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	01/16/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 4 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's comprehensive care plan was implemented on 1/7/2026 and 1/10/2026 by having two people provide incontinent care to Resident #1.This failure could place residents at risk of not receiving care and services to meet individualized medical and nursing needs.Findings included: Record review of Resident #1's Face Sheet, dated 1/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (her right side was weak and paralyzed), and contracture of the left hand (fingers and wrist stuck in a fixed position). Record review of Resident #1's MDS assessment dated [DATE] indicated that Resident #1 did not speak and required substantial assistance for all functional needs including toileting, hygiene, transfer and dressing. Record review of Resident #1's Care Plan dated 11/25/2025 indicated that Resident #1 was bedfast and required two staff to assist with all personal care needs including bathing, toileting, bed mobility, dressing, eating and transfer. Record review of Resident #1's Progress Note dated 11/25/2025 indicated that Resident #1 required two people to assist her with toileting. Record review on 1/15/26 at 12:30 p.m. of Resident #1's ADL Sheet that was not dated but was located in the binder at the nurse's station at the time of this review indicated that Resident #1 was to have two people in the room any time that care was provided. Observation on 1/15/26 at 5:15pm of video of Resident #1's bedroom recorded on 1/7/2026 at 2:31 p.m. showed CNA B completing incontinent care on Resident #1. Resident #1's bed was raised and pulled away from the wall while CNA B repositioned Resident #1 in bed. CNA B adjusted a fabric incontinent pad under Resident #1 while she was rolled on her right side, rolled Resident #1 from her right side onto her back, placed a pillow under her legs, and placed a wedge pillow by her right side. The only other individual observed in the recording present in Resident #1's room was Resident #1's visitor who was positioned in a chair against the opposite wall from Resident #1's bed. The visitor is not assisting with care and is observed watching and then operating her phone. Observation on 1/16/26 at 7:30am of video of Resident #1's bedroom recorded on 1/10/2026 at 3:49 p.m. showed CNA C performing incontinent care on Resident #1. Resident #1's bed was raised and against the wall. CNA C unfastened Resident #1's incontinent brief and placed it between Resident #1's legs. CNA C placed her hands behind Resident #1's knees and pulled her towards her to push the incontinent brief under her. CNA C rolled Resident #1 on her right side towards the wall and held her in that position with her right hand while she completed incontinent care on Resident #1. There were no other staff observed in the video present in Resident #1's room assisting with care. Record review of Grievance/Concern Report dated 1/15/2026 reflected a statement recorded by the DON which includes information that CNA B had conducted incontinent care by herself on 1/7/2026 as the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family member of Resident #1 was yelling at her to change her and threatened to call State on her if she did not change Resident #1. This document also indicated that an in-service was conducted on this date regarding safety of the residents. Record review of an undated statement given by CNA B reflected it included a hand-written statement signed by CNA B that on 1/7/2026 she went to change Resident #1 and when she went to get help to change the resident the family member began yelling at her, recording with her cell phone and questioning her with attitude. Record review of in-service entitled Safety and dated 1/15/2026 reflected It is vital that you keep yourself and residents safe during ADLs. If a family member is yelling or demanding you perform ADLs on a resident that are unsafe for you or the resident, step out of the room and call for help. You may respectfully decline to perform unsafe actions. Get another staff member or member of nurse management to help you. Report any incident of a family member pressuring you to perform unsafe actions to the DON. This document was signed by CNA B and was ongoing at the time of the review. During an interview on 1/15/2026 at 3:48 p.m. LVN A stated that the CNAs use the ADL binder and POC, a section in PCC, which is the electronic medical record, to ascertain the information regarding the resident needs or requirements for tasks such as how many staff need to assist with the task. She stated that it would not be appropriate to complete a two-person task by yourself as the directive is in the care plan for a reason and it is typically for resident safety. She stated that the nurses are always willing to assist the CNAs when they need help. During an interview on 1/15/2026 at 3:55 p.m. the DON stated that Resident #1's care plan reflects that two staff are to be in the room when any tasks are being completed for Resident #1. She stated that this was changed after Resident #1 fell out of bed when being changed by one CNA several months back. She stated that regardless of the reason it is in the care plan that it should be followed by staff and that she would implement an in-service on this issue to ensure that staff understand. During an interview on 1/16/2026 at 8:30 a.m. the DON reviewed video footage of Resident #1's bedroom on 1/7/2026 and 1/10/2026 which showed two incidents of a single staff checking and changing Resident #1 alone. She stated that the staff in the video on 1/7/2026 was CNA B and the staff on 1/10/2026 was CNA C. The DON stated that CNA B and CNA C should not have changed Resident #1 by themselves and should have asked for help. She stated that she began the in-service to correct this issue yesterday on 1/15/2026 and was under the impression that it was one staff who had done this as CNA B had stated that she had done this on 1/7/26 when the family member of Resident #1 was in the room and began yelling at her to change Resident #1 after CNA B told her that she would go and get help. DON stated that the risk involved in changing any resident that requires more assistance would be injury to the resident or staff during the task and that nurses should always be willing to assist if the CNAs are busy with other tasks. During an interview on 1/16/2026 at 11:13 a.m. CNA B stated that she has been a CNA at the facility for almost two years. She stated that on 1/7/26 she changed Resident #1 by herself because the family member of Resident #1 was in the room and asked her to be changed. CNA B stated that she informed the family member that she would go and get help, and the family member yelled at her and told her to change her immediately. CNA B stated that to avoid any further conflict, she went ahead and changed Resident #1 without assistance. CNA B stated that the DON has since talked to her about it and informed her that she needs to step out and ask for help when the family yells at her and let the administration know so that they can intervene. CNA B stated that she was trying to get Resident #1 changed so that there would be no question that she did the check and change as directed and to keep the family happy. CNA B stated that she understands that she should have waited for help as this places the resident and her at risk of avoidable injury and that she would do so moving forward. During an interview on 1/16/2026 at 11:24 a.m. CNA C stated that on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/10/2026 she changed Resident #1 with her being the only staff in the room as she had asked for help but everyone was busy at the time. CNA C stated that often Resident #1 is dry and clean when she checks and changes but due to the family concerns about Resident #1 being changed, she will often go ahead and change her. CNA C stated that she knew that the ADL sheet indicated that two staff are required for changing Resident #1 but she felt as though she could do it safely and not have to keep Resident #1 waiting and ensure that the family saw that staff were checking on their relative. Record review of the undated facility policy entitled Routine Resident Care indicated that residents should receive the necessary assistance to maintain good grooming and personal.hygiene.care is taken to maintain resident safety at all times.11. Staff members should follow the resident plan of care and update with identified resident changes.