STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676025	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Leaves Nursing and Rehab Inc	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm 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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F 0689 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 observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #1) reviewed for accident hazards. CNA A and CNA B failed to lock Resident #1's bed wheels before they raised Resident #1's bed, before they performed peri-care (removal of soiled brief, the cleaning of the genital/ anal areas and placement of a clean brief which required turning Resident #1 side to side in the bed) and pulling Resident #1 up in the bed on 10/23/25. This failure could place residents at risk of significant injury.Findings included: Record review of Resident #1's face sheet, dated 10/23/25, indicated she was 81- years- old female who was re-admitted to the facility on [DATE]. Resident #1 had with diagnoses which included hemiplegia (paralysis) and hemiparesis (weakness) following stroke affecting the right dominant side of the body, generalized muscle weakness, generalized osteoarthritis (cartilage that lines the joints is worn down and bones rub against each other. It causes joint pain, stiffness, swelling and reduced range of motion) dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking) aphasia (disorder that can impact speech, as well as the way a person understands both spoken and written language). Record review of Resident #1's MDS, dated [DATE], indicated Resident #1 had no speech, rarely/never made herself understood and rarely/never understood others. Resident #1 had short-term as well as long-term memory problems and had severely impaired cognitive skills for daily decision making. Resident #1 was completely dependent on staff for toileting and required substantial/maximal assistance with eating, oral hygiene, showering, dressing the upper and lower body, putting on/ taking foot wear and personal hygiene. Resident #1 was completely dependent on staff for chair/bed-to-chair transfers and toilet transfers. Resident #1 required substantial/maximal assistance for all other transfers, except sit to stand transfer and walking 10 feet which were not performed due to medical condition or safety concerns. Resident #1 was incontinent of bowel and bladder. Record review of Resident #1's care plan, revised on 8/18/25, indicated Resident #1 was at risk for falls. The care plan interventions included follow facility fall protocol. During an observation on 10/23/25 at 11:35 AM, CNA A and CNA B provided Resident #1 with incontinent care and repositioned her in bed. CNA A and CNA B unlocked the bed wheels and moved Resident #1's right side away from the wall. CNA B stood on the right side of the bed and CNA A stood on the left side of the bed. CNA B and CNA A raised Resident #1's bed and performed incontinent care, turning Resident #1 to the right and left of the bed while the wheels of the bed were not locked. CNA B and CNA A then lifted (using the draw sheet) Resident #1 higher in the bed. The wheels remained unlocked and the bed moved gently as they (CNA A and CNA B) moved Resident #1. During an interview on 10/23/25 at 11:50 AM, CNA B was asked if she should have done anything differently during incontinent care and repositioning of Resident #1. CNA B looked at the bed wheels of Resident #1's bed and said we forgot to lock the bed. CNA B said the bed wheels should have been locked before the bed was raised, before the incontinent care (which required turning Resident #1 side to side) and before raising her up in the bed. CNA B said not ensuring the bed wheels were locked placed Resident #1 at risk of falling out of bed and also placed the staff at risk of injury. During an interview on 10/23/25 at 11:53 AM, CNA A was asked if she should have done anything differently during the incontinent care and repositioning of Resident #1. CNA A looked at the bed wheels of Resident #1's bed and said she forgot to lock the bed. CNA A said before turning Resident #1 side to side, in the bed and before raising Resident #1 up in the bed she (CNA A) should have ensured the bed wheels were locked. CNA A said not ensuring the bed wheels were locked could have caused the bed to slide during the repositioning and could have resulted in Resident #1 falling out of the bed. During an interview on 10/23/25 at 12:39 PM, the DON said CNA A and CNA B should have double checked to ensure the bed wheels were locked before moving and repositioning Resident #1. The DON said staff had to lock the bed before providing care to any resident while they were in bed and before repositioning any resident in the bed. The DON said the CNAs body weight or the resident's body weight shifting while the bed was not locked could result in a resident falling out of the bed or staff falling themselves. During an interview on 10/23/25 at 1:20 PM, LVN D said CNA A and CNA B should have ensured the bed wheels were locked before moving the resident in bed. LVN D said not ensuring the bed wheels were locked before moving Resident #1 could have caused her to fall out of the bed and also put the CNAs at risk of injury. During an interview on 10/23/25 at