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	04/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident #1) reviewed for Resident Rights. The facility failed to ensure Resident #1 was treated with respect and dignity when CNAs spoke rudely and disrespectfully to him. This failure could place residents at risk of psychosocial harm, self-isolation, and diminished quality of life.Findings included: 1.Review of the admission Record for Resident #1 dated 4/22/26 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of prostate cancer, secondary bone cancer, and brain cancer. Review of the significant change MDS assessment for Resident #1 dated 3/6/26 indicated he had moderately impaired cognition with a BIMS score of 7. He required substantial/maximal assistance with all ADLs. He was always incontinent of bowel and bladder. He had moderately impaired vision. Review of the care plan for Resident #1 dated 2/11/26 indicated he had an ADL self-care performance deficit related to generalized weakness. Interventions were in place including ensuring and promoting resident self-esteem and dignity while performing ADL care and praise all efforts at self-care. During an interview and observation on 4/22/26 at 10:40 a.m., Resident #1 was lying in bed in his room, he appeared to be clean and well groomed. There were no visible marks, bruising, or skin tears on his skin. There was a mattress and a fall mat both positioned below the bed in resident's room. Resident #1 said he had multiple negative incidents with CNAs on the night shift. Resident #1 said he couldn't recall the names, but one CNA always talked bad to me. Resident said the CNA was always rude to him, telling him things like you peed all over yourself, you know better than that and you got yourself down there, you can get yourself up when the resident rolled off the bed. Resident #1 said he didn't like to complain because he feared the treatment would get worse if he complained. Resident #1 said it made him feel bad to be talked to in that manner. Resident #1 said he had complained to his family about the treatment. Resident #1 said he had not complained to the facility administration about the treatment. Record review of a grievance report dated 3/9/26 indicated RP E filed a grievance concerning CNA behavior. The grievance alleged that during her visit staff came into the room around 8:00 p.m. and did not announce their names or their purpose. CNAs told resident turn toward the wall and proceeded to talk about how he peed and messed up the covers and how he knows what he's doing when he puts himself on the floor. RP E stated in the grievance that Resident #1 told her aides frequently spoke to him like that, but he wanted to keep the peace. The grievance form identified an action taken of Resident #1 being interviewed who stated the aides cut up with him but his family member thinks everything is a big deal. Resident #1 reportedly said he didn't feel mistreated, and some aides were short with him, but most would stay and talk. Response to results of investigation indicated RP E insisted the care is not up to par and that the aides are all rude to him, but if he doesn't have a problem with it, she is satisfied During an interview on 4/22/26 at 12:45 p.m., RP E said Resident #1 frequently complained about his treatment at the facility to her. RP E said the resident frequently rolled out of the bed onto a mattress positioned on the floor. RP E said during a (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visit, Resident #1 was lying on the floor having rolled off his mattress. RP E said CNAs came into his room without knocking or announcing their presence. RP E said the CNAs talked to him like a drill sergeant. RP E said they came in and told him to turn toward the wall. RP E said resident was on the floor and the CNAs told him he had to get up and into the bed in order to be changed. RP E said CNAs made comments that Resident #1 knew what he was doing putting himself down there. RP E said their tone throughout was rude and disrespectful. RP E said she filed a grievance at the facility, but it didn't do anything. RP E said Resident #1 continued to complain about the treatment specifically the night shift. RP E said she was looking into taking Resident #1 out of the facility. RP E was able identify the CNA as CNA C. During an interview on 4/22/26 at 1:05 p.m., CNA A said Resident #1 complained to her previously that CNA staff on night shift were rude to him. CNA A said she didn't report the complaint to the ADM because there was no current ADM at the facility at the time of the incident which was approximately 2 months ago. CNA A said she did report the incident to a charge nurse who was no longer employed at the facility and had been gone approximately 2 months. During an interview on 4/22/26 at 2:15 p.m., CNA C said she worked the nightshift at the facility. CNA C said she had not witnessed anyone being rude or rough with Resident #1. CNA C said Resident #1 had behaviors which included rolling out of bed and pulling out his penis and urinating on the bed/mattress. CNA said she could not change resident when he was on the mattress on the floor due to her own injuries. CNA C said she had never spoken to Resident #1 rudely or disrespectfully. CNA C said she had not witnessed any staff members talking rudely or disrespectfully to Resident #1. Resident #1 said these behaviors were care-planned for the resident. CNA C said she always went into the room to provide care with another CNA as required. During an interview on 4/22/26 at 2:25 p.m., CNA D said she worked the nightshift at the facility and worked with CNA C. CNA D said she had not witnessed staff members being rude or disrespectful to Resident #1. CNA D said she had never spoken to Resident #1 in a rude or disrespectful manner. CNA D said CNAs were required to provide care of staff members at all times for Resident #1. During an anonymous interview on 4/21/26 at 2:40 p.m. , a resident at the facility who resided on the same hall as Resident #1, said that CNAs on the night shift had been rude and disrespectful towards them, but the resident said they did not want to discuss the matter or call names at that time. During an interview on 4/22/26 at 2:55 p.m., RP F said Resident #1 had complained frequently about staff being rude and/or rough with him. RP F said she had reported the concerns to the facility ADM and was told they should get a camera for Resident #1's room. RP F said that wasn't an acceptable response to her concerns. During an interview on 4/23/26 at 10:19 a.m., RP G said Resident #1 frequently complained about his treatment at the facility. RP G said Resident #1 said the staff talk bad to him. RP E said she had witnessed staff members talking roughly to the resident, telling him he knew what he was doing when he rolled out of bed or urinated in the bed. RP G was unable to specifically identify a staff member. During an interview on 4/23/26 at 12:05 p.m., the DON said she had not been notified of any previous instances of staff being rude with Resident #1. The DON said if Resident #1 reported the allegation to CNA A, the report did not make it to administration. The DON said if she had received the report, she would have thoroughly investigated the incident and reported it to the state if applicable. The DON said it was her expectation that each resident was treated with dignity and respect. During an interview on 4/23/26 at 12:15 p.m., the ADM said it was never reported to administration that Resident #1 had complained about the nightshift CNAs to facility staff. The ADM said it was not appropriate to speak to residents in a disrespectful or scolding manner such as telling them you know better than that following incontinent episodes or rolling out of bed. The ADM said they had responded to the grievance by assigning staff members to care for resident at a time. The ADM said he had discussed the concerns with this resident's family and had offered them the option of putting a camera in the room. The ADM said the family had not opted todo that. The ADM said going forward he planned to in-service staff on customer service and speaking to residents with respect. Review of the facility's policy titled Statement of Resident Rights indicated You have the right to.be treated with courtesy, consideration, and respect.