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	05/07/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for the facility's only discontinued narcotic drug storage reviewed for reconciliation. The facility failed to ensure they had a log of the discontinued narcotic drug storage on 05/05/26. This failure could place residents at risk for missing medications and medication errors.Findings included: During an observation and interview on 05/05/26 at 01:55PM, the Acting DON took this surveyor to observe the discontinued narcotic drug storage. She unlocked the door and opened it, then unlocked the cabinet and opened it. There were several narcotic medication cards inside. This surveyor picked out 3 cards at random and checked the count sheet attached to each one, and each one had accurate counts. The acting DON said however, that she did not have a log for the medications in that cabinet. She said the previous DON was supposed to help her make a log of the discontinued narcotic drug storage. She said they last had a drug disposal with the consultant pharmacist on 03/25/26. She said she did not have access to the software the previous DON used to log the controlled medications ready for disposal. She said she did not have a log to check the medications against if they went missing. She said she was the only person with a key to the discontinued narcotic drug storage. During an interview on 05/07/26 at 09:16AM, ADON C said she did not handle the discontinued narcotic drug storage. She said the DON should have had a log of the discontinued narcotic drug storage. During an interview on 05/07/26 at 09:23AM, the Acting DON said she did not have access to the scanning system for logging drug destruction. She said after this surveyor check the discontinued narcotic drug storage the other day she went and checked all the counts and made sure they were correct. She said before the previous DON left, she checked the list then and made sure there were no discrepancies. She said that was one day in the previous week. She said there was no risk to this because she was the only one with the key to the discontinued narcotic drug storage. During an interview on 05/07/26 at 10:06AM, the Administrator said they should have a log for the drug destruction narcotics. He said someone could take one of the medications, and they would be unaware it was missing. Record review of the facility's undated policy, Discarding and Destroying Medications, reflected: .Medications are to be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled medications.6. Should the community contract with a DEA-registered collector, controlled substances may be disposed of in an authorized collection receptacle located at the community.a. If a resident is transferred to another community, or dies while he or she is in lawful possession of controlled substances, the community may dispose of the controlled substance(s) by depositing in the authorized on-site collection receptacle and recorded on the drug destruction log.b. Disposal of controlled substances should take place immediately (preferably no longer than three days) after discontinuation of use by the resident.*As in the locked box in the bottom of medication cart or [NAME] cabinet in the medications room.

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 5 of 13 residents reviewed for care plans. (Resident #41, Resident #84, Resident #09, Resident #98, and Resident # 108)The facility failed to include in the care plan services Resident # 41 was a 2-person transfer with a Mechanical lift.The facility failed to include in the care plan services refused by Resident # 84 (left hand splints and dietary recommendations).The facility failed to develop and implement Resident #9's care plan for upper and lower extremity limited ROM.The facility failed to develop and implement Resident #98's care plan for wandering.The facility failed to develop and implement Resident #108's care plan for falls.These failures could place residents at risk of not having their individualized needs met in a timely manner and could result in a decline in physical well-being and care needs not being addressed. Findings included: 1.Record review of Resident #41's face sheet dated 05/5/2026 indicated Resident #41 was an [AGE] year-old female and admitted on [DATE] and with diagnoses including metabolic encephalopathy (a reversible brain dysfunction caused by systemic metabolic disturbances, leading to confusion, altered consciousness, and neurological symptoms), Type II Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels in the blood), Hypertensive heart disease with heart failure (a chronic high blood pressure forces heart to work harder to pump blood through narrowed stiffened arteries, which increases cardiac workload and oxygen demand), hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood), and muscle weakness (occurs when muscles cannot generate the expected force, and it can result from temporary fatigue, nutrient deficiencies, or underlying medical conditions). Record review of Resident #41's admission MDS assessment dated [DATE] indicated Resident #41 was usually understood and usually had the ability to understand others. The MDS indicated Resident #41 had a BIMS score of 08 which indicated she was moderately cognitively impaired. Resident #41 required substantial/maximal assistance for transfers and most ADLs. The MDS indicated Resident #41 had a fall history in the last month prior to admission to facility. Record review of Resident #41's care plan initiated on 3/3/2026 indicated Resident #41 had an ADL self-care performance deficit related to generalized weakness and recent hospitalization. Interventions included: encourage resident to use call bell to call for assistance, requires 2 staff assist to move between surfaces and resident utilized a wheelchair for mobility and required 1 person assist for locomotion. During an observation and interview on 5/5/2026 at 8:36 AM, Resident #41 was observed sitting up in a wheelchair with a gait belt around her waist. Resident #41 said it was scary when the CNAs get her back in bed because they do not use the mechanical lift. She said one CNA gets behind her and grabs her from under her arms and the other CNA swings her legs back in the bed. Resident #41 denied any falls. Resident #41 said she could not bear weight. Resident #41 said 2 therapists get her up in the mornings with a gait belt. During an observation on 5/5/2026 at 3:01 PM, observed CNA M and CNA N transferring Resident #41 using the mechanical lift. CNAs properly used the mechanical lift and safely transferred from (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair to bed. During an interview on 5/6/2026 at 12:14 PM, PTA E said Resident #41 could stand and was a 2-person transfer. She said transfer Resident #41 by herself with a gait belt. During an interview on 5/7/2026 at 9:21 AM, CNA F said Resident #41 was a 2-person transfer. She said therapy could get her up with one person and she used the mechanical lift with her partner. CNA F said sometimes Resident #41 could not stand. CNA F said therapy was the only one that used the gait belt to assist Resident #41 back to bed. CNA F said she had not observed any CNAs using the gait belt. CNA F said she looks at the care plan if the resident needed something of which she was not sure. She said she checked the care plan daily. CNA F said if the resident were not transferred properly, her legs could give out and lose her balance causing a fall. During an interview on 5/7/2026 at 9:58 AM, RN G said Resident #41 was not weight bearing and the staff used the mechanical lift. RN G said Resident #41 was a 2-person transfer on the care plan. RN G said the mechanical lift was not documented on Resident #41's care plan. RN G said the CNAs received an ADL sheet that indicated Resident #41 was a 2-person transfer and mechanical lift. RN G said the therapist cannot transfer with one person and tell other staff to transfer with 2-person. She said therapy would need to assist Resident #41 with a mechanical lift as well. RN G said the MDS nurse was responsible for updating the care plan. RN G said a resident could fall resulting in injury if the wrong transfer technique was used. During an interview on 5/7/2026 at 10:50 AM, the MDS nurse said Resident #41 did not have a mechanical lift on her care plan. The MDS nurse said Resident #41 was care planned for 2-person assist between surfaces and wheelchair. The MDS nurse said the mechanical lift should be on the care plan. She said staff and CNAs usually tell her when a resident requires a mechanical lift. She said she was responsible for putting the mechanical lift on the care plan. MDS nurse said therapy was involved with the care plan. The MDS nurse said the therapist should also follow the care plan. She said if the resident could stand and therapy used 2-person for transfer, the resident could fall or get hurt if transfer was done improperly. During an interview on 5/7/2026 at 11:45 AM, ADON C said Resident #41 was a 2-person assist. ADON C said the CNAs can get Resident #41 up without issues. ADON C said Resident #41 was not a mechanical lift resident and she did not see any weight bearing restrictions. ADON C said if the CNAs were using the mechanical lift, it should be on the care plan. ADON C said the MDS nurse was responsible for putting mechanical lift on the care plan. ADON C said she thought therapy would need to follow the care plan. She said the therapist would need to see if Resident #41 has increased or decreased possibilities to stand. ADON C said the resident would be at risk for falls if 2 CNAs transferred her improperly. During an interview on 5/7/2026 at 12:02 PM, the DON said she expected the care plan to reflect the mechanical lift. The DON said it could be confusing to the CNAs if the care plan indicated 2-person transfer and not mechanical lift. The DON said the IDT and evaluation from therapy made the determination. The DON said the therapy must follow the care plan. The therapies plan of care could be different. She said, I would have to see what therapy notes indicated. The resident could get hurt. During an interview on 5/7/2026 at 12:19 PM, ADM said he expected the mechanical lift to be care planned. The IDT (Interdisciplinary Team) was responsible for ensuring mechanical lift was on the care plan. A resident could have an improper transfer causing a potential to have an incident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #84's face sheet dated 5/5/2026 indicated Resident #84 was a [AGE] year-old male who was readmitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy (a type of cerebral palsy that causes muscle stiffness and weakness on one side of the body, usually due to brain damage occurring before, during or shortly after birth), hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood), acquired absence of left and right leg above the knee (a condition where an individual has lost part of leg), dysphagia (difficulty swallowing, can manifest through various symptoms), and hypertensive chronic kidney disease (a condition where high blood pressure damages the kidneys, impairing their ability to filter blood effectively and in turn, kidney damage can further elevate blood pressure). Record review of Resident #84's quarterly MDS assessment dated [DATE] indicated Resident #84 was sometimes understood and usually had the ability to understand others. The MDS indicated Resident #84 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #84 did not reject care. The MDS indicated Resident #84 had dysphagia (difficulty swallowing, can manifest through various symptoms) and had a contracture (occurs when soft tissues such as muscles, tendons, ligaments, or fascia become stiff and shortened due to scarring or fibrosis, reducing the hand's range of motion and potentially causing deformities) of left hand. The MDS indicated Resident #84 did not have a splint. During an interview on 5/7/2026 at 9:13 AM, CNA F said she has been at the facility since the end of March. CNA F says the resident will tell her what kind of care he needs. CNA F said he does not wear a splint on his left arm. CNA F said therapy puts on splints for residents. CNA F said Resident #84 was on a regular diet. He will tell you what he wants to eat. CNA F said they did not have access to the care plan because her log in was not working. She said she had notified HR and ADON C and a nurse on the floor. CNA F said she was not an agency CNA. CNA F said she thought the nurse puts together the care plan. CNA F said she and her partner document on the same sign-in sheet. CNA F said she would want to know if a resident was on a special diet if a resident refused a special diet but had rights to have the food. She said she would check with a nurse to see if a resident needed a splint. CNA F said a resident could receive care that they were not supposed to, impacting their independence. CNA F said ADON C was responsible for ensuring care plans were being followed. During an interview on 5/7/2026 at 9:42 AM, RN G reviewed Resident #84's care plan. RN G said she never looks at the care plan. RN G said Resident #84 did not have orders for splints. RN G said the care plan indicated how to care for the resident. RN G said it should be care planned if he had splints but said she looks at the orders. RN G said the care plan did not have resident refusal to wear splints. RN G said his diet was regular with thin liquids. RN G said it does not mention anything about mechanical soft diet and did not have a care plan indicating resident had signed a waiver for regular diet. RN G said she did not see a waiver. RN G said the care plan should have been updated indicating Resident was ordered a mechanical diet but Care plan showed Regular. RN G said she was unaware the resident had a waiver signed. RN G said the MDS nurse was responsible for updating the care plan. It should have been updated when the order was received. RN G said the resident could potentially get the wrong diet. It could be harmful to the resident if he did not have the waiver signed. During an interview on 5/7/2026 at 10:50 AM, the MDS Nurse said Resident #84 does not have splint on his care plan. She said if a resident had splints but refused, it should be care planned. The MDS nurse said she did not have refusal for splints on the care plan. The MDS nurse said Resident #84 was on a regular diet. The MDS nurse said the refusal for mechanical soft diet with waiver in place should be on the care plan. She said she was responsible for updating the care plan. The MDS nurse said he could choke and he does cough a lot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/2026 at 11:38 AM, ADON C said Resident #84 does not want to wear a splint on his left hand and it should be on his care plan. ADON C said Resident #84 reviewed care plan and said he did not have hand splint refusal on his care plan. ADON C said she did not see anything about his refusals on the care plan. She said the splint refusal should have been put on the care plan since his admission. She said the MDS nurse was responsible for putting the refusals on the care plan. ADON C said she thought the NP's notes needed to be retracted to reflect the regular diet with refusal for special diet and said Resident #84 understood the risk of doing so. ADON C said the purpose of care plan was to ensure the residents' needs were met and followed, and their wishes and rights were in place. ADON C said there would be no impact on the residents. During an interview on 5/7/2026 at 11:59 AM, the DON said she expected the refusal of splints and diet to be on the care plan. She said the IDT was responsible for the care plan. She said the staff talked about the care plan in the morning care plan meetings. The DON said the staff address concerns and updates during those meetings. During an interview on 5/7/2026 at 12:19 PM, the ADM said Resident #84 wants what he wants. The ADM said refusal of care areas such as diet and splints should be care planned. He said the IDT team was responsible for putting the refusals on the care plan. The ADM said he did not know how it could negatively impact a resident but said it was the resident's rights. 3.Record review of Resident #09's undated facesheet revealed she was a [AGE] year-old female that admitted on [DATE] with the diagnoses of CVA (the medical term for a stroke), dysphagia (difficulty swallowing), and anemia. Record review of Resident #09's quarterly MDS assessment dated [DATE] revealed Resident #09 had short and long term memory impairment. She required substantial (helper does more than half the work) assistance with dressing and bed mobility and she was dependent for oral care and eating. Resident #09 had limited range of motion to upper and lower extremities on one side of her body. Record review of Resident #09's EHR on 05/07/2026 at 10:00 a.m., revealed no care plan for limited range of motion. During an observation on 05/07/2026 at 10:15 a.m., Resident #09 had hemiplegia (severe, one-sided paralysis caused by brain or spinal cord injury, affecting the face, arm, and leg on either the left or right side) on right side of her body. 4.Record review of Resident #98's undated facesheet revealed she was a [AGE] year-old female that admitted on [DATE] with the diagnoses of dementia (an umbrella term for a decline in cognitive function—including memory, language, and problem-solving—severe enough to interfere with daily life), bipolar disorder (a chronic mental health condition characterized by severe mood swings, ranging from extreme highs [mania or hypomania] to lows [depression]), and diabetes type II (a chronic metabolic disorder characterized by high blood sugar [glucose] levels, resulting from insufficient insulin production or the body's inability to use insulin effectively). Record review of Resident #98's annual MDS assessment dated [DATE] revealed Resident #98 had a BIMS score of 09, which indicated moderate cognitive impairment. She required supervision with ADLs. Resident #98 had behaviors of wandering 1 to 3 days a week and her wandering put her at risk of getting into dangerous places. (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #98's EHR on 05/07/2026 at 10:20 a.m., revealed no care plan for wandering. 5. Record review of an undated facesheet revealed Resident #108 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of dementia (an umbrella term for a decline in cognitive function—memory, thinking, and reasoning—severe enough to interfere with daily life), history of falls, and unsteadiness on feet. Record review of a quarterly MDS dated [DATE] revealed Resident #108 had a BIMS score of 03, which indicated severe cognitive impairment. Resident #108 had no behaviors coded. Resident #108 required substantial assistance (helper does more than half) for toileting and showers. Resident #108 required supervision for dressing and personal hygiene. The MDS revealed Resident #108 had a fall while a resident since the last MDS assessment was completed. Record review of the facility Incident and Accident Log dated 05/06/2026 revealed Resident #108 had falls on 10/11/2025 and 12/08/2025. Record review of Resident #108's EHR on 05/07/2026 at 10:30 a.m., revealed no care plan for falls on 10/11/2025 or 12/08/2025 were developed or implemented. During an interview on 05/07/2026 at 11:00 a.m., the MDS Coordinator stated it was her sole responsibility to create care plans. She stated she care planned all items that triggered as a care area that needed to be addressed on the MDS. She stated she care planned major diagnoses and medications and acute things like falls and weight loss. She stated she should have care planned Resident #09's limited range of motion to her right side because it was marked on the MDS and it was an important detail for care givers to know when caring for her. The MDS Coordinator stated Resident #98 was coded for wandering at times and that should have been care planned, as well. She stated she was unsure why Resident #108's falls from October and December were not care planned. The MDS Coordinator stated care planning was important because it was a map on how to treat each resident individually. During an interview on 5/7/2026 at 11:15 a.m., the DON said she expected the falls, wandering and limited range of motion on the care plan. She said the IDT was responsible for the care plans. She said the staff talked about the care plans in the morning care plan meetings. The DON said the staff address concerns and updates during those meetings. During an interview on 5/7/2026 at 12:00 p.m., the Administrator stated he expected all specific care areas that can affect the residents to be care planned. The Administrator stated he did not know how not having something care planned could negatively impact a resident but said it was the resident's rights. Record review of the facility's policy titled Care Plan Process undated indicated .Purpose: The facility IDT team utilizes the CMS requirements of RAI as policy for reviewing and revising care plans.Responsible Disciplines.IDT members, resident, Resident Representatives.Steps: Care Plan Completion.Care plan completion based on the CAA process is required for OBRA- required comprehensive assessment.After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors to the problems.the IDT evaluates the information gained.The care plan completion date must be either later than or the same (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date as the CAA completion date.The MDS completion date must be earlier than or the same sate as the care plan completion date.For Annual assessments.Review of the CAA when the MDS is complete for these assessment types should raise questions about the need to modify or continue services. A new care plan does not need to be developed after each Annual assessment.Residents' preferences and goals may change throughout their stay, therefore the IDT should have ongoing discussions with the resident and resident representative, and staff member, so that changes can be reflected in the comprehensive assessment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to act upon the recommendations of the pharmacies report of irregularities for 3 of 7 residents (Resident #1, #88 and #108) reviewed for (DRR) Drug Regimen Review. 1.The facility failed to ensure a proper rationale was given for not following the pharmacy consultant's recommendation for a trial dose reduction for Resident #1's Oxcarbazepine (an anticonvulsant medication sometimes used off-label as a mood stabilizer), Trazodone (an antidepressant commonly used to treat major depressive disorder, anxiety disorders, and insomnia), and Alprazolam (a benzodiazepine used to treat anxiety disorders, panic disorders, and anxiety associated with depression). 2.The facility failed to ensure Residents #88 and #108 received gradual dose reduction attempts to determine whether the psychotropic medication could be decreased or discontinued. These failures could place residents at risk from maintaining their highest practicable level of physical, mental, and psychosocial well-being, and could place them at risk for adverse consequences related to medication therapy.Findings included: Record review of Resident #1's face sheet indicated she was a [AGE] year-old female that admitted [DATE] with a readmission date of 1/23/2026. She had diagnoses that included: Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life, going beyond temporary stress), unspecified depression (significant depressive symptoms, such as persistent sadness, low energy, or hopelessness), and chronic migraine (neurological disorder defined by headaches occurring on 15 or more days per month for over 3 months). Record review of the quarterly MDS dated [DATE] indicated Resident #1 had clear speech, understood others and was understood by others. She had a BIMS score of 15 indicating she was cognitively intact. The MDS indicated she took an antianxiety, antidepressant, and an anticonvulsant currently. Record review of the undated care plan indicated Resident #1 was on an antidepressant and was to be monitored for behavior and side effects of the medication. The care plan indicated she was on an antianxiety medication related to anxiety disorder, side effects and effectiveness should be monitored. The care plan indicated Resident #1 had seizure disorder and medications should be administered per MD orders. Record review of Resident #1's physician's orders indicated: -2/2/2026 - Alprazolam oral tablet 0.5 mg, give 1 tablet by mouth at bedtime for anxiety -2/2/2026 – Oxcarbazepine oral tablet 150 mg, give 1 tablet by mouth two times a day for mood stabilizer -2/2/2026 – Trazodone HCl oral tablet 50 mg, give 1 tablet by mouth at bedtime for insomnia During an interview on 5/4/2026 at 11:29 AM, the ADM said Resident #1 had left the facility to go and eat with her family. During an interview and observation on 5/5/2026 at 8:50 AM, Resident #1 was in bed and said good morning. Said she was having a good morning so far. She had numerous personal items in her room (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and a trapeze bar above her bed. She said staff was nice to her and she was pleased with the facility. During an interview on 05/06/2026 at 3:21 PM, the acting DON and ADM said the reason Resident #1's medications were all dated 2/2/2026 was because a new Medical Director took over on 2/1/2026 and he would have reordered her medications. During an interview and record review on 5/06/2026 at 3:55 PM, the acting DON said Resident #1 began her began Alprazolam, Oxycarbazepine, and Trazodone on 8/8/2025. She said the orders were written again exactly the same, when the new Medical Director came to the facility on 2/1/2026, that was why those medications were dated 2/2/2026. She showed this surveyor that the original orders were dated 8/8/2025. During a record review and interview on 5/07/2026 at 8:46 AM, ADON C brought this surveyor 2 GDR's for Resident #1 dated 1/27/2026 and 2/28/2026. Both GDR's indicated Patient will not agree. ADON C said there was no documentation of discussing any of these medications with Resident #1. Record review of the GDR's for Resident #1: Consultant Pharmacist/Physician Communication dated 1/27/2026 indicated: Current Order: Oxcarbazepine 150 mg twice daily, Trazodone 50 mg at bedtime Recommendation: Oxcarbazepine 150 mg daily, Trazodone 25 mg at bedtime The NP checked disagree and indicated Patient will not agree. The NP signed the document on 2/2/2026. Record review of the GDR's for Resident #1: Consultant Pharmacist/Physician Communication dated 2/28/2026 indicated: Current Order: Alprazolam 0.5 mg at bedtime Recommendation: Alprazolam 0.5 mg at bedtime for 10 days then trial discontinue The NP checked disagree and indicated Patient will not agree. The NP signed the document on 3/3/2026. During an interview on 5/07/2026 at 9:17 AM, Resident #1 said someone talked with her about her medications, but she did not remember who or when it was. She said she did not agree or disagree to having any medication reduced or discontinued. During an interview 5/7/2026 at 9:53 AM, ADON B looked at the GDR's for Resident #1 and indicated where the NP wrote patient does not agree was not acceptable because they should have provided education to the resident on the importance of a gradual dose reduction to prevent side effects and to see if there were other options or maybe some of her medications were not needed at that dose (continued on next page)

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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anymore. The risk of not getting a GDR is taking medications that were not needed or were not needed at that dose. During an interview on 05/07/2026 at 10:11 AM, the NP said Resident #1 would not agree with her discontinuing or lowering the dosages of any of her medications. She said Resident #1 said it took over a year for the MD's to get her medication correct and she did not want it changed. She was with it and knew what medications she took. She said she did not document the conversation she had with Resident #1 about her medications. During an interview on 5/07/2026 at10:16 AM, ADON C said the importance of a GDR was to ensure the resident was getting the lowest possible effective dose or to see if a particular medication could be discontinued. She said the risk of a GDR not being done could be oversedation or unnecessary medications given to the resident. During an interview on 5/7/2026 at 10:26 AM, the acting DON said she would expect documentation from the NP as to why Resident #1 would not agree to a reduction in dose of her medications, or a discontinuation and when the NP spoke to her. She said the risk of not getting a GDR was taking a medication or a strength that may not be needed, and could be unnecessary medication. During an interview on 5/7/2026 at 10:38 AM, the ADM said he would expect the NP or staff to document Resident #1's refusal to have her medications changed and educate the resident regarding those medications. She could be taking medications she did not need or dosages she did not need. 2. Record review of an undated facesheet revealed Resident #88 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (a progressive, irreversible brain disorder that destroys memory, thinking skills, and eventually the ability to perform daily tasks), COPD (Chronic Obstructive Pulmonary Disease is a progressive, treatable lung disease—often caused by smoking—that makes it hard to breathe due to damaged airways and air sacs), and anxiety. Record review of a quarterly MDS dated [DATE] revealed Resident #88 had a BIMS score of 05, which indicated severe cognitive impairment. Resident #88 had no behaviors or episodes of anxiety coded. Resident #88 required substantial assistance (helper does more than half) for toileting and showers. Record review of a care plan dated 02/05/2026 revealed Resident #88 was on an antianxiety medication Record review of a GDR written by Pharmacist L dated 10.31.2025 revealed Resident #88 had an 'order for lorazepam PRN. PRN orders for psychotropic drugs are limited to 14 days. If the physician or prescribing NP believes that it is appropriate for the PRN order to be extended beyond 14 days, he/she must document and indicate the duration of the PRN order.' During an interview on 05/06/2026 at 9:20 a.m., ADON C stated she was responsible for ensuring GDRs were completed for all residents on psychotropic medications that the pharmacist recommended monthly. She stated it was important to ensure no residents were on unnecessary medications, especially psychotropic medications because they had dangerous side effects like increased falls, decreased appetite, and sedation. She stated Resident #88 had a GDR for her prn (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lorazepam in October 2025 and March of 2026, but she could not find proof that the MD replied to the request to discontinue the PRN lorazepam and had no documentation of any attempts at follow up. She stated she knew it was a regulation and would ensure it was done as soon as possible. 3.Record review of an undated facesheet revealed Resident #108 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of dementia (an umbrella term for a decline in cognitive function—memory, thinking, and reasoning—severe enough to interfere with daily life), history of falls, and unsteadiness on feet. Record review of a quarterly MDS dated [DATE] revealed Resident #108 had a BIMS score of 03, which indicated severe cognitive impairment. Resident #108 had no behaviors coded. Resident #108 required substantial assistance (helper does more than half) for toileting and showers. Resident #108 required supervision for dressing and personal hygiene. The MDS revealed Resident #108 received antipsychotic medications daily. Record review of a GDR dated 03/31/2026 revealed a pharmacist recommendation to decrease Zyprexa 5mg daily to Zyprexa 2.5mg daily to ensure lowest effective dose was being utilized. Record review of a care plan dated 08/25/2025 revealed Resident #108 was on an antipsychotic medication for a mood disorder. Record review on 05/07/2026 of the following MARs for Resident #108 revealed daily use of Zyprexa 5mg: February 2026-28 daily doses March 2026-31 daily doses April 2026-30 daily doses May 2026-7 daily doses Record review on 05/06/2026 of the behavior monitoring for the use of Zyprexa revealed the following: February 2026- 0 episodes of behaviors March 2026- 0 episodes of behaviors April 2026- 0 episodes of behaviors May 2026- 0 episodes of behaviors During an interview on 05/06/2026 at 9:20 a.m., ADON C stated she was responsible for ensuring GDRs were completed for all residents on psychotropic medications that the pharmacist recommended monthly. She stated it was important to ensure no residents were on unnecessary medications, especially psychotropic medications because they had dangerous side effects like increased falls, decreased appetite, and sedation. She stated Resident #108 came to the facility on Zyprexa and a GDR was recommended by the pharmacist, but NP J had not agreed to the reduction. (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated she was unaware of any nonpharmalogical interventions that had been tried for Resident #108. She stated Resident #108 had a brief time, maybe 2 weeks to a month, where she would swat at the staff when they tried to provide care. ADON C stated she was unaware of any other behaviors Resident #108 had. She stated Resident #108 had no behaviors that were a danger to herself or others. During an interview on 05/07/2026 at 11:00 a.m., NP J stated she felt it was necessary for Resident #108 to have Zyprexa. She stated she was admitted with an order for Zyprexa, and she had several conversations with Resident #108's family and did not feel the family would agree to decrease the Zyprexa. NP J stated she had not actually spoken to the family about the pharmacist's request to decrease the Zyprexa, but the family was particular about her medications. NP J stated Resident #108 was on Zyprexa for dementia and the behaviors of resisting care by swatting at the staff and attempting to bite them when she did not want to bathe. NP J stated she was aware of the black box warning for the elderly for antipsychotic medications. NP J stated the overuse of psychotropic medications can be considered a chemical restraint because the medications are often sedating. She stated she received the request today to discontinue the PRN lorazepam for Resident #88 and she accepted the request. Durning an interview on 05/07/2026 at 11:30 a.m., the family of Resident #108 stated they were never called or talked to about the pharmacist request for a dose reduction of Resident #108's Zyprexa. They stated it was important to them to be informed of all aspects of their mother's care. During an interview on 05/07/2026 at 1:00 p.m., the DON stated it was necessary to monitor psychotropic drug use in the elderly because the goal was for the medication to be necessary and therapeutic. The DON stated antipsychotics are not recommended for residents with dementia that do not have behaviors that are potentially dangerous to themselves or others. She stated these medications are reviewed periodically by the pharmacist and the recommendations were given to the NP to review and either agree or disagree. She stated the ultimate goal was benefit over risk with all medications, but psychotropic medications have serious side effects that had to be considered closely like increased falls and sedation that could lead to weight loss and skin impairments. During an interview on 05/07/2026 at 2:00 p.m., the Administrator stated it was his expectation that all medications would be reviewed on admission and any psychotropic medications would have appropriate diagnoses and appropriate indications for use before they are administered to the residents in this facility. He stated all pharmacy requests should be followed up on and documented. He stated the family were to be notified and documentation of the family's response. Requested policy for gradual dose reduction on 05/06/2026 and 05/07/2026. No policy was provided prior to exit.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and observation, the facility failed to consistently serve a suitable, nourishing alternative meals and snacks to residents who want to eat at non-traditional times or outside of scheduled meal service times for 5 of 5 residents reviewed for snacks. (AR #1, AR #2, AR #3, AR #4 and AR #5) The facility failed to offer an evening nourishing snack routinely for residents on 4/5/2026 to 4/6/2026. This failure could put residents at risk of experiencing complications of diabetes such as low blood sugar, weight loss, or hunger during the night. During a confidential interview at an undisclosed date and time, AR#1 stated that the staff left snacks at the nurse station and residents must get snacks. The anonymous resident stated that not all residents were able to get out of bed to get snacks in the evening and not every resident was offered evening snacks. During a confidential interview at an undisclosed date and time, AR #2 on Hall 100 said the staff did not always ask if she wanted a snack in the evening. She said the staff placed snacks at the nurse station. She said they thought they would bring her a snack if she asked for it. During a confidential interview at an undisclosed date and time, AR #3 on hall 100 said the facility staff had not offered her snacks at bedtime. Resident said she was unsure if they put snacks out in the evenings. She said she sometimes got hungry and kept crackers in her drawer. During a confidential interview at an undisclosed date and time, AR #4 on Hall 500 stated she did not recall being offered snacks, but said she kept snacks in her room. During a confidential interview at an undisclosed date and time, AR #5 on Hall 200 said the facility staff did not offer him snacks at bedtime. Resident said he could not make his way to the nurse's station to get snacks due to being bedbound. During an interview on 5/7/2026 at 9:30 AM, CNA F said she did not work the night shift. CNA F stated residents should get snacks in the evening. CNA F said the kitchen staff would bring snack trays to the nurse station. CNA F said most of the time, she would ask the residents what they wanted off the snack trays. She said the nurses or the CNAs would pass out the snacks. CNA F said the CNAs would pass out the snacks if they were not too busy. CNA F said if a resident did not eat, they could get shaky due to low blood sugar or get dizzy resulting in a fall. During an interview and observation on 5/7/2026 at 10:11 AM, RN G said snacks were put out after every meal. RN G said the snacks were placed on a tray at the nurse's station. A snack tray was observed at the nurse's station with snacks with residents' names. RN G said residents with special requests had their name on the snacks, and some residents had orders for snacks. RN G said nurses and aides were responsible for passing out snacks. RN G said everyone was offered snacks. RN G said staff took the snacks down the hall to each resident, and if there was a snack they wanted, we would get it. RN G said if a resident was a diabetic, they could have a hypoglycemic episode. During an interview on 5/7/2026 at 11:00 AM, the Dietary Supervisor said snacks were placed at the nurse station at 10 am, 2 pm and 7 pm. She said she put names on snacks if they requested a special snack. The Dietary Supervisor said everyone in the facility was offered snacks. She said she put the snacks behind the nurse stations so the residents did not get something they should not have, such as peanuts. The Dietary Supervisor said the nurses were responsible for passing the snacks out. The Dietary Supervisor said there had been complaints from the residents not getting snacks. The Dietary Supervisor said she reported it to the ADM. She said it had been brought up in resident counsel. The Dietary Supervisor said it would get better, and the complaints would come back up. During an interview on 5/7/2026 at 11:52 AM, ADON C said the dietary staff brought snacks out to the nurse station. ADON C said there were snacks for diabetic residents and extra snacks for anyone who wanted one. ADON C said snacks should be offered down the halls. ADON C said the nurse staff were not asking residents if they wanted snacks unless they were ordered. ADON C said there were plenty of snacks to offer everyone. She said a diabetic's blood (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sugar could get low, or a resident with weight loss could lose more weight if a snack was not received. During an interview on 5/7/2026 at 12:11 PM, DON said snacks came from kitchen. She said everyone was responsible for offering snacks. DON said a lot of the residents had snacks in their rooms. DON said all the nurses should be offering snacks. DON said she expected the nursing staff to offer snacks at night to residents. DON said it would be the resident's right to get snacks if they wanted one. During an interview on 5/7/2026 at 12:19 PM, ADM said CNAs were responsible for offering snacks in the evening. The ADM said the snacks were available at the nurse station. The ADM said the residents could get hungry. Record review of the facility's policy titled Texture Modified Diets and Snacks dated 6/3/2025 indicated .the facility will ensure that physician orders are initiated for texture appropriate diets and snacks and provided to all residents, including available snacks. Procedures: 1. Nutrition and food service will provide bedtime snacks each night for all residents including residents with orders for a puree diet. 2. All snacks served will be appropriate for mechanical soft diets.3. Nursing will print out a diet order each morning.4. New Admissions, Readmissions diet/textures orders are reviewed in morning meeting.5. Nursing/designee the same day will enter information.6. Nursing provides the dietary manager/designee with a diet communication form.7. If communication form and Nutrition Management System consistent information.8. The Dietary manager/designee is responsible for entering additional information.9. The diet order report should be kept at the nurse's station near the snack cart for reference.The CNA staff should reference the list prior to passing foods to residents. 10. All snacks ordered at 10:00 AM and 2:00 PM will be dated and labeled with resident's name.11. The [NAME] diet manual should be used for reference.

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	676025	A. Building B. Wing	05/07/2026

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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 record review and interview, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 13 residents reviewed for resident rights. (Resident #108) The facility failed to protect and promote the rights of Resident #108 by using inappropriate techniques to check the resident for the need for incontinent care. These failures could place residents at risk for decreased self-esteem, decreased privacy and decreased quality of life.The findings included: 1. Record review of an undated facesheet revealed Resident #108 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of dementia (an umbrella term for a decline in cognitive function-memory, thinking, and reasoning-severe enough to interfere with daily life), history of falls, and unsteadiness on feet. Record review of a quarterly MDS dated [DATE] revealed Resident #108 had a BIMS score of 03, which indicated severe cognitive impairment. Resident #108 had no behaviors coded. Resident #108 required substantial assistance (helper does more than half) for toileting and showers. Resident #108 required supervision for dressing and personal hygiene. The MDS revealed Resident #108 received antipsychotic medications daily. Record review of Resident #108's care plan dated 08/25/2025 revealed Resident #108 had an ADL deficit related to dementia. Resident #108 required 1 staff assistance with ADL care. Record review on 05/05/2026 at 10:30 a.m., of a video provided by the family of Resident #108 revealed CNA K patting and squeezing Resident #108's buttock through her clothing lasting less than 30 seconds. During an interview on 05/06/2026 at 9:10 a.m., CNA K stated she did not recall patting and squeezing Resident #108's buttock at any point. She stated if she had done that it might have been to check for wetness of her clothing. CNA K stated sometimes the adulty briefs leak if they are not lined up correctly with the female anatomy. CNA K stated there were better ways to check for wetness, but she meant no harm to the resident. CNA K stated she could have assisted Resident #108 to the bathroom and checked her clothing while assisting the resident with her clothing. During an interview on 05/05/2026 at 10:30 a.m., a family member of Resident #108 stated, Resident #108 would have been furious from embarrassment if she were not stricken with dementia. [Resident #108] would not have stood for someone touching her bottom like she was a 2-year-old. The family member stated they felt it was inappropriate to treat Resident #108 like a baby. During an interview on 05/06/2026 at 10:30 a.m., the DON stated she was unaware the incident occurred. She stated it was not regular practice to check a resident for incontinence by touching them on their buttock. The DON stated it potentially could make someone feel inferior or less than the grown adult they are to be treated like a small child. The DON stated the proper way to check the resident's clothing for wetness would have been to ask the resident's permission to touch their clothing prior to and take them to the restroom where their continence status could be addressed in the appropriate environment. During an interview on 05/07/2025 at 1:00 p.m., the Administrator stated it was his expectation that all staff treat each resident with dignity and respect. He stated he did not feel CNA K was trying to be demeaning or purposely embarrass Resident #108. He stated staff education on resident rights would cover checking residents for incontinence while maintaining dignity. Review of a facility policy titled Dignity dated 2001 indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.When assisting with care, residents are supported in exercising their rights, For example, residents are: .e. provided with a dignified dining experience.

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	676025	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident's drug regimen was free from unnecessary psychotropic drugs and PRN orders for psychotropic drugs were limited to 14 days for 2 of 5 residents reviewed for unnecessary psychotropic drugs (Resident #23, and Resident #108). 1. The facility failed to ensure Resident #23 did not have a PRN order for lorazepam 0.5 mg (a prescription medication used to treat anxiety disorders-feelings of fear, dread, and uneasiness) after 14 days without an evaluation by the physician for continued treatment with a rationale in the resident's medical record and a duration for the PRN order. 2. The facility failed to ensure psychotropic medications were not used unless necessary to treat a specific diagnosed condition by continuing an antipsychotic medication for a resident with dementia without adequate clinical justification, documented behavioral symptoms, non-pharmacological interventions, or evidence of the medication regimen was necessary to protect Resident #108 or other residents. This failure could put residents at risk of possible psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: 1. Record review of Resident #23's face sheet, dated 05/05/26, reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included hypertensive heart disease with heart failure (occurs when long-term, unmanaged high blood pressure forces the heart to work too hard, causing the muscle to thicken and eventually weaken or become too stiff to pump efficiently), and anxiety disorder (serious, treatable mental health conditions characterized by excessive, persistent fear or worry that interferes with daily life). Record review of Resident #23's quarterly MDS assessment, dated 04/23/26, reflected she had a BIMS score of 14, which indicated intact cognition. She was able to make herself understood and she was able to understand others. Record review of Resident #23's Order Summary Report, dated 05/05/26, reflected an order for lorazepam oral tablet 0.5mg Give 1 tablet every 12 hours as needed for anxiety. The start date was 02/02/26. There was not an end date listed. During an interview on 05/07/2026 at 9:16 AM, ADON C said Resident #23 was not on hospice. She said the PRN lorazepam should have had a 14-day end date. She said there was not a risk because she would not receive too much medication and she would not receive an unnecessary medication. During an interview on 05/07/26 at 09:23AM, the Acting DON said she heard about an issue with PRN psychotropics on 05/04/26 and fixed it immediately. She said her expectation was that the policies and procedures were followed. She said there was not a risk to the resident having the PRN lorazepam without a stop date. During an interview on 05/07/26 at 10:06AM, the Administrator said Resident #23's PRN lorazepam should have had an end date. He said he did not know the risk of it not having an end date because he is not clinical. 2. Record review of an undated facesheet revealed Resident #108 was an [AGE] year-old female (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE] with the diagnoses of dementia (an umbrella term for a decline in cognitive function—memory, thinking, and reasoning—severe enough to interfere with daily life), history of falls, and unsteadiness on feet. Record review of a quarterly MDS dated [DATE] revealed Resident #108 had a BIMS of 03, which indicated severe cognitive impairment. Resident #108 had no behaviors coded. Resident #108 required substantial assistance (helper does more than half) for toileting and showers. Resident #108 required supervision for dressing and personal hygiene. The MDS revealed Resident #108 received antipsychotic medications daily. Record review of a care plan dated 08/25/2025 revealed Resident #108 was on an antipsychotic medication for a mood disorder-Zyprexa 5mg by mouth at bedtime. Record review on 05/07/2026 of the following MARs for Resident #108 revealed daily use of Zyprexa 5mg: February 2026-28 daily doses March 2026-31 daily doses April 2026-30 daily doses May 2026-7 daily doses Record review on 05/06/2026 of the behavior monitoring for the use of Zyprexa revealed the following: February 2026- 0 episodes of behaviors March 2026- 0 episodes of behaviors April 2026- 0 episodes of behaviors May 2026- 0 episodes of behaviors During an interview on 05/06/2026 at 9:20 a.m., ADON C stated she was responsible for ensuring GDRs were completed for all residents on psychotropic medications that the pharmacist recommended monthly. She stated it was important to ensure no residents were on unnecessary medications, especially psychotropic medications because they had dangerous side effects like increased falls, decreased appetite, and sedation. She stated Resident #108 came to the facility on Zyprexa and a GDR was recommended by the pharmacist, but NP J had not agreed to the reduction. She stated she was unaware of any nonpharmalogical interventions that had been tried for Resident #108. She stated Resident #108 had a brief time, maybe 2 weeks to a month period, where she would swat at the staff when they tried to provide care. ADON C stated she was unaware of any other behaviors Resident #108 had. She stated Resident #108 had no behaviors that were a danger to herself or others. During an interview on 05/07/2026 at 11:00 a.m., NP J stated she felt it was necessary for Resident #108 to have Zyprexa. She stated she was admitted with an order for Zyprexa, and she had several (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Leaves Nursing and Rehab Inc	321 Kilgore Drive Henderson, TX 75652

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conversations with Resident #108's family and did not feel the family would agree to decrease the Zyprexa. NP J stated Resident #108 was on Zyprexa for dementia and the behaviors of resisting care by swatting at the staff and attempting to bite them when she did not want to bathe. NP J stated she was aware of the black box warning for the elderly for antipsychotic medications. NP J stated the overuse of psychotropic medications can be considered a chemical restraint because the medications are often sedating. NP J stated there were other medications that could be tried with less serious side effects for the behaviors Resident #108 had. During an interview on 05/07/2026 at 1:00 p.m., the DON stated it was necessary to monitor psychotropic drug use in the elderly because the goal was for the medication to be necessary and therapeutic. The DON stated antipsychotics are not recommended for residents with dementia that do not have behaviors that are potentially dangerous to themselves or others. She stated the ultimate goal was benefit over risk with all medications, but psychotropic medications have serious side effects that had to be considered closely like increased falls and sedation that could lead to weight loss and skin impairments. The DON stated there were nonpharmological interventions that could have benefited Resident #108, like redirecting, getting different staff to approach, and notifying family members for them to intervene and get the care done for Resident #108. During an interview on 05/07/2026 at 2:00 p.m., the Administrator stated it was his expectation that all medications would be reviewed on admission and any psychotropic medications would have appropriate diagnoses and appropriate indications for use before they are administered to the residents in this facility. Record review of the Facility's policy, Medication and Treatment Orders, last revised July 2024, reflected: .Orders for medications and treatments should be consistent with principles of safe and effective order writing. .c. PRN medications such as psychotropic medications ordered for 14 days should have a stop date and then the need to continue be evaluated by the physician to determine a continued need for scheduling the medication ongoing.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received appropriate treatment and services to prevent further decrease of ROM (Range of Motion) for 1 of 23 residents (Resident #107) reviewed for quality of care. The facility failed to ensure Resident #107 had a contracture prevention device in place for treatment of her right-hand and left-hand contractures. This failure could place residents at risk for decrease in mobility and range of motion and contribute to worsening of contractures. Findings include: Record review of Resident #107's undated face sheet indicated she was an [AGE] year-old female that admitted [DATE] with a readmit date of 7/13/22. She had diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis or weakness on her dominant side following a stroke, damage to the brain's left hemisphere affecting motor control, balance, and often causing speech/language deficits because the dominant hemisphere is involved), contracture of the left hand (tightening of muscles, tendons, or skin leading to rigid, still joints and a fixed, often clenched-fist position), contracture of the right hand, unspecified dementia (affects memory, thinking, and the ability to perform daily activities), and pain in right and left hand. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #107 had unclear speech, was rarely or never understood, and rarely or never understood others. She had short-term and long-term memory problems. The MDS indicated she had impairment on one side on her upper extremity, one side on her lower extremity, and required substantial/maximal assistance for eating. Record review of Resident #107's undated care plan indicated Resident #107 had an ADL self-care performance deficit related to dementia, impaired balance, limited mobility, stroke with left side hemiplegia, limited physical mobility related to neurological deficits, stroke, left hand contractures. The goal was for the resident to remain free of complications related to immobility, including contractures.The care plan indicated Resident #107 had an alteration in musculoskeletal status related to contracture of the left hand. The interventions did not include a contracture prevention device. The care plan indicated she had Carpal Tunnel Syndrome and osteoarthritis (degenerative joint disease that breaks down cartilage, bone, and tissue) with 1-2+ edema (swelling) to the right arm at times with arthritis which could cause inflammation. The interventions did not include a contracture prevention device. Resident #107 had right sided hemiplegia related to a stroke. Record review of the physician's orders dated 5/6/2026, indicated Resident #107's right- or left-hand contracture was not addressed. During an observation on 5/4/2026 at 11:04 AM, Resident #107 was lying in bed in her room. The HOB was up approximately 40 degrees. She had a feeding tube with Jevity 1.5 running at 40 ml/hr with 120 ml flush every 4 hours. The Jevity feeding and water was dated 5/4/26. Her left hand appeared contracted. She had no carrot (a cone-shaped orthosis designed to manage severe hand contractures by painlessly lifting fingers from the palm), or hand contracture splint (specialized or adjustable orthoses designed to support and stretch curled, rigid, or spastic fingers and wrists) on her left hand. Her right hand was covered with the blanket. During an interview on 5/5/2026 at 9:10 AM, the DOT said Resident #107 had therapy about a month ago. She said therapy worked with her about every 2 months. She said Resident #107 had a splint she wore on her right hand that was applied and removed by the nurses. She said she did not know where that was documented. During an interview and record review on 5/5/2026 at 9:22 AM, the DOT said Resident #107's left hand could not be splinted because it was too difficult and painful to get a splint in her hand. She said the splint for her right had been on back order, and she had not had a splint in her right hand for a couple of months. She said the right hand was splintable. She said Resident #107's left hand could have a single layer of a rag/washcloth but she had not been applying that in her left hand and did not know if the nurses were or not. She said there was no risk for not having splints in Resident #107's hands because her contractures were not any worse. She (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she knew that from working with her all the time. She said when Resident #107 was in PT, the goal was for her not to get worse. She said she screened her quarterly/every 3 months. The DOT went to look at her computer, and said the last time she saw or evaluated Resident #107 was 2/23/26 and printed and provided the evaluation. She said nursing was responsible for the splints when the resident was not in therapy, but since nursing did not ease in splints like therapy knew how, it would be the responsibility of the therapy department, and once a splint could easily go in a resident's hand, nursing could do it. She stated Therapy had modalities (help to loosen and move and make the hand more pliable) and nursing did not do that. The Therapy Screen she provided dated 2/23/26 indicated it was the quarterly screen for Resident #107. The Therapy Screen indicated under Recommendations: No recent changed and/or deficit noted. Also, Patient has no change in functional status contractures are managed by nursing staff. During an interview and record review on 5/5/26 at 11:26 AM, ADON B said she was the nurse for hall 300 today. She said Resident #107 had not had a splint or brace in either hand in months. She agreed there were no splints in either hand while this surveyor had been in the building. She said Resident #107 had a splint, before, in one of her hands, but she did not know which one and could not remember when. She got her computer and looked for a discontinued order for splints for Resident #107, and did not see any discontinued orders for splints. She showed this surveyor she went back to 2025. She said she could not tell by looking at the computer, the last time nursing applied splints on both or either of Resident #107's hands. ADON B said Resident #107 should have orders for splints/carrots/brace for her hands to prevent her contractures from getting worse. She said the risk of not having splints was that her contractures could get worse. She said normally the DOT would tell the DON when therapy was finished and let the DON know that she should get orders for the splints to be applied by nursing. She said therapy was responsible for letting the DON know. During an interview on 5/520/26 at 1:54 PM, the DOT said she did not write orders for splints or applying them. She said if a resident needed a splint after therapy had finished, she would let the DON know that therapy had ended and a particular resident needed a splint(s). She said Resident #107 had not had a splint in her left hand for years. She said she told the prior DON at the morning meeting (unknown day) that Resident #107 was about to discharge from therapy or had just discharged from therapy and she would need a splint for her right hand. She said it may have been early December but she could not remember. She said neither of them would have documented the conversation because they never did. She said Resident #107's left hand would be very painful with a splint, but she would be able to tolerate a one-layer rag/washcloth in her left hand to help with moisture, however that would not keep it from contracting more. She said her left hand had not gotten worse, but it could get worse in the future. However, if Resident #107 had no stress (causing her arm to tense up) the contracture could stay the same. She said the muscles in Resident #107's left arm were not tight. She said right now her left arm was flaccid (soft, limp, or weak/lacking in muscle tone). She said if her left hand was left alone, and untreated it may stay the same. She said she did not follow up with the prior DON to see if she had put orders in for the splint for Resident #107's right hand. She said therapy would re-evaluate and readdress Resident #107's right and left hand. During an interview on 5/5/2026 at 2:08 PM, ADON B said she was the nurse today for Resident #107's hall. She said the normal procedure for a resident having a splint or splints, after therapy discharge was for the DOT to let the DON know that therapy was about to be finished, or was finished and the DON would either put in the orders herself, or ask one of the ADON's to do it. She said this usually came up in the morning meeting. She said she was not asked to put in orders for splints for Resident #107 and did not put in any orders. She said she was not sure where the ball could have dropped. She said it could have been the communication between the DOT and the DON, or it could have been the DON forgot to do it. She said not having splints was a risk of a contracture getting worse. She said she had been at the facility since 2020 and she remembered years ago putting splints in one or both hands for Resident #107, but that was years ago. She knew Resident #107's left hand was painful. During an interview on 5/06/2026 at 8:11 AM, the acting DON said there was no documentation for the morning meetings (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/15/25 - 12/15/25 as requested by this surveyor. She said she was not here at that time, and they had no morning meeting notes. During an interview and record review on 5/6/2026 at 8:25 AM, the Medical Records staff said the DOT would go directly to her if she wanted a splint, brace, or carrot, and she would order those things. She said she ordered a left hand splint on 10/13/25 that was delivered on 10/14/25. She ordered a right hand splint on 1/19/26 that was delivered 1/20/26. She said she believed those items were for Resident #107, but she was not sure. She said the DOT asked her yesterday (5/5/26) if she had a hand splint or brace on back order and she searched and never found a splint or brace on back order. During an interview and observation on 5/6/2026 at 8:37 AM, the DOT said there was only one splint ordered for Resident #107 and it was for her right hand. She said when Medical Records ordered splints and braces she (Medical Records) did not know what resident it was for. She said yesterday, they found the splint for Resident #107's right hand in her room in a drawer. The DOT and this surveyor went to Resident #107's room. She was in a low bed with a splint on her right hand. Her left hand had no splint, brace, or carrot. It was contracted. HOB was up approximately 40 degrees, she was positioned to her right with a wedge. Her tube feed was running at 40 ml/hr with a 120 ml flush every 4 hours. Jevity 1.5 and water was dated 5/6/26. During an interview on 5/6/2026 at 9:09 AM, ADON C said normally the DOT would tell the DON in the morning meeting if a splint/brace/carrot needed to be taken up by the nursing staff, because therapy was about to finish or had finished. She said she did not remember hearing the DOT tell the DON that Resident #107's therapy was finishing. The DON had not told her to put in an order for a splint/carrot/brace for Resident #107. During an interview on 5/7/2026 at 9:53 AM, ADON B said she expected residents with contractures to work with therapy and get orders implemented so the contracture did not get worse. She said that did not happen with Resident #107. She said there was miscommunication somewhere, because the order for the right-hand splint was never done for nursing to take over. She stated there were no orders involving the left hand, per therapy, and there should have been, because Resident #107 had a contracture on her left hand too. She stated the risk of not having therapy was the contracture could get worse, resulting in decreased mobility. However, she said Resident #107 was unable to move either hand. During an interview on 5/07/2026 at 10:16 AM, ADON C said regarding Resident #107, therapy usually evaluated and ordered the splints or carrots that were needed. ADON C said in the last couple of months, she had seen nothing, no brace, splint, or carrot in either of Resident #107's hands. She said if a resident had contractures, that resident should have something in their hand, a portion of the day, whether it was a carrot, brace, or washcloth. She stated untreated contractures could cause skin issues such as pressure ulcers, yeast infections, or worsening contractures. ADON C said Resident #107 had not had an order for a brace/splint/carrot on her left hand after 12/1/2022. She said that was what she found on her computer when she checked for nursing orders. During an interview on 5/7/2026 at 10:26 AM, the acting DON said regarding Resident #107's hand contractures, she did not know her history or the severity. She said they wanted to manage contractures and make sure they did not worsen. She was not aware Resident #107 had not been treated for her hand contractures. The risk of not being treated for hand contractures was worsening of the contracture, which could be loss in range of motion and use of her hands. She said skin integrity, yeast infection, and cleanliness would also be a concern. During an interview on 5/7/2026 at 10:38 AM, the ADM said Resident #107 was not being treated for her hand contractures, but he was not aware of that. She should have had orders for treatment for both her hands. He stated he was new in the building, and did not know all the residents well yet. He said the risks of no treatment for hand contractures could be pressure sores, an infection, a worsening contracture, or her fingernails could cut into her hands. They provided the only policy they had regarding contractures. During a telephone interview on 5/07/2026 at 11:45 AM, the prior DON returned this surveyor's call. She said she did not remember the DOT telling her Resident #107 was discharging from therapy and nursing would need to take over. She said she would have remembered that, because she would have had a lot of questions regarding the contracture management. Record (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #107's Occupational Therapy Evaluation and Plan of Treatment dated 5/5/2026 - 6/3/2026 indicated: 1.New Goal - Patient will exhibit a decrease in pain with movement to 6/10 in the left hand and in the right hand in order to tolerate right resting hand splint and washcloth or carrot to left hand. 2.New Goal - Patient will safely wear a resting hand splint on right hand for up to 4 hours with minimal signs and symptoms of redness, swelling, discomfort or pain. 3.New Goal - Patient will tolerate washcloth or carrot to left hand for up to 8 hours in order to decrease risk for skin breakdown. Reason for Referral: Patient is an [AGE] year-old female who presents to rehab to assess current resting hand splint and possible decrease in range of motion in bilateral hands. Patient able to tolerate gentle PROM with severe pain expressed initially but with increased time patient was able to relax hand and gain greater ROM with good skin integrity. OT to address wearing schedule with staff education. Record review of an undated Contracture Management and Prevention Policy indicated: Purpose: The Omnibus Reconciliation Act (OBRA) act of 1990 established regulations that require the long-term care facility to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Goal: To provide services to assist residents in their positioning, mobility and range of motion through focused tasks and interventions to reduce the potential for the development of contractures and if admitted with contractures to avoiding further decline in range of motion. Treatment: The individualized care plan should address the following: -Strengthening for joints that have limitations in AROM (Active Range of Motion), but not PROM (Passive Range of Motion)-Limitations in PROM that can be reversed or partially reversed.-Use of adaptive equipment to facilitate/maintain residual function-Splints and/or positioning devices necessary to maintain, reduce, or prevent decline in the affected joint(s)-Caregiver/staff education in application, care, and use of device DocumentationDocumentation should include:-The therapy evaluation documented including all items/measurements identified during the assessment.-Record and track the resident on the Contracture Management and Prevention Grid/Log-Document staff training provided on splint or positioning device (with return demonstration). Contracture Management and Prevention ProgramUpon discharge - Resident results and discharge plan should be recorded on the Contracture Management and Prevention Log with the following information documented: -Name, location of limitation, type of device and the date it was issued, last day of skilled therapy and six-month reassessment due date.-Update the Contracture Management and Prevention Log every six months upon reassessment if modifications to plan of care are indicated. MonthlyResidents identified as having contractures or limitation in range of motion that require splint or positioning device should be listed/discussed for review at the Quality Improvement/Quality Assurance Meeting.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 21 residents (Resident #29) reviewed for adequate supervision.The facility failed to securely store hydrogen peroxide and Isopropyl Alcohol 50% for Resident #29.This failure could place residents at risk for adverse reactions.Findings included:Record review of the face sheet indicated Resident #29 was [AGE] years old and was admitted on [DATE] and most recently re-admitted on [DATE] with diagnoses including Alzheimer's Disease (a progressive, irreversible brain disorder-and the most common form of dementia-that destroys memory and thinking skills), Chronic Obtrusive Pulmonary Disease (a progressive, treatable lung disease-primarily caused by smoking-that restricts airflow, making it hard to breathe), Hypothyroidism (an underactive thyroid condition where the gland fails to produce enough hormones, slowing the body's metabolism). Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #29 was understood and understood others. The MDS indicated a BIMS score of 15, indicating Resident #29 was cognitively intact. Record review of a care plan revised on 01/14/26 indicated Resident #29 had an activity of daily living self-care performance deficit related to Alzheimer's, Impaired balance. During an observation on 5/4/26 at 10:16 a.m. Resident #29 had a bottle of hydrogen peroxide and Isopropyl Alcohol 50% in her room. Resident #29 was not in her room at that time to be interviewed. During an attempted interview and observation on 5/5/26 at 9:00 a.m. Resident #29 was uninterested or did not want to speak about the chemicals in her room, and changed the subject to an unrelated matter. The hydrogen peroxide and Isopropyl Alcohol 50% was still in her room. During an interview on 05/07/2026 at 10:18 a.m. with the Acting DON she said that residents should not have hydrogen peroxide and Isopropyl Alcohol 50% in their rooms. She said they were prohibited items and should have been stored in a medication cart or a medication room. She said that residents could be placed at risk of harm if they misused chemicals. She said that it was everyone's responsibility to make sure these items were stored properly. During an interview on 05/07/2026 at 10:30 a.m. with the Administrator, he said that residents should not have hydrogen peroxide and Isopropyl Alcohol 50% in their rooms. He said that medications or medically related chemicals should be stored in the medication rooms or medication carts. He said it was the responsibility of everyone to ensure that chemicals were not left in residents' rooms. He said that residents could be harmed if they didn't use the chemicals in their intended manner. Review of an undated facility policy titled, Delivery, Receipt, and Storage of Medication revealed that Storage of Medication: The facility should ensure that only authorized facility staff should have access to the medication storage areas. Authorized facility staff should include nursing staff and those authorized to administer medications.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure a resident with bowel and urinary incontinence, received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible 2 of 2 residents to reviewed for urinary and bowel incontinence (Resident #11 and Resident #41)The facility failed to ensure Resident #11 had a catheter securement device in place on 05/07/26.The facility failed to ensure CNA N and CAN M performed proper incontinent care by ensuring Resident #41 was completely clean after bowel movement and before placing a new brief on 3/5/2026.These failures could place residents at an increased risk for urinary tract infections. Findings included: 1.Record review of Resident #11's face sheet, dated 04/05/26, reflected that he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included obstructive and reflux uropathy (a blockage in the urinary tract that stops urine from flowing, causing it to back up into the kidneys) and acute cystitis (a sudden bladder inflammation, typically caused by a bacterial infection). Record review of Resident #11's quarterly MDS assessment, dated 03/31/26, reflected that he was usually able to make himself understood and he was usually able to understand others. He had a BIMS score of 08, which indicated moderate cognitive impairment. He had an indwelling catheter (a flexible tube inserted through the urethra or abdominal wall into the bladder to drain urine, held in place by a balloon). Record review of Resident #11's Order Summary Report, dated 05/05/26, reflected an order for suprapubic catheter for obstructive and reflux uropathy. The order date was 02/02/26. Further, there was an order for suprapubic catheter care every shift and as needed – check for stabilization device to be in place every shift. The start date was 02/02/26. Record review of Resident #11's care plan, included a focus, last revised 11/19/25, reflected the resident was at risk for impaired urinary elimination related to diagnosis. He was at high risk for continuous urinary tract infections. During an observation and interview on 05/06/2026 at 10:50 AM LVN P performed catheter care on Resident #11. Immediately before LVN P started the care and was washing her hands in the bathroom, Resident #11's catheter tubing had a dependent loop (a loop of the catheter tubing that hangs below the bag and fills up with urine) and that loop was beneath the opening of the catheter bag. There was yellow urine with sediment accumulating in the dependent loop. This surveyor asked LVN P about the dependent loop and she said it should not be lower than the drainage bag. LVN P removed the blanket covering Resident #11 and the catheter was not secured to his leg. There was no catheter securement device present. She performed the catheter care and placed a new securement device. She also pulled up the dependent loop higher than the drainage bag. During an interview on 05/06/26 at 11:10AM, LVN P said the aide told her earlier that day that Resident #11's catheter securement device was missing. She said she waited until the catheter care to place a new securement device and do it all at once. She said the resident should have a securement device because if he did not have one in place his catheter could be accidentally pulled on and dislodged. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/26 at 09:23AM, the acting DON said LVN P told her that she waited to replace the catheter securement device so that she could do it all at once. She said the Resident #11 messes with his catheter a good bit. She said the risk was that without the securement device the catheter could become dislodged. During an interview on 05/07/26 at 10:06AM, the Administrator said Resident #11's catheter should be secured. He said the risk was that the catheter could become dislodged and cause issues. 2. Record review of Resident #41's face sheet dated 05/5/2026 indicated Resident #41 was an [AGE] year-old female and admitted on [DATE] with diagnoses including metabolic encephalopathy (a reversible brain dysfunction caused by systemic metabolic disturbances, leading to confusion, altered consciousness, and neurological symptoms), Type II Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels in the blood), Hypertensive heart disease with heart failure (a chronic high blood pressure forces heart to work harder to pump blood through narrowed stiffened arteries, which increases cardiac workload and oxygen demand), hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood), and muscle weakness (occurs when muscles cannot generate the expected force, and it can result from temporary fatigue, nutrient deficiencies, or underlying medical conditions). Record review of Resident #41's admission MDS assessment dated [DATE] indicated Resident #41 was usually understood and usually had the ability to understand others. The MDS indicated Resident #41 had a BIMS score of 08 which indicated she was moderately cognitively impaired. Resident #41 required substantial/maximal assistance for transfers and most ADLs. The MDS indicated Resident #41 had a fall history in the last month prior to admission to facility and was always incontinent of bowel and bladder. Record review of Resident #41's care plan initiated on 3/3/2026 indicated Resident #41 had an ADL self-care performance deficit related to generalized weakness and recent hospitalization. Interventions included: encouraged resident to use call bell to call for assistance, required 2 staff assist to move between surfaces and resident utilizes a wheelchair for mobility and requires 1 person assist for locomotion. The Care plan also indicated Resident #41 had interventions for 2-person to assist with toileting. During an observation on 05/05/2026 at 3:01 PM, Resident #41 was observed being transferred to bed to where perineal care was performed. CNA M was observed wiping from front to back using a wipe and then rolled Resident #41 over and CNA N cleansed her bottom from top of bottom downward. CNA M then used a wipe in one swipe from front to back and then folded the wipe and continued to wipe front to back using the same dirty wipe but folded. Resident #41 had feces still in the vaginal area and CNA M placed a new brief and covered up Resident #41. During an observation and interview on 5/5/2026 at 3:37 PM, LVN O and DON returned to room after requested re-assessment of incontinent care. The DON set up a tray with gloves, wipes, and trash bags. The DON washed her hands and donned (process of putting on gloves) clean gloves. DON cleansed perineal area using one swipe and disposing of used wipe, removing gloves, and using hand sanitizer between glove changes. The DON wiped the vaginal area, and feces were removed from the vaginal area. The DON said the resident may have had a bowel movement again prior to her arrival to re-assess. During an interview on 5/5/2026 at 3:48 PM, CNA M said she was to the right of Resident #41 during (continued on next page)

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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perineal care. CNA M said she felt she and CNA N did fine with providing perineal care on Resident #41. She said the proper way to cleanse perineal area was wiping from front to back. She said everyone was trained differently. CNA M said she could fold a wipe that was already used and use the clean side of the wipe again. CNA M said the staff could wipe from all sides of perineal area. CNA M said when they turned Resident #41, she tinkles. CNA M said it had been a while since she was trained on perineal care. She said a resident could get a bacterial infection, or a yeast infection if not cleaned properly. CNA said the skin could also breakdown. CNA M said the CNAs were responsible for ensuring the residents were clean prior to putting on a new brief. During an interview on 5/5/2026 at 3:56 PM, CNA N said she was to the left of Resident #41. CNA N said she felt Resident #41 was clean prior to her clean brief being placed. CNA N said different people do things differently. CNA N said she wiped Resident #41 from front to back. She said she wiped from the bottom upward. CNA N said she had been in-serviced on peri-care but did not state when. CNA N said they could fold the used wipe and use the clean side. CNA N said the CNAs were responsible for ensuring the residents were clean. She said a resident could get a urinary tract infection or skin could break down. During an interview on 5/7/2026 at 9:26 AM, CNA F said she would wipe front to back using wipes or if large bowel movement, she would use towels. CNA F said normally Resident #41's bowel movement would be all over her back and she would give her a sponge bath. CNA F said she turned Resident #41 to her side and wiped the same way, then applied the brief and straighten brief back up. CNA F said she wiped again from front to back to ensure she was clean. CNA F said they should not wipe downward from the top of bottom down. CNA F said it could cause feces to get in vaginal area and could cause urinary tract infection. CNA F said CNAs were responsible for ensuring the residents were clean and no feces on resident skin. During an interview on 5/7/2026 at 10:08 AM, RN G said the nurses and CNAs were responsible for ensuring a resident is clean and dry. RN G said a resident should be wiped from front to back, and wiping from front to back on the backside. She said wiping incorrectly could cause bacterial infection or a urinary tract infection. She said whoever was providing care was responsible. RN G said the staff should be making sure there is nothing in vaginal area or left behind to ensure they are clean. During an interview on 5/7/2026 at 11:49 AM, ADON C said they have done incontinence care in-services but could not recall when. ADON C said the staff should wipe Resident during incontinent care from front to back. ADON C said when the resident was turned, the staff should wipe from bottom down. ADON C said the staff could fold a wipe and use the clean side. ADON C said the staff should make sure the perineal area is clean before placing the brief. ADON C said the residents could have skin issues, and possible infection if not performed properly. She said all nursing staff were responsible for ensuring the residents were clean. During an interview on 5/7/2026 at 12:07 PM, the DON said she expected the CNAs to make sure the residents were clean before applying a clean brief. She said she expected them to use proper technique in wiping. The DON said one wipe, one swipe. The DON said she thought someone in the schools were teaching the CNAs the wrong way. The DON said she expected the CNAs to wipe female resident from front to back and perineal up when turned over to clean up bowel movements. The DON said it was all nursing responsibility to ensure the residents were clean and dry. The DON said improper perineum care could cause urinary tract infections, or skin breakdown. During an interview on 5/7/2026 at 12:19 PM, the ADM said he expected the staff to perform proper (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perineal care. He said if done improperly, it could cause an infection. The ADM said the nursing administration was responsible for ensuring care was provided correctly. Record review of the Facility's policy, Indwelling Urinary Catheter Care, dated January 2026, reflected: Purpose: To maintain the indwelling urinary drainage system and to help [avoid] urinary tract infections and proper securing of the catheter for safety. Guidelines for Maintaining the Urinary Drainage System:. .2. Check that the catheter remains secured with tape/stabilizer device or leg strap to reduce friction and tension/pulling and movement at the insertion site. .5. Check that urine is draining freely through the system. .7. Keep the urine-collecting bag below the level of the bladder at all times to prevent backflow of old urine into the bladder. Maintain position of urine-collecting bag according to manufacture guidelines. 8. Keep the drainage tubing and bag off the floor at all times to prevent contamination and damage. Record review of the facility's policy titled Perineal Care dated revised February 2018 indicated . the purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . steps in the procedure .Place equipment on the bedside stand.wash and dry hands thoroughly.fill the wash basin on-half (1/2) full of warm water.Fold the bedspread or blanket toward the foot of the bed.Fold the sheet down to the lower part of the body.Raise the gown or lower the pajamas.Put on gloves.Ask the resident to bend their knees.For Female resident: Wet washcloth and apply soap or skin cleansing agent.Wash perineal area, wiping from front to back.Separate labia and wash area downward from front to back.Continue to wash the perineum moving from inside outward to thighs.Continue to wash the perineum moving from inside outward to the thighs.Gently dry perineum.wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks.Rinse and dry thoroughly.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide or obtain laboratory services to meet the needs of 1 of 13 residents reviewed for laboratory services. (Resident #108) The facility failed to obtain the following labs for Resident #108 per physician's orders:BMP- basic metabolic panel (a common blood test that measures eight key substances to evaluate kidney function, fluid/electrolyte balance, and blood sugar levels)Lipid panel (a routine blood test that measures cholesterol and triglyceride levels to evaluate cardiovascular risk, including potential heart disease and stroke risk)Liver panel (a blood test that measures enzymes, proteins, and bilirubin to assess liver health, damage, or disease)These failures could place residents at risk of not having their medications at a therapeutic level, delays in treatment, and/or deterioration in condition.Findings include: 1. Record review of an undated facesheet revealed Resident #108 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of dementia (an umbrella term for a decline in cognitive function-memory, thinking, and reasoning-severe enough to interfere with daily life), history of falls, and unsteadiness on feet. Record review of a quarterly MDS dated [DATE] revealed Resident #108 had a BIMS score of 03, which indicated severe cognitive impairment. Resident #108 had no behaviors coded. Resident #108 required substantial assistance (helper does more than half) for toileting and showers. Resident #108 required supervision for dressing and personal hygiene. The MDS revealed Resident #108 received antipsychotic medications daily. Record review of a care plan dated 08/25/2025 revealed Resident #108 has coronary artery disease related to atherosclerosis (a disease characterized by the slow, progressive buildup of plaque-a mixture of fat, cholesterol, calcium, and other substances-within the artery walls) and hypercholesterolemia (a condition characterized by abnormally high levels of low-density lipoprotein [LDL or bad cholesterol] in the blood). Record review of physician's orders dated May 2026 revealed Resident #108 had an order dated 08/25/2025 for a BMP, Lipid, and Liver Panel every 3 months. Record review of the EHR on 05/06/2026 revealed Resident #108 had no lab results for ordered BMP, Lipid panel or liver panel. During an interview on 05/06/2026 at 9:30 a.m., ADON C stated the lab was recently integrated with the EHR system the facility used and the lab is automatically notified when the labs are due for all residents through the EHR. ADON C stated she could not find any lab results for Resident #108's BMP, Lipid or Liver panel. She stated she called the lab and they had no results for the BMP, Lipid or Liver panel for Resident #108. ADON C stated she felt like the labs were missing related to the integration of the lab system and the EHR system. She stated ordered labs not being performed could lead to the MD or NP not adjusting medications to provide the greatest benefit to the resident. ADON C stated it was her job to track the lab results and lab orders to ensure all of the labs ordered are drawn and the results get to the MD. She stated she must have overlooked Resident #108 when auditing the labs. During an interview on 05/06/2026 at 10:47 a.m., the DON said she expected labs to be obtained as ordered by the physician. The DON said all of the missing labs were likely an oversight during the integration of manual lab requisitions to automatic lab requisitions. She stated it was the responsibility of the ADONs to monitor all lab draws and reports. The DON stated not having ordered labs could lead to not having therapeutic medication dosages. She stated Resident #108 was on medications that dosages would be adjusted related to lab results. She stated the lipid panel showed how her cholesterol was, the liver panel showed how well her liver was working to break down the medications she was taking, and basic metabolic profile showed levels of important electrolytes like potassium and sodium in the blood. Record review of the facility's undated policy titled, Lab and Diagnostic Test Results- Clinical protocol, indicated. the staff will process test requisitions and arrange for tests. a nurse will try to determine whether the test was done.c. to monitor a drug level.d. report results to ordering MD

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	676025	A. Building B. Wing	05/07/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 22 residents (Residents #13 and Resident #11) reviewed for infection control practices.1. The facility failed to properly store or dispose of a used feeding tube syringe for Resident #13.2. The facility failed to ensure Resident #11's catheter bag was not lying on the floor on 05/04/26.These failures placed residents at risk for cross contamination and infection.Findings include: 1. Record review of the face sheet indicated Resident #13 was [AGE] years old and was admitted on [DATE] and most recently re-admitted on [DATE] with diagnoses including Autistic Disorder (a neurodevelopmental condition affecting communication, social interaction, and behavior), Intermittent Asthma (a mild form of asthma characterized by short-term symptoms occurring less than two days a week, with nighttime awakenings 3–4 times a month or fewer), and Dysphagia (difficulty swallowing). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #13 was rarely or never understood and rarely or never understood others. The MDS indicated a BIMS score of 00 indicating Resident #13 was unable to complete a BIMS interview. Record review of a care plan revised on 01/28/26 indicated Resident #13 required tube feeding related to swallowing problems. During an observation and attempted interview on 5/4/2026 at 9:51 a.m. it was observed that Resident #13 had a feeding tube syringe lying on the resident's bedside dresser that had a dried white substance on the tip of the syringe and condensation inside the syringe. The syringe had not been stored inside a bag. Resident #13 was attempted to be interviewed but was unintelligible. During an interview on 05/07/2026 at 10:18 a.m. with the Acting Director of Nurses she said that tube feeding syringes that had been used should have been either thrown away or stored in a bag. She said that it was the responsibility of nurses to ensure that tube feeding syringes were stored or disposed of properly. She said that residents could be placed at risk of infections if proper infection prevention protocol was not followed. During an interview on 05/07/2026 at 10:30 a.m. with the Administrator he said that tube feeding syringes should be stored properly after it was used. He said that it is the responsibility of nurses to make sure that the syringes are stored and used properly. He said that residents could be placed at risk of infection if tube feeding syringes were not stored properly. Requested a facility policy from the Administrator on 05/07/2026 regarding storage of equipment regarding tube feeding syringes. An undated facility policy provided titled, Tube Feeding did not describe how to properly store or dispose of tube feeding syringes after usage. 2. Record review of Resident #11's face sheet, dated 04/05/26, reflected that he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included obstructive and reflux uropathy (a blockage in the urinary tract that stops urine from flowing, causing it to back up into the kidneys) and acute cystitis (a sudden bladder inflammation, typically caused by a bacterial infection). (continued on next page)

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	676025	A. Building B. Wing	05/07/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #11's quarterly MDS assessment, dated 03/31/26, reflected that he was usually able to make himself understood and he was usually able to understand others. He had a BIMS score of 08, which indicated moderate cognitive impairment. He had an indwelling catheter (a flexible tube inserted through the urethra or abdominal wall into the bladder to drain urine, held in place by a balloon). Record review of Resident #11's Order Summary Report, dated 05/05/26, reflected and order for suprapubic catheter for Obstructive and reflux uropathy. The order date was 02/02/26. Further, there was an order for suprapubic catheter care every shift and as needed – check for stabilization device to be in place every shift. The start date was 02/02/26. Record review of Resident #11's care plan, included a focus, last revised 11/19/25, reflected, the resident was at risk for impaired urinary elimination related to diagnosis. He was at high risk for continuous urinary tract infections. During an observation on 05/04/2026 at 9:52 AM, Resident #11 was lying in bed resting. He had a urinary catheter, and the bag was on the floor. He did not respond to surveyor questions. During an observation on 05/04/2026 at 10:47 AM, Resident #11 was lying in bed. His catheter bag was still lying on the floor. During an interview on 05/07/26 at 09:16AM, the ADON said the catheter bag should have been hung on the bed frame and not on the floor. She said the risk was that Resident #11 could get an infection. During an interview on 05/07/26 at 09:23AM, the Acting DON said she found Resident #11's bag on the floor on 05/04/26 and was the person that fixed it. She said the risk to the resident was a possible infection. She said her expectation was that the policy and procedure was followed. During an interview on 05/07/26 at 10:06AM, the Administrator said Resident #11's catheter bag should have been hung on the bed. He said the risk was a possible infection. Record review of the Facility's policy, Indwelling Urinary Catheter Care, dated January 2026, reflected: Purpose: To maintain the indwelling urinary drainage system and to help [avoid] urinary tract infections and proper securing of the catheter for safety. Guidelines for Maintaining the Urinary Drainage System:. .2. Check that the catheter remains secured with tape/stabilizer device or leg strap to reduce friction and tension/pulling and movement at the insertion site. .5. Check that urine is draining freely through the system. .7. Keep the urine-collecting bag below the level of the bladder at all times to prevent backflow of old urine into the bladder. Maintain position of urine-collecting bag according to manufacture guidelines. 8. Keep the drainage tubing and bag off the floor at all times to prevent contamination and damage.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rationale, by the provider, when an antibiotic was used despite criteria, to determine the appropriate use of an antibiotic for 2 of 9 residents reviewed for antibiotic use (Resident #16 and Resident #68). 1. The facility failed to ensure Resident #16 did not have an order for Cephalexin (an antibiotic used to treat a variety of bacterial infections) for prophylactic antibiotic use. 2. The facility failed to ensure Resident #68 did not have an order for Macrobid (an antibiotic used to treat bacterial infections) for prophylactic antibiotic use. These failures could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: 1. Record review of Resident #16's face sheet, dated 05/06/26, reflected that she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included neuropathic bladder (a dysfunction where nerve damage from disease or injury disrupts signals between the brain and bladder, causing loss of bladder control) and neurocognitive disorder (a category of acquired mental health conditions characterized by a decline in cognitive functions). Record review of Resident #16's quarterly MDS assessment, dated 03/24/26, reflected that the BIMS was not conducted because she was rarely/never understood. She was also rarely/never able to understand others. Record review of Resident #16's care plan, included a focus that the resident was on prophylactic antibiotic therapy, last revised 11/24/25. Interventions included:*Administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness every shift.*Monitor/document/report PRN signs and symptoms of secondary infection related to antibiotic therapy. Record review of Resident #16's Order Summary Report, dated 05/06/26, reflected an order for cephalexin oral capsule 500mg, give 1 capsule by mouth one time a day for urinary prophylactic. The start date was 02/02/26. There was not an end date. 2. Record review of Resident #68's face sheet, dated 05/06/26, reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (an umbrella term for a decline in cognitive function severe enough to interfere with daily life) and neuromuscular dysfunction of bladder (refers to what happens when an injury or disease interrupts the electrical signals between your nervous system and bladder function). Record review of Resident #68's quarterly MDS assessment, dated 02/19/26, reflected she had a BIMS score of 02, which indicated severe cognitive impairment. She was usually able to understand others and usually able to make herself understood. Record review of Resident #68's care plan, included a focus that the resident was on antibiotic therapy related to urinary tract infection and she would be on it prophylactically, last revised 03/25/26. Interventions included:*Administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness every shift.*Monitor/document/report PRN signs and symptoms of secondary infection related to antibiotic therapy. Record review of Resident #68's Order Summary Report, dated 05/06/26, reflected an order for macrobid oral capsule 100mg give 1 capsule orally on time a day for prophylaxis. The order start date was 03/25/26. There was not an end date. During an interview on 05/07/26 at 09:16AM, ADON C said Resident #16 and Resident #68 were taking prophylactic antibiotics. She said they both had a history of recurring urinary tract infections. She said she felt like that was a proper indication for those antibiotic orders. During an interview on 05/07/26 at 09:23AM, the Acting DON said she was not a fan of starting any antibiotic without a culture. She said she was working with the nurses to empower them and have them speak with the physicians regarding prophylactic antibiotics. She said she was working on culture change in the facility. She said her expectation was that they will follow their policy. She said the risk was that it could be an unnecessary medication for an unknown organism. During an interview on 05/07/26 at 10:06AM, the Administrator said Resident #16 and Resident #68 should not have been on prophylactic antibiotics. He said the risk was that it could (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	create a resistant or super bug bacteria. Record review of the facility's policy, Antibiotic Stewardship, last revised December 2016, reflected: .3. Appropriate indications for use of antibiotics include:a. criteria met for clinical definition of active infection or suspected sepsis; andb. pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending).