STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 16 residents (CR #1) reviewed for quality of care. -The facility failed to ensure CR #1 returned to the Orthopedic Clinic for a follow-up appointment post right hip surgery in three weeks from the date last seen on 11/18/2021. -The facility failed to start CR #1 on oral antibiotics when CR #1 had completed her IV antibiotic regimen as recommended by the Orthopedic Clinic on 11/18/21. -The facility failed to obtain wound cultures on CR #1's right hip as ordered by the NP on 12/03/21. CR #1 had to be transferred to the hospital due to altered mental status and increase drainage from the right hip on 12/17/21. CR #1 had to return to surgery for re-infection of the right hip on 12/18/2021 An Immediate Jeopardy (IJ) was identified on 02/15/22 at 10:48 a.m While the IJ was removed on 02/18/2022 , the facility remained out of compliance at a severity level of no actual harm, with the potential for more than minimal harm that is not immediate jeopardy, and a scope of isolated, due to the facility's need to evaluate the effectiveness of their Plan of Removal (POR). These failures could place residents with surgical wounds at risk for serious wound infections, harm, or death. Findings Included: CR#1 Record review of CR #1's face sheet revealed a [AGE] year-old female admitted on [DATE] with the following diagnoses: infection following a procedure other surgical site subsequent encounter, muscle wasting and atrophy (gradual decline in effectiveness due to under use or neglect), psychoactive substance abuse, bipolar disorder, hypertension, pain, and gastro-esophageal reflux disease without esophagitis (inflammation of the esophagus). (continued on next page)

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
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's Care Plan dated 10/15/21 revealed she was care planned for altered skin integrity non pressure related: surgical wound to right upper and lower hip present upon admission with the following interventions: *Observe for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. *Treatments as ordered. Record review of CR #1's MDS dated [DATE] revealed CR #1's BIMS score was 9 indicating cognition level was moderately impaired. Further review revealed CR #1 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. Further review revealed CR #1 was frequently incontinent of urine and always incontinent of bowel. Record review of CR #1's Physician Order Summary Report revealed the following orders: *Ceftriaxone (antibiotic) 1gm intravenously every 12 hours for right hip infection, date of order 10/16/21 with end date 11/11/2021. *Vancomycin (antibiotic) 1000mg intravenously every 12 hours for infection, date ordered 10/20/21 with end date 11/12/21. *Tramadol 50mg give 1 tablet by mouth every 8 (eight) hours as needed for chronic pain and give 1 tablet by mouth every 8 hours for pain, order dated 11/15/21. *C&S of right hip one time, date ordered 12/03/21. Record review of the MAR for November 2021 revealed CR #1 received ceftriaxone 1gm intravenously from 10/16/21to 11/11/21. Further review of the MAR revealed CR #1 received vancomycin 1gm intravenously 10/20/21 to 11/12/21. CR #1 was not receiving any oral antibiotics. Record review of the TAR for December 2021 revealed on the 5th LVN C documented the C&S of the right hip was collected. Record review of CR #1's outpatient Orthopedic Clinic report dated 11/18/21 revealed in part: .To whom it may concern .CR #1 was seen in our clinic today for her orthopedic injuries .CR #1 states that her IV antibiotics were discontinued a week ago and is unsure if she was receiving any antibiotics orally at this time. If her IV antibiotic regimen has completed, she needs to continue oral antibiotics at this time .We will plan to see her back in 3 weeks for repeat evaluation at that time. If possible, the patient should bring in pictures of her lateral wound after her wound vac changes for evaluation at her next appointment . Record review of CR #1's Progress Notes dated 11/18/21 at 1:20 p.m. documented by LPN D (with no mentioning of CR #1 returning to clinic in 3 weeks) read in part: .CR #1 returned from appointment with orders to continue oral antibiotics . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the 24-hour report from 11/18/21 through 12/17/21 revealed no documentation of a follow-up appointment with the Orthopedic Clinic, recommendation of oral antibiotics after CR #1 completed IV antibiotics, or to obtain culture of CR #1's right hip. Record review of CR #1's Progress Notes dated 12/03/21(Friday) at 8:46 a.m. documented by LPN D revealed in part: .CR #1 alert and responsive to verbal and physical stimuli, able to make needs known .CR #1 complain of pain to right hip .Tramadol 50mg given as ordered for pain .CR #1 stated doing exercise with therapy causing pain to her right hip .LPN D assessed right hip, blood tinged dressing at incision site, 3 sutures noted to open area .LPN D changed dressing site .LPN D notified therapy regarding exercise .LPN D notified the M. D., X-ray to right hip ordered . Record review of a radiology exam report of CR #1's right hip dated 12/03/21 revealed the following: No acute fracture or dislocation, no acute abnormalities. Record review of CR #1's Progress Notes dated 12/3/21 at 10:43 a.m. late entry documented by the NP revealed in part: .The patient's care was discussed with the nursing staff on duty. Nursing report discharge from hip that is foul smelling . Further review of CR #1's Progress Notes dated 12/17/21 at 10:32 a.m., by NP revealed in part: .The patient care was discussed with the staff on duty. The patient noted with altered mental status and increase discharge from right hip wound along with foul smell . Record review of CR #1's Hospital Transfer Form dated 12/17/21 at 2 p.m., revealed the reason for transfer was altered mental status. Record review of CR #1's hospital records revealed admitting diagnosis on 12/17/21 significant for leukocytosis (elevated white blood count) of WBC 12.7 (3.7-10.4) with septic arthritis/osteomyelitis (infection of a bone) as the source of sepsis of the hip. Further review revealed that CR #1 was take back to surgery on 12/18/21 for incision and drainage of the right hip. Interview on 01/11/22 at 10:00 a.m., the Wound Care Doctor said he came to the NF on a weekly basis. The Wound Care Doctor said CR #1 was not on his list of residents to see at the NF. The Wound Care Doctor said if a resident had a surgical wound, he would not be providing care unless due to COVID and the surgeon was unable to see the resident and the resident needed to be seen. The Wound Care Doctor said the surgeons provided care for their own residents or patients. Interview on 01/11/2022 at 10:20 a.m., the Administrator said CR #1 was still in the hospital. The Administrator said she did not know the details of why CR #1 had to be transferred to the hospital other than CR#1 had experienced a change in condition and would have to view CR #1's records. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 01/11/2022 at 10:25 a.m., the OT said CR #1 was receiving therapy prior to her discharge. The OT said approximately 3 weeks prior to CR #1 being admitted to the hospital, CR #1 had shared in her last therapy session, her whole body ached. OT said herself and CR #1 agreed to do less repetitions with her exercise and the OT said she reported to the PT what CR #1 had shared with her. The OT said the PT was in agreement with the exercise regimen of doing less repetitions. The OT said on the day CR #1 was transferred to the hospital, during therapy, CR #1 was hurting all over especially in her back and lower body area. Interview on 01/11/2022 at 11:20 a.m., LVN A said when CR #1 resided at the NF, the previous DON was working at the NF and the NF had an interim DON at present time. LVN A said it was the DON and ADON who coordinated the resident (s) doctor appointments. LVN A said she did not know if CR #1 returned to her follow-up doctor appointment with the surgeon after seeing the surgeon on 11/18/2021. LVN A said the NF had two treatment nurses, RN B and LVN C that provided care for wounds in the NF that were stageable wounds or surgical wounds. LVN A said the nurses on the units provided care for minor wounds such as skin tear or abrasions. LVN A said all the nurses could place a dressing on a wound if the dressing came off. LVN A said RN B worked Monday through Friday. LVN A said RN B no longer worked at the NF and believed stopped working at the NF sometime during the Thanksgiving or Christmas Holidays. LVN A said LVN C still worked at the facility and worked Saturday and Sunday. Interview on 01/11/22 at 12:11 p.m., a call was placed to the Orthopedic Physician Office regarding CR #1. The Investigator spoke with staff Medical Assistance, who said the last time CR #1 was seen in the Orthopedic Office was 11/18/21 and according to records, CR #1 had to go to surgery on 12/18/21 for a right hip infection with purulent drainage (white, yellow, or brown fluid sometimes thick in texture, unpleasant smell, sign of infection) requiring incision and drainage. The Medical Assistance said CR #1 was discharged from the hospital on 01/04/22 and while viewing records, did not reveal where CR #1 was discharged too. Interview on 01/11/22 at 12:35 p.m., the NP said he had been an NP for [AGE] years and made rounds at the NF on Friday's. The NP said CR #1 was admitted to the NF with a right hip surgical wound and IV antibiotics that she had completed. The NP said the last time he saw CR #1's wound, it looked infected draining pus secretions with a foul odor. The NP said he did not recall reviewing CR #1's Orthopedic Surgeon Notes on 11/18/21. The NP said he relied on the nurses to communicate to him regarding resident doctor visits. The NP said he was not responsible for treating CR #1's infection, but had given a verbal order to get an X-ray of CR #1's right hip as well as a C&S of CR #1's right hip. The NP said when he returned to the NF the next week, he saw that the C&S of the right hip was not done. The NP said in retrospect, could have taken the next step and reached out to the Orthopedic Surgeon to clarify what antibiotic to prescribe for CR #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 01/11/22 at 1:00 p.m., RN B said she used to work Monday through Friday from 8am-5pm, she said she stopped working at the NF on 12/1/21. RN B said when a resident came back from a doctors appointment, the nurse on the unit would provide a copy to her most of the time entailing the residents visit to the doctor. RN B said most of the time, she would take it upon herself to view the communication of the resident doctor visit to see if there were any recommendations. RN B said the nurse on the unit would reach out to the PCP or NP letting either one know what recommendations were suggested. RN B said if there were any recommendations, usually the PCP or NP would address the recommendations. RN B said she did not remember seeing anything about oral antibiotics for CR #1 after her Orthopedic visit on 11/18/21 and if she had, she would think that the surgeon wanted to placed CR #1 on oral antibiotics after completing her IV antibiotic regimen as a prophylactic measure given the history of infection to CR #1's right hip. Interview on 01/11/22 at 1:23 p.m., LPN D said she worked at the NF full time on the 6a-2p shift. LPN D said typically when a resident with a wound and required a wound vac, it was usually the treatment nurse who coordinated the follow-up doctor appointments. LPN D said when CR #1 returned from her Orthopedic Doctor visit, she had reached out to the NP regarding the recommendations for oral antibiotics via text when he did not respond to her call. LPN D said when she contacted the NP via text regarding the recommendations for oral antibiotic, the NP responded okay. LPN D said on 12/3/21 (Friday), CR #1 was receiving physical therapy and had medicated CR #1 for pain, but it was not effective and therefore reached out to the NP. LPN D said she had asked the NP for an X-ray order due to CR #1 complaining of a lot of pain to make sure that CR #1's hip was not dislocated. LPN D said the NP gave an order for an X-ray of the right hip. LPN D said the NP never gave her an order for a C&S of the right hip. Interview on 01/11/22 at 2:00 p.m., LVN A said after reviewing CR #1's records, a C&S of CR #1's right hip was not done. Interview via phone on 01/11/22 at 2:10 p.m., the previous DON said he stopped working at the NF on a Friday and did not recall CR #1. The DON said the NF had meetings regarding any changes in resident (s) condition. The DON said it was the nurses on the units that were responsible for coordinating a resident follow-up. The DON said if the unit nurse was unable to coordinate the resident doctor appointment, he would intervene to assist provided if the information was relayed to him. The DON said before RN B stopped working at the NF, RN B was the buffer in between the nurses on the units in coordinating resident(s) doctor appointments and follow-up appointments. The DON said when RN B stopped working at the NF, LVN C would have been the one to step up to ensure that the resident(s) were going to their follow-up doctor appointments. The DON said the NF communicated on the 24-hour report in the computer regarding resident care. The DON said if the nurses did not communicate the resident doctor visit in the computer on the 24-hour communication, it was missed. The DON said some of the nurses were still trying to write the communication on paper instead of the computer. The DON said himself and the ADON would follow-up in the computer on any new communications. The DON said regarding the recommendations for oral antibiotics for CR #1, the nurses on the unit or the NP could have reached out to the Orthopedic Clinic for clarification. The DON said the NP that was caring for CR #1 had a history of telling the staff okay when the staff would contact him regarding resident(s) care. The DON said because the NP knew he was coming to the facility to make rounds and thought he would take care of or address the issue but end of not addressing the issue. The DON said he would have reached out to the doctor in the past to let the doctor know the issue was not addressed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/15/2022 at 10:48 a.m., the interim DON said she started working at the NF on 01/10/22. Interview on 02/15/2022 at 11:15 a.m., LVN A said the NF viewed CR #1's records again and the NF did not start CR #1 on oral antibiotics after completing her IV antibiotic regimen. LVN A said the facility did not obtain a C&S of CR #1's right hip nor did CR #1 go for her follow-up appointment with the Orthopedic Surgeon. LVN A said it was the nurses on the units that received the paperwork when a resident returned from an appointment. LVN A said the unit nurse were the ones who coordinated resident appointments and follow-ups as well as the ADON. Interview on 02/15/2022 at 11:22 a.m., the Administrator said the ADON no longer worked at the NF. Interview on 02/16/21 at 11:25 a.m., Clinical Operations said although LVN C documented on the MAR that a C&S was done on CR #1's right hip on 12/05/21, there was no records to show that it was done. Interview on 02/16/2022 at 11:46 a.m., the ADON said she stopped working at the NF before Christmas. The ADON said she remembered CR #1 having a wound vac. The ADON said her responsibility while working at the NF included viewing the resident (s) medical records when first admitted to the NF. The ADON said the nurse on the unit transcribed the resident (s) physician orders in point click care. The ADON said she followed-up to ensure all orders were transcribed in point click care. The ADON said the NF had started going paperless therefore, if received a verbal order, would transcribe directly in point click care. The ADON said if this was not done, it could get missed. The ADON said it was the nurse on the unit that coordinated the resident (s) doctor appointments. The ADON said if the nurse on the unit was having issues in coordinating a resident doctor appointment, the DON or ADON stepped in to assist with the process. The ADON said when a doctor sent back a communication form of the resident visit, it is given to the nurse on the unit and that nurse is responsible in communicating any recommendations or new orders as well as setting up follow-up transportation for follow-up doctor appointments by communicating with the doctor office and in house transportation. The ADON said the treatment nurses were responsible for obtaining wound cultures after the unit nurse informed the treatment nurse a culture was needed. The ADON said someone at the NF should have followed with the Orthopedic Clinic regarding oral antibiotics. The ADON said the NF had morning meetings discussing what events took place over the prior day and night as well as weekends. The ADON said the recommendations from the Orthopedic Clinic should have been mentioned on the 24-hour communication form. The ADON said she thought in November, the NF was still using the paper method for 24-hour communication regarding the resident (s) status. Interview via phone on 02/16/22 at 12:55 p.m., LVN C said she worked the weekend shift as the NF treatment nurse. LVN C said she obtained a culture of CR #1's right hip over the weekend on a Sunday (12/05/21). LVN C said she did not follow-up on the results of the culture because she just worked the weekend shift and therefore when she returned to work, she assumed it had been taken care. LVN C said she was not aware of CR #1 needing to follow-up with the Orthopedic Clinic or of the recommendations of CR #1 needing to be on oral antibiotics after completing her IV antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/17/2022 at 11:40 a.m., LPN D said she no longer worked at the NF. LPN D said she stopped working at the NF 2-3 weeks ago. LPN D said she did not recall setting up a follow-up appointment for CR #1 with the Orthopedic Clinic but did remember texting the NP regarding recommendations for oral antibiotics if done with IV antibiotics. LPN D said when a resident returned from a doctor visit and required a follow-up appointment, the nurse on the unit called transportation after confirming the follow-up appointment date to schedule transportation. LPN D said the nurse then put the actions taken on the 24-hour report sheet. LPN D said she never saw an order to obtain a culture on CR #1's right hip. Interview on 12/18/2022 at 12:15 p.m., the NF Medical Director said he heard about what happened regarding CR #1. The Medical Director said it was clearly the communication of care for CR #1 had fallen through the cracks. The Medical Director said he had a meeting with the Administrator to ensure that would not happen again. The Medical Director said moving forward, when a resident (s) return from a doctor visit requiring a follow-up appointment, the staff is required to communicate in point click care so the appointment does not go missed. The Medical Director said the NF could have reached out to the Orthopedic Clinic to see what oral antibiotic could have been prescribed for CR #1 or the NF could have done a culture of CR #1's right hip to see what bacteria was growing and treat. Record review of the NF Policy on Neglect revised 2019 revealed in part: .Failure of the center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . The Administrator was notified on 02/15/22 at 10:48 AM that an Immediate Jeopardy (IJ) situation had been identified due to the above failures. The IJ template was provided to the Administrator on 02/15/22 at 11:00 AM. The following Plan of Removal (POR) was submitted by the NF Administrator and was accepted on 02/16/22 at 8:48 AM: [NAME] Oaks Healthcare & Rehabilitation Center Plan of Removal 2/16/2022 Immediate Actions: c CR#1 was discharged on [DATE]. Review of the medical record completed to determine root cause analysis of missed follow up appointment, recommendations, and labs c Residents with surgical and pressure wounds were reviewed for ABT and appointments to ensure being scheduled and completed as ordered. No additional concerns were noted c A lab audit was conducted to determine if there were any additional missed labs. c All current resident appointments have been reviewed for potential omissions. None noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c All current resident appointments were reviewed to assure all recommendations have been acted upon. c The above audits were completed by Interim Director of Nursing Services; Director of Clinical Education and Director of Clinical Operations on 2/15/2022. c Current residents with surgical or pressure/arterial/venous ulcers wounds will be assessed for s/s of infection on 2/16/2022 with the Wound MD from Vohra. All findings will be documented in the progress notes by the Wound Care MD. Systematic Education Completed: c Licensed Nursing Team members were educated on receiving lab orders, orders for appointments, and other recommendations from the Director of Clinical Education and the Director of Clinical Operations on 2/15/2022. c Going forward, the nurse will assure that all orders received from outside appointments, including labs and recommendations are recorded in the electronic medical record. All recommendations will be called into MD for further instructions if any. c When taking orders for outside appointments, the order will go under the Lab description. The licensed nurse will check daily for appointments on the EMAR to ensure completed for the day. Nurse will document when resident leaves and returns from appointment. Nurse will document in medical record progress note section status of resident discharge and return from appointments. If resident has new orders they will be communicated with the MD/NP and documented in the medical record. c When the nurse is given orders for labs, they will be put under the Lab description. The nurse will check daily to ensure that labs are completed as ordered. If resident refuses the lab, the MD/NP will be notified for further follow up. c In daily clinical review all new orders will be reviewed to ensure that they have been completed and results reported to MD/NP and documented in the medical record. c During Clinical Review, the DNS or her designee will verify pending orders for labs and follow up appointments are completed as required. The DNS or designee will ensure the lab and/or appointment has been scheduled; in regard to an appointment the DNS or designee will ensure transportation has been scheduled and all notifications of pending lab and or appointment has been communicated to RP as needed. If a resident refuses the lab or appointment, the MD/NP will be notified for further follow-up. All licensed nursing team members were provided education on the expectation and the new process of handling follow up appointments and recommendations. The education and training were provided on 2/15/2022 by the Director of Education and the Director of Clinical Operations. Currently the facility does not utilize agency currently. Director of Clinical Education will educate all new hires and document education of these expectations during the orientation process before a new licensed team member is allowed to accept a schedule. For any applicable nursing team members who are currently off or on leave, The Director of Clinical Education will in-service those team members prior to their working their next shift. c QAPI: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A focused QAPI meeting addressing the finding was initiated and completed on 2-15-2022 with the attendance of the Administrator, DNS, Director of Clinical Operations, Regional Director of Operations and Medical Director. The focused QAPI reviewed procedures for resident outside appointments; labs; and new orders from outside appointments to ensure all areas were addressed. Going forward, the QAPI members will review all outside appointments to assure recommendations have been followed as ordered weekly for 4 weeks and then monthly for 2 months. Any variance from the recommendations will be corrected immediately and addressed in QAPI. The center acted swiftly with the corrective actions, team member re-education, and ensured auditing measures were in place to monitor the plan. The center utilized the QAPI process to address the identified deficient practice immediately and completed actions on or before 2-15-2022. Monitoring was initiated on 02/17/22 at 1:20 p.m. Interview on 02/17/22 at 1:20 p.m., LVN F said she had received in-services on labs (how to document in point click care, how to run the report on labs), resident doctor appointments, and communicating with the physician and family regarding resident (s) care. LVN F said she had also been in-serviced on documenting in point click care a resident (s) follow-up appointments, setting up transportation for doctor visits, and to following up that task had been completed. Interview on 02/17/22 at 1:25 p.m., LVN G who worked the 6a-2p shift said had been in-serviced on resident follow-up appointments and how to document in PCC, arrange transportation, documenting task in PCC. LVN G said when a resident returned from a doctor appointment to document in the Progress Notes any recommendations or new orders, labs were to be transcribed in PCC and in 24-hour communication in PCC. Interview on 02/17/22 at 1:30 p.m., LVN H who worked the 6a-2p shift said she had been in-serviced in the following areas; abuse and neglect, transcribing orders in PCC to flag in the computer. LVN H said when order was flagged it would stay yellow until the task had been carried out. LVN H said she was in-serviced on following up with labs that were ordered and to communicate with the physician of the results. LVN H said she was in-serviced on transcribing resent doctor appoints in PCC where all shifts could view. Interview on 02/17/22 at 2:00 p.m., LVN I who worked the weekend shift said he had been in-serviced on transcribing orders in PCC and to follow-up to ensure it was done and communicated to the physician as well as resident doctor appointments and recommendations or new orders. LVN I said he was also in-serviced on setting up transportation and communicating all on the 24-hour communication that was done in PCC as well. Interview on 02/17/22 at 2:15 p.m., LVN K said she worked the weekend shift. LVN K said she had be in-serviced in the following areas; transcribing all orders in PCC as well as doctor appoints and follow-ups along with any recommendations, following up on lab results and communicating to the physician, and documenting in PCC as well as Progress Notes communicating with all shifts to ensure all orders were being carried out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/17/22 at 2:20 p.m., RN L said she was a treatment nurse that worked 4p-8p and had been working at the NF for 2 months. RN L said she had received in-services on following up on resident appointments, communicating with the doctor and NP, entering all orders and doctor appoints in PCC under the lab section, if a resident lab or doctor appointment was missed communicate that to the doctor and NP, document all resident appointments going or coming utilizing the 24-hour communication form in PCC. Interview on 02/17/22 at 3:00 p.m., RN M said he worked the 2p-10p shift and had been in-serviced on doctor appointments ensuring all visits were being communicated and carried out, setting up doctor visits and transportation for the resident (s), transcribing all labs and doctor visits in PCC so that all disciplinaries could see it, and ensuring that all labs were being done with follow-up communicating with the doctor/NP of the results documenting in the Progress Notes. Interview on 02/17/22 at 4:25 p.m., LVN C she had been in-serviced in resident with follow-up appointments ensuring that all recommendations with the doctor office was communicated with the doctor or NP and placing those communications/recommendations in PCC, if resident had a follow-up appointment be sure to set up transportation, carrying out all physician orders and following up to see if it had been done, documenting in the Progress Notes and on the 24-hour communication regarding residents plan of care. Interview on 02/17/22 at 6:50 p.m., RN O said she said she worked the 2p-10p shift Monday through Friday. RN O said she had been in-serviced on transcribing all resident(s) with doctor appointment and follow-up appoints in PCC under lab section, following up on all physician orders and doctor appoints to ensure the order was carried out communicating on the 24-hour communication section in PCC and in the Progress Notes, and coordinating transportation for resident(s) doctor appointments. Interview on 02/17/22 at 7:00 p.m., LVN MM said she the night shift 10-6p. LVN MM said she had been in-services on transcribing all physician orders in PCC and communicating in PCC regarding 24-hour reporting on residents to ensure all shifts could view and nothing was missed, scheduling doctor appointments along with follow-up appointments including transportation. Interview on 02/18/22 at 12:45 a.m., RN Q said she worked the 10p-6a shift. RN Q said she had been in-serviced on transcribing physician orders, carrying all orders out, and communicating all test results to the doctor. RN Q said she also had been in-serviced on transcribing doctor appointments and follow-up appointments in PCC under labs and setting up transportation of resident(s) with doctor appointments ensuring all had been carried out. Interview on 02/18/22 at 10:50 a.m., RN P said he worked the weekend shift 6a-6p. RN P said he had been in-serviced in the following areas; transcribing all orders, doctor appointments, transportation for resident(s) with appointments outside of the facility documenting in PCC and the Progress notes. On 02/18/22 at 12:45 PM, the NF Administrator was notified the Immediate Jeopardy (IJ) was lowered. However, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 26454 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accidental hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one of ten residents (Resident #2) reviewed for accidents and supervision. The facility failed to provide adequate supervision and a safe environment free of safety hazards for Resident #2, who was cognitively impaired with a history of multiple falls and resulted in a serious injury. This failure placed cognitively impaired residents at risk of experiencing serious injuries from falls. Findings included: Record review of Resident #2's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with Alzheimer's Disease, dementia, acute kidney failure, diabetes, functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition), cognitive communication deficit, muscle wasting and atrophy, insomnia (persistent problems falling and staying asleep), contracture of left and right knees, anxiety, fall from bed-subsequent encounter, contusion of scalp-subsequent encounter, contusion of left eyelid and periocular area-subsequent encounter, and contusion of head-subsequent encounter. Resident #2 was discharged to a local acute care hospital on 01/17/2022 and returned to the facility on [DATE]. Resident #2 passed away in the facility in the facility on 02/05/2022. Record review of Resident #2's MDS dated [DATE] revealed she was rarely/never understood, no BIMS was conducted; her cognitive skills for daily decision making were moderately impaired; she required extensive physical assistance from at least one staff member for bed mobility, dressing, toilet use, personal hygiene, and locomotion, and total staff assistance with bathing; she was wheelchair bound and she was always incontinent of bowel and bladder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #2's care plan, updated 01/01/2022, revealed she was admitted to hospice care on 01/25/2022 related to end of life care and changes in condition; she had an ADL self-care performance deficit due to muscle weakness and Alzheimer's Disease; she required total assistance on her wheelchair; she had impaired cognitive function due to Alzheimer's Disease; she was at risk for falls due to gait/balance problems; she had actual falls without injury related to unsteady gait on 03/06/2020, 09/12/2020, and 10/29/2020; she had an actual fall from bed without injury on 08/06/2020; she had a fall from wheelchair after attempting to reach for her ice water on a table in front of her on 08/13/2021; she had a fall from bed while reaching for the stuffed animal at bed side table without injury on 01/14/2022; she had a fall sliding out of the wheelchair without injury on 01/15/2022; and she was observed on the floor beside her bed, agitated with a hematoma in the left forehead and was sent to the hospital for further evaluation on 01/17/2022 (Interventions included: Anticipate and meet the resident's needs: 04/29/2019, Be sure the resident's call light is within reach and encourage the resident to use it for assistance. The resident needs prompt response to all requests for assistance: 04/19/2019, Bed will remain in lowest position at all times: 08/06/2020, Educate the staff about safety reminders and what to do if a fall occurs: 04/29/2019, Review information on past falls and attempt to determine cause of fall. Record possible root causes. Alter/remove any potential causes if possible: 04/29/2019, The resident needs a safe environment with even floors free from spills and/or clutter, adequate glare-free light, a working and reachable call light, the bed in low position at night: 04/29/2019, Ensure that stuffed animal is with her in bed so she does not need to reach out for it and have a fall: 01/20/2022, Wheelchair assessment will be conducted by rehab department due to wheelchair safety and prevention of falls: 01/20/2022, Staff will ensure all items are within reach of resident when up in wheelchair: 08/13/2021, Bed may remain in lowest position at all times except with ADL care: 10/29/2020, Monitor/document/report PRN to doctor for signs and symptoms of pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, and agitation: 09/11/2019, Perimeter mattress so resident cannot fall from the edge of the bed: 01/21/2022; Resident will be in view of staff with door open, in central area when up in wheelchair except with meals: 10/29/2020) Record review of an incident report dated 01/14/2022 revealed LVN H wrote, Resident fell from bed to floor while reaching for stuffed animal at bedside, fall witnessed. Resident did not hit head. Resident assessed; no injury noted. Vital signs stable . MD/NP notified. When asked by writer what happened, resident pointed to stuffed animal while on floor. Once assessed and placed back into bed resident stated, [thank you mama] . Witnesses - No witnesses found . Record review of Post Fall Review (fall assessment) completed by LVN H dated 01/14/2022, revealed, 1. Date and time of fall: 01/14/2022, 5:45 p.m., 2. Activity at time of fall: Bed to floor, 3. Location of fall: in resident's room, 4. Prior to fall, patient was: In Bed, Reaching out, 5. Patient's explanation of how they fell , if able to communicate: pointed to stuff animal on floor, resident was reaching out, 6. Objective/underlying factors: History of falls (if selected, document details below), 6a. resident has dementia and is unaware of safe judgement . Recommendations/Interventions: Wheelchair positioning/seating devices, Evaluation of Footwear, Change in Footwear, Change in footwear, Night light, Bed in low position, Recliner chair, Mechanical lift for transfer, Toileting schedule, Physical Therapy, Perimeter mattress, Safety cues/reinforcement/reminder, Assistive device within reach, Signage- Stop sign, Evaluate timing of medications, Occupational Therapy, Daily nap, Restorative program, Psych Evaluation, Medical Evaluation, Anti-tippers, Pain assessment, Body pillow (s) for positioning, Wider mattress, Drop seat in wheelchair, Anti-rollback brakes, Wheelchair brake extensions with tops painted orange for additional visual cues, Medical Review, Evaluate Activity Program and encourage participation . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of an incident report dated 01/15/2022, revealed RN P wrote, CNA reported resident slipping off her wheelchair, landing on the ground on her left shoulder. Patient alert, denied pain, no signs of pain noted, no bruise on both shoulders. Immediate Action Taken, Description: Assisted patient back on wheelchair and back to her room and put in bed . Witnesses - No witnesses found . Record review of, Post Fall Review (fall assessment) completed by LVN A dated 01/15/2022, revealed, Date and time of fall: 01/15/2022, 2:51 p.m., 2. Activity at time of fall: Chair to floor, 3. Location of fall: nurse station, 4. Prior to fall, patient was: Other, 5. Patient's explanation of how they fell : sitting in wheelchair at nurse station, 6. Objective/underlying factors: History of falls (if selected, document details below) - 6a. fell yesterday . Recommendations/Interventions: Wheelchair positioning/seating devices, Evaluation of Footwear, Change in Footwear, Change in footwear, Night light, Bed in low position, Recliner chair, Mechanical lift for transfer, Toileting schedule, Physical Therapy, Perimeter mattress, Safety cues/reinforcement/reminder, Assistive device within reach, Signage- Stop sign, Evaluate timing of medications, Occupational Therapy, Daily nap, Restorative program, Psych Evaluation, Medical Evaluation, Anti-tippers, Pain assessment, Body pillow (s) for positioning, Wider mattress, Drop seat in wheelchair, Anti-rollback brakes, Wheelchair brake extensions with tops painted orange for additional visual cues, Medical Review, Evaluate Activity Program and encourage participation . Record review of an incident report dated 01/17/2022, at 3:00 p.m., revealed LVN H wrote Summoned to resident's room by CNA due to resident observed on the floor with brief off and in process of removing her shirt. Bed observed in lowest position, resident assessed, hematoma observed to left forehead, above eyebrow. Agitation noted, resident remained conscious and verbal. NP notified; Alert Medical Response called for transport to ER. Cold compress applied to hematoma and resident medicated with Tylenol due to possible pain . unable to explain: Dementia . Mental Status . Alert times 1, remained conscious but unable to express pain .Level of Pain: 2 . Facial Expression - Score 2: Facial Grimacing . Witnesses - No Witnesses found . Record review of Resident #2's hospital records revealed she was admitted on [DATE] and discharged back to the facility on [DATE]. The document read in part, . History of Present Illness: . presents to the emergency room after she had a witnessed fall from the bed. She fell from the bed while trying to get up and dressed. That happened around 3 p.m. in the afternoon. She immediately noticed to have left periorbital hematoma and a black eye. She was sent to the ER for further evaluation . Assessment/Plan: 1. Accidental fall from bed 2. Closed head injury 3. Contusion of scalp (left scalp hematoma, no intracranial bleed or trauma noted, Facial bone CT unremarkable) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with LVN A on 01/26/2022 at 11:00 a.m., she stated Resident #2 was normally pleasantly confused, she spoke English off and on (mostly Spanish), she had a little stuffed animal that she said was her baby, and she thought everyone was her daughter. LVN A said recently, Resident #2 took everything off, including her diapers and clothes. She said they told Resident #2 to put everything back on and she said ok, but then she took it all off again. She said Resident #2 was not ambulatory and required staff assistance to transfer to her wheelchair. She said Resident #2 could sometimes push herself in her wheelchair, but she did not walk. She said Resident #2 scooted while she was in her wheelchair and staff had to tell her to scoot back. She said in bed, Resident #2 scooted to one side of the bed while laying down. She said taking her shirt and brief off was normal for Resident #2 (for about four months) but it was not normal for her to fall. LVN A said on that day (01/17/2022), during shift change (around 2:00 p.m.), she was putting boxes outside the milk room door (which was almost directly across the hall from Resident #2's room) and she heard Resident #2 yell out, Mommy! She said CNA R was coming up the hall and heard the resident yell too. She observed CNA R peep her head into Resident #2's room and then called to LVN A that she was on the floor. She said she, CNA R, and LVN H all went into Resident #2's room and found her on the floor, faced-down with her arm inside her shirt (it looked like she was trying to take it off) and her brief was on the floor. She said when they turned Resident #2 over, she had a hematoma over left eyebrow. She said they tried to talk to her in Spanish, but she just rambled and did not answer question. She said she and the other staff found Resident #2 between her bed and the nightstand and the hematoma looked like and egg. She said they put Resident #2 in bed, they started doing vitals, called the doctor, then they called transport to take her to the hospital. She said since Resident #2 returned from the hospital, she had not been as talkative as she was before the fall. LVN A said when they got Resident #2 up in her wheelchair, she tried to get up and do stuff. She said Resident #2 was in a low bed when she fell and nobody else was in the room but her roommate (who was bed bound and not cognitively abled to participate in an interview). She said CNA R had just given Resident #2 care and commented that the resident kept taking her brief off when she came out of the room. CNA R told her Resident #2 was laying in the bed when she left her room. LVN A said Resident #2 could still move around when she wanted to and could put herself in a sitting position from laying. In an interview with LVN H on 01/26/2022, at 11:30 a.m., she said Resident #2 had a baby doll she liked to carry, and she tried to reach for it, so the staff kept it close to her. She said since Resident #2's fall on 01/17/2022, she would not eat, and she refused her medication. She said on 01/17/2022, her shift was over, and she was about to go home when CNA R came back up the hall to get her jacket and asked her to go to Resident #2's room because she was on the floor. She said she and the other staff turned Resident #2 over and saw she had a large hematoma, like she may have hit her head on something. She said LVN A was two doors down and went in first. LVN H said Resident #2's brief was off and, on the floor, and it looked like the resident was trying to get her shirt off when she fell . She said she called transportation and told them it was an emergency, so they were there in less than 20 minutes. She said CNA R went into Resident #2's room first, then when she went in, she saw the resident was down on her face. She said Resident #2 she was moving and squirming like she was trying to get her clothes off. She said when CNA R rolled Resident #2 over, they immediately saw a large hematoma and she said, Jesus Christ! LVN H said Resident #2 was in a low bed at that time and she would often have to redirect her from trying to get up. She said she and the aides would get her up into her wheelchair, but they knew she was always ready to go back to bed. She said when Resident #2 returned from the hospital, she saw that her face was all bruised. She said now, they have to monitor Resident #2 closely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with CNA R on 01/26/2022 at 11:50 a.m., she said she usually cared for Resident #2. She said Resident #2 was sometimes agitated and fussy and she had not been able to self-propel in her wheelchair for the last couple of months. CNA R said Resident #2 sometimes tied to get up and get on the edge of bed, so they got her up. She said Resident #2 could go from lying to sitting position by using the quarter rails at the head of her bed. She said that day (01/17/2022), Resident #2 was agitated, she did not want to eat, and she kept getting out of her brief and gown. She said at the end of her shift, she put Resident #2's gown and brief on and left her laying in her low bed. She said she was getting ready to leave and realized she forgot her jacket in the room next to Resident #2's. She said there was only about five minutes between the time she left Resident #2's room and when she returned to find her on the floor. She said she did not hear Resident #2 yell, just looked inside her room as she passed and saw her on the floor. She said she called for LVN H and LVN A to come and when they turned Resident #2 over, they saw a hematoma on her eye. She said Resident #2 fell in front of the nightstand that was beside her bed. CNA R said Resident #2 was so small that it may have looked like she was between the bed and the nightstand with her right side was down. She said Resident #2 was just repeating, Mommy. She said they asked Resident #2 if she was in pain, but she said no. Observation and interview with Resident #2 and CNA R on 01/26/2022, at 12:15 p.m. revealed Resident #2 was asleep and laying in a low bed with plastic bumpers on each side (perimeter mattress). Resident #2's bed was against the wall on her left and there was a nightstand to the right with approximately one foot of space between the nightstand and the bed. Resident #2's face was bruised with dark purple across her cheeks, nose, and under her eyes. Both of her eyes were dark purple. Resident #2 had a very large hematoma (a pool of mostly clotted blood that forms in an organ, tissue, or body space) that was dark purple to her left forehead. There was a small scab on the tip of the hematoma. Resident #2's top lip and the area under her nose were dark purple. CNA R demonstrated where Resident #2 was found on the floor on 01/17/2022. CNA R pointed and said Resident #2's head was found slightly between the bed and nightstand. Resident #2 woke up at that time and just looked. Resident #2 did not respond to questions, but she kept saying, alright when questioned. Resident #2 grabbed CNA R's hand several times and kissed it. CNA R said Resident #2 had on a hospital gown on 01/17/2022. In an interview with the Physical Therapist on 02/18/2022 at 12:15 p.m., she said physical therapy had just discharged Resident #2 on 01/13/2022, before she started falling again in January. She said they were about to pick Resident #2 up again and the wheelchair assessment to see about getting her a new one was scheduled for the day she went out to the hospital. She said she recalled hearing at the morning meeting the day after Resident #2 fell out of her wheelchair (01/15/2022) while she was sitting in the TV room (which was located near a nurse's station and the physical therapy room). Unsuccessful attempts were made to contact RN P by phone and text on 02/18/2022 at 11:04 a.m. and 02/24/2022 at 12:20 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with Interim DON on 02/18/2022 at 3:22 p.m., she said she was familiar with Resident #2 because she fell in the first week she started working at the facility. She said when Resident #2 fell on [DATE], her stuffed doll was out of reach, so the intervention was to make sure all of her things were within reach either in the bed or on the table. She said Resident #2's next fall was when she slid out of her wheelchair, but she could not recall if it was witnessed. Interim DON said for Resident #2's next fall, she was sent out and the intervention was a perimeter mattress. She said environmental assessments were done with fall assessments and it was routine to look at everything. She said she could not say if the environmental assessment was documented on the fall assessment. She said everything was taken into consideration with falls, including height of bed and environmental factors. She said the nightstand was not the cause of either of Resident #2's falls and they would not have care planned to move the table because the staff used it to feed her and keep her things close. Record review of facility policy dated February 2017, titled, Falls revealed, Purpose, To establish a process that identifies risk and establishes interventions to mitigate the occurrence of falls . Post fall . The post fall evaluation is completed to assist in developing interventions to prevent future falls . Implement interventions identified . Record review of, Provider Investigation Report, dated 02/01/2022 revealed Resident #2's injury was reported to Health and Human Services Commission on 01/25/2022 (the written report was submitted on 01/01/2022). The document read in part . Description of the Allegation; Resident was sitting on bed attempting to take off her shirt and slid off the bed and fell between the bed and the nightstand . Description of Injury; Hematoma to left forehead above her eyebrow . Provider response; Resident was assessed on the floor and then put into bed which was in the lowest position . Nightstand was immediately moved to other side of bed. In-service initiated with staff on abuse and falls by LVN A . Record review of, In-Service Training Record, dated 01/17/2022 revealed all facility staff were educated on preventing falls. The document read in part, Preventing Slips, Trips, and Falls in Patient Care Areas and Hallways; We know everyone has completed Slips, Trips, and Falls training however, due to an increase in falls inside and outside our center, we would like to re-visit a few specifics around preventing these types of team-member injuries in our center. Key things to remember in preventing injuries include the following: Make sure equipment, such as wheelchairs, lifts, and bed side tables are properly positioned and are not in the path of travel into and out of the room and bathroom .