. She said ultimately the CNAs provided care and they should be checking to make sure residents had call lights. She said a resident not having a call light did not have any way to call staff for help. She said it could cause them to try to get up and cause them to fall.</p> <p>During an interview on 03/19/25 at 12:56 p.m., the DON said CNAs and floor staff were responsible for making sure resident could reach their call lights. She then said everyone was responsible for keeping call lights in reach of residents. She said she would have expected for the residents to have had their call lights. She said a resident not having a call light might need something and not be able to get to staff.</p> <p>During an interview on 03/19/25 at 1:23 p.m., the Administrator said he just had in-serviced staff on call lights about making sure the call lights were visible and within reach . He said the call lights should be attached to the pillow or clothes so the residents could respond in a time of need. He said he would have expected each of the resident to have had their call light within reach.</p> <p>Record review of an In-Service Training Report for RNs, LVNs, and CNA dated 02/25/25 at 4:15 p.m. reflected, Please make sure (when you are doing rounds) that CALL LIGHTS are easily in reach and are clipped onto linens/night clothes/etc. Too many families (and) residents are complaining that the CALL LIGHT is not reachable. If you need clips - Let someone know . The In-Service was signed by 34 staff members.</p> <p>Record review of an Answering the Call Light facility policy dated 03/2021 indicated, .The purpose of this procedure is to ensure timely responses to the resident's requests and needs .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .</p> <p>Record review of an undated Certified Nurse Aide Standards of Clinical Practice facility policy indicated, .The CNA answer call lights promptly and assists residents as required and checks for call light in reach prior to leaving the room .</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on observation, interviews and record review, the facility failed to ensure residents had the right to a clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safety, for 1 of 4 halls (Hall 200) reviewed for a homelike environment.</p> <p>The facility failed to ensure Hall 200's armed exit door near the designated smoke area and laundry, was functioning correctly and not alarming on 3/17/25 and 3/18/25.</p> <p>This failure could place residents at risk for diminished quality of life in an environment that is not homelike.</p> <p>Findings included:</p> <p>During an observation on 3/17/25 at 11:11 a.m., the Hall 200 exit door was entered by a staff member. The Hall 200 exit door shut behind the staff member. The Hall 200 exit door started alarming. The staff member who entered the exit door was partially down the hall when the Hall 200 door alarmed. A housekeeping staff member securely shut the exit door previously entered by another staff member. The Hall 200 exit door stopped alarming.</p> <p>During an interview on 3/17/25 at 11:41 a.m., Anonymous Resident (AR) #1 said the Hall 200 exit door alarmed all day and night. AR #1 said the alarm was annoying and interrupted his/her sleep.</p> <p>During an interview on 3/17/25 at 4:15 p.m., Anonymous Resident #2 said Hall 200 was very loud. AR #2 said the exit door alarming got on his/her nerves.</p> <p>During an observation on 3/18/25 at 8:49 a.m., the Hall 200 exit door alarmed after a staff member entered the exit door. The staff member who entered the exit door was partially down the hall when the Hall 200 door alarmed. Another staff member securely shut the exit door previously entered by another staff member. The Hall 200 exit door stopped alarming.</p> <p>During an observation on 3/18/25 at 9:03 a.m., the Hall 200 exit door alarmed after a staff member exited the door. Another staff member securely shut the exit door previously exited by another staff member. The Hall 200 exit door stopped alarming.</p> <p>During an interview on 3/18/25 at 1:27 p.m., Anonymous Resident #3 said the Hall 200 exit door was the general smoking area used mostly by the staff. AR #3 said the alarm went off all the time. AR #3 said the weather changes made the exit door alarm more. AR #3 said the alarm had gone off for at least 10 minutes before someone stopped it. AR #3 said the residents who ate their meals on the hall, had to stop eating to turn off the alarm on the exit door. AR #3 said the alarm on the exit door interrupted his/her sleep and meals.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/19/25 at 10:00 a.m., CNA G said she had worked at the facility on and off for [AGE] years. She said she primarily worked the 200 hall. She said the facility fixed the Hall 200 exit door sometime last week. She said when staff went out of the door, the magnet did not latch and caused a loud beeping noise. She said a lot of the resident from room [ROOM NUMBER]-224 complained about the loud beeping noise. She said the loud beeping noise, from the door not latching good, had been going on since at least February 2025. She said when she came back full time to the facility in February 2025, the 200 hall exit door alarmed excessively. She said staff had been instructed to make sure the exit door was completely shut. She said a lot of staff said they were not going to make sure it was closed because maintenance needed to fix it. She said the exit door excessively alarmed all times of day and night. She said the excessive alarming probably affected the resident's sleep.</p> <p>During an observation on 3/19/25 at 10:25 a.m., a staff member exited the Hall 200 exit door. When the exited door closed, a motor sound was heard then a latching noise. The Hall 200 door did not alarm.</p> <p>During an interview on 3/19/25 at 12:51 p.m., LVN K said the Hall 200 exit door near the smoking area had been alarming a lot for about a year. She said it was the excessive beep noise was terrible and she felt bad for the residents. She said staff had been told to make sure the exit door was completely closed. She said a lot of the resident had complained about the exit door alarming excessively. She said the excessive alarming affected the resident's mood and sleep.</p> <p>During an interview on 3/19/25 at 2:10 p.m., the Maintenance Supervisor L said the Hall 200 exit door had intermittent issues for the last 4 months. He said about 4 months ago, one of the ADONs reported to him the maglock (is a locking device that consists of an electromagnet and an armature plate) was ripped off the door. He said after that incident, the 200 hall exit door started excessively alarming. He said he tried to fix the door himself several times. He said he also tried to adjust the door several times. He said the 200 hall exit door was not locking causing it to alarm. He said when the exit door alarmed excessively, it was all the time, day, and night. He said he only knew of one resident complaining about the excessive alarming. He said the facility had called out to a company to look at the exit door. He said the company came out last Friday (3/14/25) and Wednesday (3/19/25) to look at the 200 hall exit door. He said the door was completely fixed now.</p> <p>During an interview on 3/19/25 at 2:15 p.m., the DON said a company was just at the facility fixing the 200 hall exit door. She said she knew at a period of time, the exit door had issues. She said no residents had complained to her about the excessive alarming. She said the noise level would be loud and disruptive if the Hall 200 exit door was excessively alarming. She said the facility tried to provide the resident a homelike environment, but there was going to be noise.</p> <p>During an interview on 3/19/25 at 3:23 p.m., the Administrator, with the VP of Operations present, said the facility had an issue with the Hall 200 exit door alarming excessively. He said the issue with the Hall 200 exit door had not been for a long period. He said the Maintenance staff were aware of the issue and attempted to fix it. He said there was a period of trial and error trying to get the exit door to stop excessively alarming. He said the staff were instructed to secure the exit door. He said the resident did complain about the excessive alarming.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of an undated facility Quality Assurance and Performance Improvement policy which indicated .the community is designed, constructed, equipped, and maintained to protect the health and safety of resident .the accommodation's facilities are expected to make to satisfy the needs of its residents .sound . of particular concern to comfortable sound levels is the resident's control over unwanted noise .</p>		