STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455855	A. Building B. Wing	11/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennedy Health & Rehab	504 N John Redditt Dr Lufkin, TX 75904

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interview, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for 2 of 3 residents (Resident #1 and Resident #5) observed for care in that: The facility failed to ensure Resident #1's and Resident #5's urinary drainage bag (a bag at the end of an indwelling catheter that drains urine from the bladder) had a privacy cover in place on 10/26/24. This failure could affect residents in the facility who received care and could result in residents not being treated with dignity and respect. Findings include: 1.Record review of a facility face sheet dated 10/26/24 for Resident #1 indicated that he was a [AGE] year-old male originally admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: quadriplegia (a symptom of paralysis that affects all limbs and body from the neck down), urinary tract infection, and neuromuscular dysfunction of bladder (when a problem in your brain, spinal cord, or central nervous system makes you lose control of your bladder). Record review of a comprehensive MDS assessment dated [DATE] for Resident #1 indicated that interview for BIMS score should not be conducted due to resident being rarely/never understood. Section C (cognitive patterns) indicated that he was independent with cognitive skills for daily decision making. He was dependent with all ADLs. He had an indwelling urinary catheter and an ostomy. Record review of a comprehensive care plan dated 10/3/24 for Resident #1 indicated that he had an indwelling catheter due to wounds with the following intervention: .ensure catheter is placed in a privacy bag . 2.Record review of a facility face sheet dated 10/26/24 for Resident #5 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: epilepsy (a seizure disorder), type 2 diabetes (uncontrolled blood sugar), and peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an admit/readmit screener dated 10/25/24 for Resident #5 indicated that she was oriented to person, place, time, and situation; she was dependent for most all ADLs; and she had a catheter. Record review of electronic medical record for Resident #5 indicated that MDS assessment was in process and not completed yet. Record review of a baseline care plan for Resident #5 dated 10/25/24 indicated that she had an indwelling catheter with no interventions listed. During an observation on 10/26/24 at 12:20 pm Resident #1 was observed up in a motorized wheelchair in the dining room. He was observed with a urinary drainage bag on the left side of his chair with no privacy cover in place. During an observation and interview on 10/26/24 at 12:35 pm Resident #5 was observed lying in bed. She had a urinary drainage bag hanging on the side of her bed with no privacy cover in place. Resident's door was open, which would allow passersby to see her urinary drainage bag. She said she had just admitted last night. She said no one at the facility had said anything about a privacy cover for her urinary drainage bag. She said, That would be really nice. During an interview on 11/1/24 at 9:57 am Administrator said she started at the facility in August of 2024. She said privacy bags needed to be in place for resident's dignity. During an interview on 11/2/24 at 3:56 pm DON said she expected her staff to ensure privacy bags were in place for residents with a urinary drainage bag. She said it was a dignity issue for the residents. She said she would be monitoring to ensure they were used going forward. Record review of a facility policy titled Catheters - Insertion and Care - Indwelling, Straight, Supra-pubic and External dated 5/2017 read .place catheter drainage bag in a cover to preserve dignity of the resident . Record review of a facility policy titled Resident Rights dated 2001 and revised in December 2016, read . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 2 of 6 residents reviewed for ADLs (Residents #1 and Resident #6) 1. The facility failed to give Resident #6 a bath as scheduled or clean/groom his fingernails. Resident #6 had long, overgrown fingernails with skin buildup and a black substance underneath them and his skin was dry and scaly from 10/30/2024-11/1/2024. 2.The facility failed to give Resident #1 a bath as scheduled or clean/groom his fingernails. Resident #1 had long fingernails that had brown substance underneath them from 10/30/2024-11/1/2024. These failures could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity, and health. Findings included: 1.Record review of an Admission Record for Resident #6 dated 10/30/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of type 2 diabetes, quadriplegia (paralyzed from the neck down that affected both arms and legs), contracture to right elbow (shortening and hardening of the muscles leading to deformities). Record review of a Significant Change MDS assessment dated [DATE] for Resident #6 indicated he did not have any impairment in thinking with a BIMS score of 15. He was dependent on staff with showering/bathing and personal hygiene. Record review of a care plan for Resident #6 dated 6/18/2024 indicated he had an ADL self-care performance deficit with interventions for bathing/showering: showers are to be done on scheduled shower days, as requested, and as needed. Personal hygiene/oral care: he was dependent on one staff for personal hygiene and oral care. Record review of the bathing task for Resident #6 dated 10/30/2024 for 9/1/2024-9/30/2024 indicated only two baths were documented for the entire month that included 9/18/2024 and 9/25/2024. All other dates for the Monday, Wednesday, Friday schedule were blank. Record review of the bathing Task for Resident #6 dated 10/30/2024 for 10/1/2024-10/31/2024 indicated only one bath was documented on 10/18/2024.All other dates for the Monday, Wednesday, Friday schedule were blank. Record review of shower sheets for October 2024 for Resident #6 indicated only one shower sheet was found dated 10/28/2024 and said the resident was in the hospital, and it was signed by the DON. Record review of an undated shower schedule at the nurse desk in a binder indicated Resident #6 scheduled shower days were Monday, Wednesday, and Friday on the 2 pm -10 pm shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/30/2024 at 7:35 AM, Resident #6 was in the hospital in bed awake, alert, and oriented to person, place, and time. He said he was unsure of when he arrived at the hospital. He had contractures noted to both hands, skin was dry and scaly. His right hand had dry skin buildup that was white/brown in color on his palm and around his fingernails. His fingernails were long on both hands and had a black substance underneath them. He said there was a lack of getting showers at the nursing facility, but they did give him bed baths at times. During an observation and interview on 11/1/2024 at 8:41 AM, Resident #6 was back at the facility in his room awake in bed. He said he came back to the facility on yesterday 10/31/2024. His skin was dry, scaly, and fingernails long on both hands with a brown substance underneath them. His hands were contracted, and fingernails had an overgrowth of skin present. During an observation and interview on 11/1/2024 at 8:56 AM, CNA H was present on the hall were Resident #6 resided. She said she had been employed at the facility for a year and worked the 6 am-2 pm shift, but they rotated halls when they worked. She said the nurse aides were responsible for giving the resident's showers. She said the showers for residents on the hall were Resident #6 resided were on Monday, Wednesday, and Friday. She said they filled out a shower sheet with each bath given and documented if they noticed any skin issues. She said part of their tasks were to clip and file fingernails and toenails, but if the residents were diabetic then the nurses were responsible for it. She said Resident #6 used to be on the Monday, Wednesday, and Friday 2 pm -10 pm shower schedule because the residents that had baths scheduled on the 2 pm -10 pm shift were not getting them. She said she had never given him a bath because he was on the 2 pm -10 pm shift, but he was scheduled to get one that day 11/1/2024. She observed Resident #6 in bed and said he looked like he needed a bath, his fingernails were long and dirty, skin was dry and needed a shave. She said his right hand was dirty. She said it had been about a month or so when they noticed there were issues with residents not getting their showers and the DON and Administrator were aware. She said the staff were told they were trying to get it worked out. She said she would feel nasty and untended to if it was her that did not get baths or showers on a regular basis. She said Resident #6 did not refuse care. During an observation and interview on 11/1/2024 at 9:16 AM, LVN J was the nurse assigned to the hall where Resident #6 resided. She said she had been employed at the facility for [AGE] years and worked 6 am -2 pm shift. She observed Resident #6 and said he had scaly skin; his nails were long and had dirt underneath them and needed to be cut. She said she had cut them before, and it may have been about 2 weeks ago. She said since he was diabetic the nurses were responsible for cutting his nails. She said they were supposed to check weekly, but it was not on the TAR, and they would just have to remember to check. She said she would not like it if she needed care, and her skin was scaly. She said he also needed a shave. She said the nurse aides were responsible for giving the residents their baths and they were to fill out a shower sheet after each bath, if a resident refused, they would put that on the sheet and turn it into the nurse who would then enter a progress note into the resident's electronic health record. She said the form would then be given to the DON to sign. 2. Record review of an Admission Record for Resident #1 dated 11/2/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of hypotension (low blood pressure), quadriplegia (paralyzed from the neck down that affected both arms and legs), chronic respiratory failure (difficulty breathing) and encounter for attention to tracheostomy (opening in the neck that connects to the windpipe that helps with breathing). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Significant Change MDS Assessment for Resident #1 dated 7/16/2024 indicated he did not have any impairment in thinking with a BIMS score of 15. He was dependent with self-care that included bathing and personal hygiene. Record review of a care plan for Resident #1 dated 7/30/2024 indicated he was dependent with two people for assistance and had ADL self-care performance deficit musculoskeletal impairment (quadriplegia) with interventions to set-up, assist, give shower, shave, oral, hair, nail care per schedule and PRN. Record review of shower sheets for October 2024 for Resident # 1 indicated only one shower sheet was found dated 10/12/2024 and it indicated he refused and was signed by the DON. Record review of an undated shower schedule at the nurse desk in a binder indicated Resident #1 scheduled shower days were Monday, Wednesday, and Friday on the 2 pm -10 pm shift. During an observation and interview on 10/31/2024 at 7:50 AM, Resident #1 was in bed sitting up, hands contracted, fingernails were long with a brown substance underneath all of his nails. He said he had taken a shower a few times but liked to get bed baths. His facial hair was long, had food particles and white flakes on his face and in his beard. He said he had not received a bed bath/shower since he came back from the hospital this last time on 10/28/2024 and could not remember the last time he had a bath. He said the staff had not offered him one and was unsure of when his showers days were. He said the staff never ask to trim his fingernails and would like to have them trimmed. He said he did refuse wound care sometimes but most times, they did not ask if he wanted to get a bath or not. During an observation and interview on 11/1/2024 at 8:30 AM, Resident #1 was in bed awake, said he came back from the hospital last night about 9 pm after going to the ER for treatment. He said they told him nothing was wrong and just drew blood. His fingernails on both hands were still long with a light brown substance underneath them. During an observation and interview on 11/1/2024 a 9:09 AM, CNA F was on the hall where Resident #1 resided. She said she had never given him a bath before, and he was always in and out of the hospital. She said she never assisted someone else with giving him a bath either. She said his shower days were Monday, Wednesday, and Friday on the 2 pm -10 pm shift but this past Wednesday the schedule changed to Monday, Wednesday, and Friday on the 6 am -2 pm shift. She said the nurse aides were responsible for giving the residents their baths that included washing their hair, checking for skin issues, checking toenails, clean and clip nails if they were not diabetic. She said if they were diabetic then it was the nurse responsibility to trim their nails. She said Resident #1 was contracted and if she gave him a bath, she would make sure to clean his hands. She went in his room and looked at his hands and said his fingernails were long and needed to be clipped and they had dirt underneath them. She said his palms were dry and needed lotion. She said it would make her want to die and not live if she did not get the care she needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 9:30 AM, the DON said they were having a shortage of staff on 2 pm - 10 pm and moved the showers to the 6 am - 2 pm shift and put the people that only needed supervision or minimal assistance on the 2 pm - 10 pm shift. She said the nurse aides should be washing hair, body, notifying the nurse of any skin issues, document on the shower sheets after each shower, and give them to the charge nurse. She said cleaning fingernails were the responsibility of the nurse aides and nurse aides can trim but not diabetics when needed and if they were too thick to trim, they were placed on the podiatrist list who visited the facility every 3 months. She said whenever Resident #6 went to the hospital, she noticed that he only had one shower done for the month of October 2024 after checking the bathing task that were in the electronic health record. She said if it was not documented, then it was not done. She said she tried to locate the shower sheets for him but could not find any more shower sheets. She said the nurse aides gave Resident #6 bed baths. She said he was one on the 2-10 shift along with Resident #1 and was moved to the 6 am-2 pm shift. She said she would be upset about not getting showers and her fingernails cleaned. She said they noticed there was an issue about a week ago and changed the shower schedule that week. During an interview on 11/1/2024 at 9:57 AM, the Administrator said she hired at the facility in August 2024. She said she was aware of the issues with ADL care about 3 weeks ago, talked to the DON and realized that the 2 pm-10 pm shift was not giving the showers and they reworked the shower schedule and moved the minimal assist residents to 2 pm-10 pm shift. She said the nurse aides were responsible for baths, nurses were responsible for diabetic nail care, the podiatrist visited the facility once every 3 months and if the resident were not diabetic then the nurse aides could provide nail care. She said there was a risk for infections and if not properly groomed it could be embarrassing. Record review of a facility policy titled Activities of Daily Living dated 5/2017 indicated, .It is the policy of this home to assure residents have their activities of daily living needs met .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview and record review the facility failed to ensure a resident received care consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated it was unavoidable and residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 4 residents (Resident #6 and Resident #7) reviewed for pressure ulcers. The facility failed to ensure Resident's #6 and #7 received accurate and weekly skin assessments to prevent the development of or worsening of pressure ulcers. These failures could place residents at risk for improper wound management, the development of new pressure ulcers and deterioration in existing pressure ulcers/injuries. The findings include: 1. Record review of an Admission Record for Resident #6 dated 10/30/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of type 2 diabetes, quadriplegia (paralyzed from the neck down that affected both arms and legs), contracture to right elbow (shortening and hardening of the muscles leading to deformities). Record review of a Significant Change MDS assessment dated [DATE] for Resident #6 indicated he did not have any impairment in thinking with a BIMS score of 15. He was dependent on staff with showering/bathing and personal hygiene. He was at risk for developing pressure ulcer/injuries but did not have any unhealed pressure ulcers/injuries. Record review of a care plan for Resident #6 dated 6/18/2024 indicated he had actual impairment to skin integrity of the right lateral ankle related to immobility revised on 8/19/2024 with interventions to monitor/document location, size, and treatment of skin injury. Had actual impairment to skin of the sacrum initiated on 8/16/2024. Record review of active orders for Resident #6 dated 10/30/2024 indicated an order to clean sacral wound with normal saline, apply collagen powder, hydrogel with silver and cover with gauze island border one time a day that started on 10/18/2024. Record review of weekly skin assessments for Resident #6 indicated he did not have a skin assessment for the following weeks: o 8/18/2024-8/24/2024 o 10/20/2024-10/26/2024 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/30/2024 at 7:35 AM, Resident #6 was in the hospital in bed awake. He was alert and oriented to person, place, and time. He said he has a wound to his left leg and the facility performed wound care about once a month and he did not refuse care from anyone at the facility. He said he also had a wound to his left knee and buttocks. 2. Record review of an Admission Record for Resident #7 dated 10/30/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of displaced intertrochanteric fracture of right femur (break in the upper part of the thigh bone between the bony protrusions where the thigh and hip muscles attach), hypothyroidism (when the thyroid gland does not make enough thyroid hormone) and Alzheimer's disease. Record review of an Admission/5 Day MDS Assessment for Resident #7 dated 10/28/2024 was in progress and not completed. Record review of a care plan for Resident #7 indicated she had actual impairment to skin integrity of the right hip related to surgical wound date initiated on 10/30/2024 with interventions to monitor/document location, size, and treatment of skin injury. Follow facility protocols for treatment of injury. Record review of active physician orders dated 10/30/2024 for Resident #7 indicated an order to change enclosed dressing system once a week on 2 pm-10 pm one time a day every Monday. Record review of a skin assessment for Resident #7 dated 10/21/2024 indicated there were skin issues noted that included bruising to groin and right thigh with three incisions with staples present and wound vac to incision lines. The skin assessment did not indicate any other skin issues. During an observation and interview on 10/30/2024 at 10:45 AM, the Sitter of Resident #7 was at the nurse desk talking to LVN C. The Sitter showed LVN C a picture of an area she found on Resident #7's right heel that morning. LVN C followed the Sitter to the room for a skin assessment. Resident #7's right heel was noted with a hardened area, pink and blue discolored area to back of her heel. LVN C said she would notify the physician. During an observation and interview on 10/30/2024 at 10:50 AM, the Sitter of Resident #7 was in the room after LVN C left. She said the facility staff would only come in the room when she told them to. She said she was not providing care to Resident #7 and was only a companion to her. She said she visited Monday-Thursday from 8:30 am -12:30 pm. She said on admission last Monday (10/21/2024) to the facility, she had a small hardened callous area to her right heel and thinks it was from the swelling she had while in the hospital. She said the area had increased in size from last Monday (10/21/2024) and she alerted the nurse to be aware. She said she did not think they were aware of it until she showed LVN C the picture. She said the resident would speak occasionally but had Alzheimer's. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 1:11 pm, CNA F said she had been employed at the facility for 3 years and worked 6 am - 2 pm and rotated halls when she worked. She said if the nurse aides observed a new skin area, they were to report as soon as possible to the charge nurse and they could also chart in the computer. She said she had been off for a few days and that day 10/30/2024was her first day with Resident #7. She said she assisted with getting her up out of bed and changed her. She said the resident had a private sitter that would feed and sit with the resident. She said she did not notice anything new skin issues with the resident during care that morning. She said the resident did have boots on and the sitter removed them when she was positioned in her chair. She said the facility had a lack of communication. During an interview on 10/30/2024 at 1:16 PM, LVN C said she had been employed at the facility for 4 months and worked 6 am-2 pm. She said the nurses were responsible for skin assessments on the day shift on Tuesdays. She said she was not aware of the area on Resident #7's heel until the sitter brought it to her attention that morning. She said the residents all had a different schedule for skin assessments, but all residents should have a skin assessment conducted weekly. She said there could be a risk of not having treatment orders, risk for decline in health and medical conditions, if left untreated could lead to worsening of things. She said the charge nurses have a printed TAR in a binder on the nurse cart for treatment orders, but the skin assessments were done in the computer system. During an interview on 11/1/2024 at 9:30 AM, the DON said the floor nurses were responsible for skin assessment and should be done once a week. She said she recognized an issue with skin assessments not being done and had been an ongoing issue for about a month. She said she made a list for the nurses and was making them go back and complete the skin assessments. She said skin assessments were documented in the electronic health record. She said and on admission it was inside the admission assessment. She said there could be a risk for missed assessments with wounds or something else if they were not done weekly. During an interview on 11/1/2024 at 9:57 AM, the Administrator said she hired at the facility in August 2024. She said the nurses were responsible for the skin assessments in the facility. She said the skin assessments should be done weekly and as needed. She said there could be risk for unnoticed wounds starting, venous, and pressure sores if they did not get their weekly skin assessment. She said the skin did not take long to break down due to being compromised. Record review of a facility policy titled Skin-Treatment Guidelines for Pressure Injuries revised 5/2017 indicated, .It is the policy of this home to utilize treatment guidelines when providing care for residents with pressure injury and to prevent further deterioration of pressure injury. Stage 4: 14. Indicate dressing change date, time, and initials on dressing. Complete the skin assessment flow sheet form in the clinical software weekly until injury is resolved. 15. Document dressing completion on the treatment administration record (TAR). Unstageable: 13. Indicate dressing change date, time, and initials on dressing. Complete the skin assessment flow sheet form in the clinical software weekly until injury is resolved. 14. Document dressing completion on the treatment administration record (TAR) . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Skin-Integrity Monitoring System dated 5/2017 indicated, .It is the policy of this home that: 1. A system will be in place to assure that all residents will be assessed and monitored for any type of skin breakdown. 2. A system will be in place to assure that all residents will be assessed, and preventative measures will be in place to prevent the development of pressure injuries. 3. A system will be in place to assure any type of skin conditions that do not constitute pressure injuries, will be monitored closely for any type of complications. Assessment and monitoring: 3. All residents will be assessed weekly using the (Weekly Skin Assessment) form for any type of skin integrity complications; this will include pressure injury and non-pressure related complications. The (Weekly Skin Assessment) will be documented on the (Weekly Skin Assessment) in clinical software .

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	455855	A. Building B. Wing	11/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennedy Health & Rehab	504 N John Redditt Dr Lufkin, TX 75904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 46273 Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 4 residents (Resident #2 and Resident #5) reviewed for incontinent care and catheter care. The facility failed to ensure CNA A and CNA B properly cleaned the penis of Resident #2 during incontinent care. The facility failed to ensure Resident #5's indwelling catheter (drains urine from your bladder into a bag outside your body) had a securement device to anchor her catheter. The facility failed to ensure Resident#5's urinary catheter drainage bag tubing did not touch the floor. This failure could place residents at risk for urinary tract infections and catheter related injuries. Findings include: Resident #2 Record review of a facility face sheet dated 10/26/24 for Resident #2 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: cerebral infarction (stroke), cerebral palsy (a group of conditions that affect movement and posture caused by brain damage before birth), and hyperlipidemia (high cholesterol). Record review of a comprehensive MDS assessment dated [DATE] for Resident #2 indicated that he had a BIMS score of 3, which indicated that he had severely impaired cognition. He was dependent with toileting hygiene. He was always incontinent of bladder and bowel. Record review of a comprehensive care plan dated 10/17/24 for Resident #2 indicated that he was incontinent of both bladder and bowel and had an intervention to monitor for incontinence every 2 hours and prn and change promptly. During an observation on 10/26/24 at 3:10 pm CNA A and CNA B were observed performing incontinent care on Resident #2. During incontinent care, CNA A was observed to wipe down the penis from the bottom of the shaft to the tip, on the topside. She did not pick up the penis and clean the tip or the entire shaft. During an interview on 10/26/24 at 3:30 pm CNA A said she did not pick up the penis and clean it properly. She said she should have cleaned the tip and the shaft. She said today was her fourth day at the facility and she did not know why she did not properly clean Resident #2's penis. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 Record review of a facility face sheet dated 10/26/24 for Resident #5 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: epilepsy (a seizure disorder), type 2 diabetes (uncontrolled blood sugar), and peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs). Record review of an admit/readmit screener dated 10/25/24 for Resident #5 indicated that she was oriented to person, place, time, and situation; she was dependent for most all ADLs; and she had a catheter. Record review of electronic medical record for Resident #5 indicated that MDS assessment was in process and not completed yet. Record review of a baseline care plan for Resident #5 dated 10/25/24 indicated that she had an indwelling catheter with no interventions listed. During an observation on 10/26/24 at 12:35 pm Resident #5 was observed lying in bed with a urinary drainage bag hanging on the side of her bed. The tubing for the urinary drainage bag was observed lying on the floor. There was no catheter strap to secure tubing to her leg. During an interview on 11/1/24 at 9:30 am the DON said when peri care was provided to a male resident, staff should be wiping the tip of penis and wipe downward. She said tubing for foley drainage bags should never be on the floor and it should be anchored to the skin on the resident's thigh. She said residents could be at risk for infections due to improper peri care. During an interview on 11/1/24 at 9:57 am the Administrator said she had been employed at the facility since August of 2024. She said residents could be at risk for trauma and infection if staff do not follow proper procedures with incontinent care and foley care. She said the tubing should be positioned on the thigh with a secured clamp, and never on the floor. Record review of a facility form titled CNA Proficiency Audit for CNA A dated 10/3/24 indicated that CNA A had been trained on perineal care for a male. Record review of a facility policy titled Incontinent Care/Perineal Care with or without a catheter dated 5/2017 read .clean head of penis in a circular motion .wash complete shaft of penis working down the shaft - pat dry . Record review of a facility policy titled Catheters - Insertion and Care - Indwelling, Straight, Suprapubic and External dated 5/2017 read .secure urinary drainage bag below the level of the bladder and keep off the floor. Coil extra tubing and secure .attach catheter strap to leg to assist in securing tubing .

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive care plan, and the residents' goals and preferences for 1 of 1 resident (Resident #1) reviewed for respiratory care. The facility failed to ensure LVN C did not reuse a single use suction catheter with Resident #1 on 10/31/24. The facility failed to ensure LVN C employed sterile technique during suctioning and tracheostomy care with Resident #1 on 10/31/24. The facility failed to ensure LVN C did not use tap water when performing tracheal suctioning for Resident #1 on 10/31/24. The facility failed to ensure LVN C used intermittent suctioning during care on 10/31/24. The facility failed to train nursing staff on proper tracheostomy care and tracheal suctioning procedures. An Immediate Jeopardy (IJ) was identified on 10/31/2024. While the IJ was removed on 11/2/2024 at 3:02 p. m., the facility remained out of compliance at a scope of no actual harm with potential for more than minimal harm that is not immediate jeopardy and scope of isolated due to the facility's need to monitor and evaluate the effectiveness of their corrective systems. These failures could place residents requiring tracheostomy care and tracheal suctioning at risk for respiratory complications, infections, and/or death. Findings included: Record review of a facility face sheet dated 10/26/24 for Resident #1 indicated that he was a [AGE] year-old male originally admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: quadriplegia (a symptom of paralysis that affects all limbs and body from the neck down. Record review of a comprehensive MDS assessment dated [DATE] for Resident #1 indicated that interview for BIMS score should not be conducted due to resident being rarely/never understood. Section C (cognitive patterns) indicated that he was independent with cognitive skills for daily decision making. He was dependent with all ADLs. He had a tracheostomy, an indwelling urinary catheter and an ostomy. Record review of a comprehensive care plan dated 10/3/24 for Resident #1 indicated that he had a tracheostomy and had the following interventions: .will have sterile suctioning procedure as needed . and . will have sterile tracheostomy care: cleanse around trach site and replace drain sponge. Change trach ties as needed . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a physician's order summary report dated 11/2/24 for Resident #1 indicated he had the following physician's orders: .Tracheostomy care one time a day . and .may suction prn for secretions . During an interview and observation on 10/28/24 at 2:30 pm Resident #1 was observed at [hospital name] lying in his hospital bed. Resident #1 said the facility changed his ties and did trach care once a week. He said he felt like the facility was unequipped to handle his trach care. During an interview and observation on 10/31/24 at 7:50 am Resident #1 was observed in bed sitting up in bed. He said the facility did not have the staff to properly take care of him and they did not clean his trach often as they should. During an observation on 10/31/24 at 7:37 am LVN C was in Resident #1's room to provide suctioning to his trach per his request. She went into the room and washed her hands, put on a gown and nonsterile gloves in the hallway and entered the room with a plastic cup and a sterile water container. She then put on another pair of nonsterile gloves on top of the pair of gloves that were on her hands for a total of 2 gloves on each hand. She then placed the cup and sterile water on the nightstand beside the bed. She turned on the overbed light and then removed a pair of gloves and placed them in the trash. She placed another pair of nonsterile gloves on top of the gloves that were on her hands. She pulled the linens down on the resident and removed the cap that was on the trach. She removed a pair of gloves and placed them in the trash. She put on another pair of nonsterile gloves on top of the pair of gloves that were already present on her hands for a total of 2 gloves on each hand. She turned the suction machine on and removed the suction tubing from the plastic package that was already opened on one end and inserted the tubing down into the trach and suctioned. She placed the tubing in the sterile water to clean the tubing of any secretions and placed it back inside the plastic packaging that it was in previously. She placed the cap on the trach and removed her gloves and gown and placed them in the biohazard box that was in the room. She washed her hands in the bathroom and exited the room. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 10/31/24 at 9:25 am LVN C was observed performing suctioning and tracheostomy care on Resident #1. She did not use sterile technique during care. She was observed wiping down overbed table, she then washed her hands, donned gown, mask, and non-sterile gloves. She was observed to apply a second pair of non-sterile gloves over the first pair. She then opened a packet containing a sterile drape/towel and laid it on the cleaned table. She then opened trach care kit and with non-sterile gloved hands, removed each item from kit and placed it on the sterile field/drape that had been laid on an overbed table. She then opened the sterile water container and poured it into the open tray that was on sterile field with lid folded underneath it. She then opened the peroxide, also pouring it into the tray. She was observed touching all the ends of the cotton swabs and twirling them around in her fingers before placing them back down onto the sterile field. She then opened another trach kit and removed supplies from it with non-sterile gloved hand, also placing them on the sterile field and placed kit tray with lid folded underneath it on sterile field as well. She then removed top pair of gloves and discarded them. Resident #1 then requested to be suctioned. She walked away from sterile field with the supplies on it and left room. She reenters room with another sterile water container. She then removed her PPE, placed water on table next to sterile field and washed hands in restroom. She returned to hall to don more PPE, re-entered room and with non-sterile gloved hands, applied a second pair of non-sterile gloves. She then poured sterile water into a non-sterile plastic cup, turned on suction machine and removed the purple cap from resident's trach. She laid the cap on his hoodie on his chest. She then took the suction tubing in non-sterile gloved hand and removed suction catheter from previously opened bag and inserted it into resident's tracheostomy opening. After resident began to cough, she put her thumb over the opening in the tubing and suctioned the entire time she slowly withdrew (approximately 10-15 seconds, then suctioned water into the tubing. She repeated this twice. She then placed the suction catheter back into the open packaging and laid it back on table. Resident exhibited facial grimacing during the procedure. She threw away the outer gloves and applied another pair of non-sterile gloves over the first pair. She then removed the inner cannula. Inner cannula was placed in peroxide to soak. She picked up the package of sterile gloves and moved them to the edge of the sterile field. She then unvelcroed the right side of his trach collar and removed the split gauze. She then removed outer gloves and opened sterile gloves. She applied the sterile gloves over her non-sterile gloves. She then took sterile drape and placed it over his chest and just underneath his neck. She poured sterile water into the 2nd trach care plastic tray and then peroxide as well. She then placed gauze in the peroxide, squeezed out excess liquid and cleaned top of trach tube flange. She then repeated to clean the bottom. She then cleaned with cotton swabs to remove thick, yellow substance from underneath trach tube. She was observed cleaning the inside of inner cannula with pipettes and then placed it in sterile water to soak. She then removed the trach collar from the right side and attached the new collar to the right side and then walked around to the other side of resident, held outer tube in place with her left hand and unvelcroed the left side of old collar. She then pulled new collar behind his neck and velcroed in place. She then secured both sides with Velcro and placed a new split gauze. She then was observed patting dry the inner cannula with gauze pad and placed it back inside trach tube. She then removed her sterile gloves and put on a pair of non-sterile gloves over the original pair. She placed another sterile drape over his chest, turned on suction machine, took a non-sterile plastic cup into bathroom and came out with water in cup. She then suctioned him again using same technique as above with same suction catheter and then replaced suction tubing catheter back into packaging and left it lying on table. Resident again exhibited facial grimacing while suctioning. She then replaced purple trach tube cap, removed gloves and PPE, washed hands, and exited room. Date and time on suction catheter tubing observed to be 10/31/24 8:39 am. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/31/24 at 11:50 am LVN C said she had been employed at the facility for approximately 4 months. She said during the trach care provided to Resident #1 this morning, she was not sure what she did wrong, just maybe would have changed her gloves more. She said she did have training before employment but not a check off at the facility on trach care. She said she had never had any competency training with someone where she had to do a return demonstration and was told if the skills were correct or not. She said no skills check off were conducted. She said she thought that she had done all the correct steps. She said she was told the suction tubing was supposed to be changed out today, she thought it was changed out that morning. She said they normally use sterile water or distilled or sometimes they must use the water from the bathroom sink. She said she had not actually received any training. She said when she started, they asked her if she had trach training at another facility. She said she had 3 days of orientation, and she wasn't physically shown how to do the care but had just been told verbally how to do it. She said she was never asked if she felt comfortable with caring for him. She said sometimes she did not feel comfortable with caring for him and did not have the skills nor training to care for him. She said residents could be at risk for harm and not being properly cared for. During a telephone interview on 10/30/24 at 3:31 pm LVN D said she had been employed at the facility since August of 2024 and worked the 6am-2pm shift, rotating halls. She said she had not received any training since being in the facility. She said she had not had any training on trach care and suctioned him at least twice during her shifts and sometimes more. She said she had some trach knowledge from a previous job. During an interview on 10/31/24 at 12:20 pm the DON said trach care training with nursing staff was done on hire and yearly thereafter. She said they had an RT who would come to the facility yearly to conduct trach training with the staff. She said the last time they were at the facility was about a year ago and it was time for them to come back. She said she had trained the new employees in the facility as she had been trained by RT to train other staff on the proper procedures to care for a trach resident. She said she would train the staff unless the RT would be conducting the training. She said the training she provided to the staff was not as extensive as the RT's training. She said once the training was completed, the staff were to complete a return demonstration to show competency. She said there was a risk for improper care to the residents in the facility if the staff had not been trained on how to care for a resident who had a trach. She said trach care was a sterile technique and sterile water should be used when cleaning or suctioning. She said suction should be intermittent and not continuous when pulling the tubing out. She said trach care should be performed once a day and the floor nurses were responsible for providing trach care. During an interview on 10/31/24 at 12:46 pm Medical Director said he was the facility medical director and began his employment with the facility in September 2024. He said nursing was responsible for training the staff on proper tracheostomy care and technique. He said there was a risk for introducing organisms into the trach if the care was not done properly. He said he was not aware of any issues with tracheostomy procedures at the facility. He said he had made rounds at the facility the other day and he was aware that Resident #1 did have a trach. He said staff should follow sterile technique when providing care to a resident who had a trach. He said if care was not done properly with a trach resident, they could be at risk for pneumonia and aspiration. He said it was never acceptable for staff to use tap water when providing trach care. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 10/31/24 at 4:10 pm LVN G said she had been trained on trach care by LVN C but mainly with LVN D. She said they had shown her how to suction Resident #1, clean the tubing, flush before and after fluid return, and if he asked her to go deeper when she suctioned him to tell him she could not go any farther than resistance when she inserted the tubing. She said she was told to tell him that she could not. She said she did not receive any training from RT or the DON on trach care. During an interview on 11/1/24 at 9:30 am the DON said in the last year they have had a lot of new staff, new management, and no consistent nurse manager to help her. She said LVN C was observed by her initially to do trach care and suctioning and breathing treatments, but she never received the training on trach care. The DON said she filled out the form yesterday for LVN C because she had done observation with her but did not take the test. She said the nurses should be trained yearly. She said they were done yearly. She said residents could be at risk for infections and incorrect care from not having proper training. During an interview on 11/1/24 at 9:57 am the Administrator said she was hired at the facility in August 2024. She said DON was responsible for training staff on respiratory care and said she was going to see about getting an RT to train the staff for more expertise in that area. She said residents could be at risk for trauma, infection if staff do not follow proper procedures. Record review of a competency evaluation for LVN D indicated that on 8/1/24 she was satisfactory with trach care. Record review of a competency evaluation for LVN K indicated that on 5/9/24 she was satisfactory with trach care. Record review of a competency evaluation for LVN C indicated that on 6/5/34 she was satisfactory with trach care. Record review of a competency evaluation for LVN J indicated that on 6/2/22 she was successfully trained on respiratory/trach. Record review of a facility policy titled Tracheostomy Care dated 5/2017 read .It is the policy of this home to provide Tracheostomy care in accordance with current standards of practice to ensure airway patency, maintain skin integrity, and prevent infection . and .Aseptic technique must be used/sterile gloves must be worn: during tracheostomy tube changes (non-disposable and disposable); during cleaning and sterilization of non-disposable tracheostomy tubes; .and .during endotracheal suctioning . The Administrator and DON were notified of an IJ on 10/31/24 at 2:07 pm and was given a copy of the IJ template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 10/31/24 at 5:18 pm and included the following: 10/31/2024 Trach care Immediate actions: (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Review of facility records identified 1 resident receiving Trach care. This was verified on 11/2/24 - Resident #1 o Resident #1 PCP notified, and care plan reviewed and updated as needed. o Resident #1 will be assessed and monitored q Shift for signs and/or symptoms of infection related to trach care. o One on one training and return demonstration to be conducted with LVN identified. o All nurses will show understanding by return demonstration. o One nurse from each shift will be properly trained by DON with return demonstration and be the sole nurse providing trach care on that shift by 5 pm on 10/31/2024 DON will be responsible for the procedure until one nurse on each shift is trained. o Remaining nurses will be trained and provide return demonstration by: in-service completed On: 11/01/2024 by 5 PM. Any nurse that is not trained will be trained prior to returning to their next shift. On 11/2/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Verified that Resident #1 was the only resident in facility with a tracheostomy. PCP notification verified on 11/2/24 by record review of a progress note documenting MD notification and record review of Resident #1's care plan indicating update occurred on 11/2/24. Record review of TAR verified that trach monitoring was now included for Resident #1. In-service regarding tracheostomy care and suctioning and respiratory therapy training was held on 11/2/24 at 6 am and was signed by DON (instructor) and LVN C In-services on tracheostomy care and suctioning and respiratory therapy trainings were held 10/31/24 through 11/2/24, instructed by DON and attended by 14 licensed nurses. Return demonstration on dummy setup observed on 11/2/24 with 7 nurses in facility. At least one nurse from each shift. Observations and interviews on 11/2/24 between the hours of 12:00 pm and 2:45 pm Licensed nurses (LVN C, LVN G, LVN J, LVN L, LVN M, and LVN N) were observed performing a verbal return demonstration on a dummy setup and were able to verbalize procedure was a sterile technique and demonstrate sterile technique via return demonstration on dummy set-up. LVN C, LVN G, LVN J, LVN L, LVN M, and LVN N said they were in-serviced on tracheostomy care and suctioning. They said they would never use any water other than sterile water and would use intermittent suctioning and never continuous suctioning. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 11/2/24 at 1:00 pm the DON was observed performing appropriate tracheostomy care and suctioning on Resident #1 with no breaks in infection control or sterile technique. She wore appropriate PPE, used sterile water in sterile water container, and appropriately used intermittent suctioning. On 11/2/24 at 3:02 pm the DON was informed the IJ was removed; however, the facility remained out of compliance at a scope of no actual harm with potential for more than minimal harm that is not immediate jeopardy and scope of isolated due to the facility's need to monitor and evaluate the effectiveness of their corrective systems.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 4 of 4 staff (CNA A, CNA B, LVN C, and LVN D) reviewed for competent nursing care. CNA A failed to clean Resident # 2's penis properly during incontinent care provided on 10/26/24. CNA A and CNA B failed to wear PPE for enhanced barrier precautions during incontinent care for Resident #2 on 10/26/24. LVN D failed to wear PPE for enhanced barrier precautions during wound care on Resident # 3 on 10/28/24. LVN C failed to utilize sterile technique when performing trach care and suctioning on Resident #1 on 10/31/24. These deficient practices affect residents who depend on nursing care and could place residents at risk for infection and harm. Findings included: Resident #2 Record review of a facility face sheet dated 10/26/24 for Resident #2 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: cerebral infarction (stroke), cerebral palsy (a group of conditions that affect movement and posture caused by brain damage before birth), and hyperlipidemia (high cholesterol). Record review of a comprehensive MDS assessment dated [DATE] for Resident #2 indicated that he had a BIMS score of 3, which indicated that he had severely impaired cognition. He was dependent with toileting hygiene. He was always incontinent of bladder and bowel. Record review of a comprehensive care plan dated 10/17/24 for Resident #2 indicated that he was incontinent of both bladder and bowel and had an intervention to monitor for incontinence every 2 hours and prn and change promptly. He also had a pressure ulcer to the sacrum with focus initiated on 9/18/24 with the following intervention: .administer treatments as ordered and monitor for effectiveness . Care plan did not address enhanced barrier precautions. Resident #3 (continued on next page)

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Kennedy Health & Rehab	504 N John Redditt Dr Lufkin, TX 75904

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a facility face sheet dated 10/27/24 for Resident #3 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: dementia, anemia (low iron in blood), and hypertension (high blood pressure). Record review of a quarterly MDS assessment dated [DATE] for Resident #3 indicated that she had a BIMS score of 11, which indicated that she had moderately impaired cognition. She required moderate to total assist with most all ADLs. She was always incontinent of bowel and bladder. Record review of a physician's progress note dated 10/24/24 for Resident #3 indicated that she had a stage 3 pressure wound to the right buttock for greater than 48 days. Record review of a comprehensive care plan for Resident #3 dated 8/23/24 indicated that care plan did not address enhanced barrier precautions. Resident #1 Record review of a facility face sheet dated 10/26/24 for Resident #1 indicated that he was a [AGE] year-old male originally admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: quadriplegia (a symptom of paralysis that affects all limbs and body from the neck down), urinary tract infection, and neuromuscular dysfunction of bladder (when a problem in your brain, spinal cord, or central nervous system makes you lose control of your bladder). Record review of a comprehensive MDS assessment dated [DATE] for Resident #1 indicated that interview for BIMS score should not be conducted due to resident being rarely/never understood. Section C (cognitive patterns) indicated that he was independent with cognitive skills for daily decision making. He was dependent with all ADLs. He received tracheostomy care and suctioning. Record review of a comprehensive care plan dated 10/3/24 for Resident #1 indicated that he had a tracheostomy with the following interventions: .will have sterile suctioning procedure as needed . and .will have sterile tracheostomy care: cleanse around trach site and replace drain sponge. Change trach ties as needed . During an observation on 10/26/24 at 3:10 pm CNAs A and B were observed to provide incontinent care on Resident #2. Both were observed to wash their hands before beginning care. Neither one donned PPE for enhanced barrier precautions. CNA A donned gloves and unfastened resident's brief and exposed his peri area. She then wiped each side of groin/inner thigh area and was then observed to wipe straight down middle of peri area, over the topside of resident's penis. She did not pick penis up to clean tip or shaft. Resident was then turned, and CNA B completed incontinent care on resident's anal/rectal/buttocks area. They were then observed to place new brief on resident, reposition him in bed, lower his bed to lowest position and place his call light within reach. Both were then observed to wash their hands and dispose of trash. During an interview on 10/26/24 at 3:25 pm CNA A said she should have picked the penis up and cleaned the tip and shaft appropriately. She did not know why she did not do that. She said she had been trained on proper peri care for male residents. She said she had not been trained on enhanced barrier precautions and she did not know what they were. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/26/24 at 3:30 pm CNA B said she also did not know what enhanced barrier precautions were and had not been trained on them. During an interview on 10/16/24 at 3:40 pm Administrator was asked for the policy on enhanced barrier precautions. She said she had already given it to me, it was the one titled MDRO When informed that CNA A and B both said they had not been trained on enhanced barrier precautions, her reply was They probably haven't, if that is what they said. She said Resident #2 did not have an MDRO and did not need enhanced barrier precautions. During an interview on 10/26/24 at 3:45 pm DON said she had not considered Resident #2's wound chronic. She said it was open and he had had it for about 2 months. She said they would train staff on enhanced barrier precautions. She said they had now printed out the provider letter and they would have a meeting and would also be training new staff. She said both CNA A and CNA B were new. During an observation on 10/28/24 at 1:00 pm LVN D was observed to perform wound care on Resident #3. She did not don PPE for enhanced barrier precautions during wound care. During an interview on 10/28/24 at 1:15 pm LVN D said she was not aware of enhanced barrier precautions and had not been trained on them. During a telephone interview on 10/30/24 at 3:31 pm LVN D said she had been employed at the facility since August of 2024 and worked the 6am-2pm shift, rotating halls. She said she had not received any training since being in the facility. She said she had not had any training on trach care and suctioned him at least twice during her shifts and sometimes more. She said she had some trach knowledge from a previous job. During an observation on 10/31/24 at 7:37 am LVN C was in Resident #2's room to provide suctioning to his trach per his request. She went into the room and washed her hands, put on a gown and nonsterile gloves in the hallway and entered the room with a plastic cup and a sterile water container. She then put on another pair on nonsterile gloves on top of the pair of gloves that were on her hands for a total of 2 gloves on each hand. She then placed the cup and sterile water on the nightstand beside the bed. She turned on the overbed light and then removed a pair of gloves and placed them in the trash. She placed another pair of nonsterile gloves on top of the gloves that were on her hands. She pulled the linens down on the resident and removed the cap that was on the trach. She removed a pair of gloves and placed them in the trash. She put on another pair of nonsterile gloves on top of the pair of gloves that were already present on her hands for a total of 2 gloves on each hand. She turned the suction machine on and removed the suction tubing from the plastic package that was already opened on one end and inserted the tubing down into the trach and suctioned for about 15 seconds with continuous suction when she was pulling the tubing back up out of the trach. The resident had facial grimacing and was trying to cough. She removed the tubing and placed in the container of sterile water to remove any secretions that were present. She inserted the tubing a second time down the trach and suctioned for about 15 seconds with continuous suction when she was pulling the tubing back up out of the trach. The resident continued to have facial grimacing when she was suctioning and was trying to cough. She placed the tubing in the sterile water to clean the tubing of any secretions and placed it back inside the plastic packaging that it was in previously. She placed the cap on the trach and removed her gloves and gown and placed them in the biohazard box that was in the room. She washed her hands in the bathroom and exited the room. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 10/31/24 at 9:25 am LVN C was observed performing suctioning and tracheostomy care on Resident #1. She did not use sterile technique during care. She was observed wiping down overbed table, she then washed her hands, donned gown, mask, and non-sterile gloves. She was observed to apply a second pair of non-sterile gloves over the first pair. She then opened a packet containing a sterile drape/towel and laid it on the cleaned table. She then opened trach care kit and with non-sterile gloved hands, removed each item from kit and placed it on the sterile field/drape that had been laid on an overbed table. She then opened the sterile water container and poured it into the open tray that was on sterile field with lid folded underneath it. She then opened the peroxide, also pouring it into the tray. She was observed touching all the ends of the cotton swabs and twirling them around in her fingers before placing them back down onto the sterile field. She then opened another trach kit and removed supplies from it with non-sterile gloved hand, also placing them on the sterile field and placed kit tray with lid folded underneath it on sterile field as well. She then removed top pair of gloves and discarded them. Resident #1 then requested to be suctioned. She walked away from sterile field with the supplies on it and left room. She reentered room with another sterile water container. She then removed her PPE, placed water on table next to sterile field and washed hands in restroom. She returned to hall to don more PPE, re-entered room and with non-sterile gloved hands, applied a second pair of non-sterile gloves. She then poured sterile water into a non-sterile plastic cup, turned on suction machine and removed the purple cap from resident's trach. She laid the cap on his hoodie on his chest. She then took the suction tubing in non-sterile gloved hand and removed suction catheter from open bag and inserted it into resident's tracheostomy opening. After resident began to cough, she put her thumb over the opening in the tubing and suctioned the entire time she slowly withdrew (approximately 10-15 seconds, then suctioned water into the tubing. She repeated this twice. She then placed the suction catheter back into the open packaging and laid it back on table. Resident exhibited facial grimacing during the procedure. She threw away the outer gloves and applied another pair of non-sterile gloves over the first pair. She then removed the inner cannula. Inner cannula was placed in peroxide to soak. She picked up the package of sterile gloves and moved them to the edge of the sterile field. She then unvelcroed the right side of his trach collar and removed the split gauze. She then removed outer gloves and opened sterile gloves. She applied the sterile gloves over her non-sterile gloves. She then took sterile drape and placed it over his chest and just underneath his neck. She poured sterile water into the 2nd trach care plastic tray and then peroxide as well. She then placed gauze in the peroxide, squeezed out excess liquid and cleaned top of trach tube flange. She then repeated to clean the bottom. She then cleaned with cotton swabs to remove thick, yellow substance from underneath trach tube. She was observed cleaning the inside of inner cannula with pipettes and then placed it in sterile water to soak. She then removed the trach collar from the right side and attached the new collar to the right side and then walked around to the other side of resident, held outer tube in place with her left hand and unvelcroed the left side of old collar. She then pulled new collar behind his neck and velcroed in place. She then secured both sides with Velcro and placed a new split gauze. She then was observed patting dry the inner cannula with gauze pad and placed it back inside trach tube. She then removed her sterile gloves and put on a pair of non-sterile gloves over the original pair. She placed another sterile drape over his chest, turned on suction machine, took a non-sterile plastic cup into bathroom and came out with water in cup. She then suctioned him again using same technique as above with same suction catheter and then replaced suction tubing catheter back into packaging and left it lying on table. Resident again exhibited facial grimacing while suctioning. She then replaced purple trach tube cap, removed gloves and PPE, washed hands, and exited room. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/31/24 at 11:50 am LVN C said she had been employed at the facility for approximately 4 months. She said during the trach care provided to Resident [NAME] this morning, she was not sure what she did wrong, just maybe would have changed her gloves more. She said she did have training before employment but not a check off at the facility on trach care. She said she had never had any competency training with someone where she had to do a return demonstration and was told if the skills were correct or not. She said no skills check off were conducted. She said she thought that she did all the correct steps. She said she was told the suction tubing was supposed to be changed out today, she thought it was changed out that morning. She said the Administrator had told her that she would have to change the tubing out. She said they normally use sterile water or distilled or sometimes they must use the water from the bathroom sink. She said she had not actually received any training. She said when she started, they asked her if she had trach training at another facility. She said she had 3 days of orientation, and she wasn't physically shown how to do the care, but just told verbally. She said she was never asked if she felt comfortable with caring for him. She said sometimes she did not feel comfortable with caring for him and did not have the skills nor training to care for him. She said residents could be at risk for harm and not being properly cared for. During an interview on 10/31/24 at 12:20 pm DON said trach care training with nursing staff was done on hire and yearly thereafter. She said they had an RT who would come to the facility yearly to conduct trach training with the staff. She said the last time they were at the facility was about a year ago and it was time for them to come back. She said she had trained the new employees in the facility as she had been trained by RT to train other staff on the proper procedures to care for a trach resident. She said she would train the staff unless the RT would be conducting the training. She said the training she provided to the staff was not as extensive as the RT's training. She said once the training was completed, the staff were to complete a return demonstration to show competency. She said there was a risk for improper care to the residents in the facility if the staff had not been trained on how to care for a resident who had a trach. She said trach care was a sterile technique and sterile water should be used when cleaning or suctioning. She said suction should be intermittent and not continuous when pulling the tubing out. She said trach care should be performed once a day and the floor nurses were responsible for providing trach care. During an interview on 11/1/24 at 9:30 am DON said in the last year they have had a lot of new staff, new management, and no consistent nurse manager to help her. She said LVN C was observed by her initially to do trach care and suctioning and breathing treatments, but she never received the training on trach care. DON said she filled out the form yesterday for LVN C because she had done observation with her but did not take the test. She said the nurses should be trained yearly. She said they were done yearly. She said when care was provided to a male resident, staff should be wiping the tip of penis and wipe downward. She said residents could be at risk for infections and incorrect care from not having proper training. During an interview on 11/1/24 at 9:57 am Administrator said she had started at the facility in August 2024. She said she had in serviced staff on EBP. DON was the Infection Preventionist and was responsible for training staff on infection control. The ADON was new and would be responsible for training staff on hire and once a year. DON was responsible for training staff on respiratory care. She said she was going to see about getting an RT to train the staff for more expertise in that area. Residents could be at risk for trauma and infections if staff do not follow proper procedures with incontinent care. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a competency evaluation for LVN D indicated that on 8/1/24 she was satisfactory with trach care. Record review of a competency evaluation for LVN C indicated that on 6/5/34 she was satisfactory with trach care. Record review of a facility form titled CNA Proficiency Audit for CNA A and dated 10/3/24 indicated that CNA A had been trained on perineal care for a male. Record review of a facility policy titled Incontinent Care/Perineal Care with or without a catheter dated 5/2017 read .clean head of penis in a circular motion .wash complete shaft of penis working down the shaft - pat dry . Record review of a facility policy titled Tracheostomy Care dated 5/2017 read .It is the policy of this home to provide Tracheostomy care in accordance with current standards of practice to ensure airway patency, maintain skin integrity, and prevent infection . and .Aseptic technique must be used/sterile gloves must be worn: during tracheostomy tube changes (non-disposable and disposable); during cleaning and sterilization of non-disposable tracheostomy tubes; .and .during endotracheal suctioning . Record review of a facility policy titled Competency of Nursing Staff dated 1/2024 read .licensed nurses and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care . and .facility and resident-specific competency evaluations will include: a. lecture with return demonstration for physical activities; a pre- and post-test for documentation issues; c. demonstrated ability to use tools, devices, or equipment used to care for residents .

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 43994 Based on record review and interviews, the facility failed to conduct and document a comprehensive facility-wide assessment for the past year to determine what resources were necessary to care for its residents competently during day-to-day operations and review and update the assessment at least annually for 1 of 1 facility reviewed. The Facility Assessment had not been updated since February 2023. This failure could place residents at risk of their needs going unmet and result in a lack of services provided by the facility to competently care for all residents. The findings included: Record review of the Facility Assessment indicated last review date of February 2023. During an interview on 10/31/2024 at 8:10 AM, the Administrator said she had been employed at the facility since July 26, 2024, but her first day in the facility was not until August 1, 2024. She said she looked at the facility assessment shortly after she started work and knew that there were some new requirements per state and saw that the number for the acuity of the resident population was accurate. She said the facility bed classification was updated on October 1, 2024. She said the last time the facility assessment was updated was in February 2023. She said at a minimum it should be updated at least once a year. She said she updated the first page to reflect the facility had a new Medical Director and dated it August 2024 but did not update anything else in the assessment. She said she thought she had more things to tend to, looked through the assessment and it was accurate. She said she knew it should have been updated prior to her employment at the facility. Record review of a facility policy titled Facility Assessment revised October 2023 indicated, .A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. 9. The facility assessment is reviewed and updated annually, and as needed .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to establish and maintain an infections 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 3 of 6 residents (Resident #1, Resident #2, and Resident #3) and 4 of 4 staff (CNA A, CNA B, LVN C, and LVN D) reviewed for infection control. 1. The facility failed to ensure CNA A and CNA B wore appropriate PPE for enhanced barrier precautions when providing incontinent care to Resident #2 on 10/26/24. 2. The facility failed to ensure CNA B sanitized or washed her hands between glove changes while providing incontinent care to Resident #2 on 10/26/24. 3. The facility failed to ensure LVN D wore appropriate PPE for enhanced barrier precautions when performing wound care on Resident # 3 on 10/28/24. 4. The facility failed to ensure LVN C used appropriate sterile technique when performing trach care and suctioning for Resident #1 on 10/31/24. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: 1. Record review of a facility face sheet dated 10/26/24 for Resident #2 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: cerebral infarction (stroke), cerebral palsy (a group of conditions that affect movement and posture caused by brain damage before birth), and hyperlipidemia (high cholesterol). Record review of a comprehensive MDS assessment dated [DATE] for Resident #2 indicated that he had a BIMS score of 3, which indicated that he had severely impaired cognition. He was dependent with toileting hygiene. He was always incontinent of bladder and bowel. Record review of a comprehensive care plan dated 10/17/24 for Resident #2 indicated that he was incontinent of both bladder and bowel and had an intervention to monitor for incontinence every 2 hours and prn and change promptly. He also had a pressure ulcer to the sacrum with focus initiated on 9/18/24 with the following intervention: .administer treatments as ordered and monitor for effectiveness . Care plan did not address enhanced barrier precautions. During an observation on 10/26/24 at 3:10 pm CNA A and CNA B were observed performing incontinent care on Resident #2. Neither CNA wore gowns during incontinent care for enhanced barrier precautions. CNA B was observed removing gloves after providing incontinent care on rectal/anal area and applying a new pair of gloves without sanitizing or washing her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/26/24 at 3:25 pm CNA A said she was unaware of enhanced barrier precautions, did not know what they were, and the facility had not trained her on enhanced barrier precautions. During an interview on 10/26/24 at 3:30 pm CNA B said she did not sanitize or wash her hands after removing the gloves. She said she should have done that. She also said she was unaware of enhanced barrier precautions and had not received any training on them from the facility. 2. Record review of a facility face sheet dated 10/27/24 for Resident #3 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: dementia, anemia (low iron in blood), and hypertension (high blood pressure). Record review of a quarterly MDS assessment dated [DATE] for Resident #3 indicated that she had a BIMS score of 11, which indicated that she had moderately impaired cognition. She required moderate to total assist with most all ADLs. She was always incontinent of bowel and bladder. Record review of a comprehensive care plan for Resident #3 dated 8/23/24 indicated that care plan did not address enhanced barrier precautions. Record review of a physician's progress note dated 10/24/24 for Resident #3 indicated that she had a stage 3 pressure wound to the right buttock for greater than 48 days. During an observation on 10/28/24 at 1:00 pm LVN D was observed to perform wound care on Resident #3. She did not wear a gown for enhanced barrier precautions during wound care. During an interview on 10/28/24 at 1:15 pm LVN D said she was not aware of enhanced barrier precautions and had not been trained on them. 3. Record review of a facility face sheet dated 10/26/24 for Resident #1 indicated that he was a [AGE] year-old male originally admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: quadriplegia (a symptom of paralysis that affects all limbs and body from the neck down), urinary tract infection, and neuromuscular dysfunction of bladder (when a problem in your brain, spinal cord, or central nervous system makes you lose control of your bladder). Record review of a comprehensive MDS assessment dated [DATE] for Resident #1 indicated that interview for BIMS score should not be conducted due to resident being rarely/never understood. Section C (cognitive patterns) indicated that he was independent with cognitive skills for daily decision making. He was dependent with all ADLs. He had an indwelling urinary catheter and an ostomy. Record review of a comprehensive care plan dated 10/3/24 for Resident #1 indicated that he had a tracheostomy and had the following interventions: .will have sterile suctioning procedure as needed . and . will have sterile tracheostomy care: cleanse around trach site and replace drain sponge. Change trach ties as needed . Record review of a physician's order summary report dated 11/2/24 for Resident #1 indicated he had the following physician's orders: .Tracheostomy care one time a day . and .may suction prn for secretions . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/31/24 at 7:37 am LVN C was in Resident #2's room to provide suctioning to his trach per his request. She went into the room and washed her hands, put on a gown and nonsterile gloves in the hallway and entered the room with a plastic cup and a sterile water container. She then put on another pair on nonsterile gloves on top of the pair of gloves that were on her hands for a total of 2 gloves on each hand. She then placed the cup and sterile water on the nightstand beside the bed. She turned on the overbed light and then removed a pair of gloves and placed them in the trash. She placed another pair of nonsterile gloves on top of the gloves that were on her hands. She pulled the linens down on the resident and removed the cap that was on the trach. She removed a pair of gloves and placed them in the trash. She put on another pair of nonsterile gloves on top of the pair of gloves that were already present on her hands for a total of 2 gloves on each hand. She turned the suction machine on and removed the suction tubing from the plastic package that was already opened on one end and inserted the tubing down into the trach and suctioned. She placed the tubing in the sterile water to clean the tubing of any secretions and placed it back inside the plastic packaging that it was in previously. She placed the cap on the trach and removed her gloves and gown and placed them in the biohazard box that was in the room. She washed her hands in the bathroom and exited the room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennedy Health & Rehab	504 N John Redditt Dr Lufkin, TX 75904

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/31/24 at 9:25 am LVN C was observed performing suctioning and tracheostomy care on Resident #1. She was observed wiping down overbed table, she then washed her hands, donned gown, mask, and non-sterile gloves. She was observed to apply a second pair of non-sterile gloves over the first pair. She then opened a packet containing a sterile drape/towel and laid it on the cleaned table. She then opened trach care kit and with non-sterile gloved hands, removed each item from kit and placed it on the sterile field/drape that had been laid on an overbed table. She then opened the sterile water container and poured it into the open tray with lid folded underneath it that was on sterile field. She then opened the peroxide, also pouring it into the tray. She was observed touching all the ends of the cotton swabs and twirling them around in her fingers before placing them back down onto the sterile field. She then opened another trach kit and removed supplies from it with non-sterile gloved hand, also placing them on the sterile field and placed kit tray with lid folded underneath it on sterile field as well. She then removed top pair of gloves and discarded them. She walked away from sterile field with the supplies on it and left room. She reentered room with another sterile water container. She then removed her PPE, placed water on table next to sterile field and washed hands in restroom. She returned to hall to don more PPE, re-entered room and with non-sterile gloved hands, applied a second pair of non-sterile gloves. She then poured sterile water into a non-sterile plastic cup, turned on suction machine and removed the purple cap from resident's trach. She then took the suction tubing in non-sterile gloved hand and removed single use suction catheter from already open bag and inserted it into resident's tracheostomy opening to suction resident. She cleaned suction tubing catheter with water before placing the suction catheter back into the open packaging and laid it back on table. She threw away the outer gloves and applied another pair of non-sterile gloves over the first pair. She then removed the inner cannula. Inner cannula was placed in peroxide to soak. She picked up the package of sterile gloves and moved them to the edge of the sterile field. She then unvelcroed the right side of his trach collar and removed the split gauze. She then removed outer gloves and opened sterile gloves. She applied the sterile gloves over her non-sterile gloves. She then took sterile drape and placed it over his chest and just underneath his neck. She then performed trach care for resident. After completions she removed her sterile gloves and put on a pair of non-sterile gloves over the original pair. She placed another sterile drape over his chest, turned on suction machine, took a non-sterile plastic cup into bathroom and came out with water in cup. She then suctioned him again using same technique as above with same suction catheter and then replaced suction tubing catheter back into packaging and left it lying on table. Resident again exhibited facial grimacing while suctioning. She then replaced purple trach tube cap, removed gloves and PPE, washed hands, and exited room. During an interview on 10/31/24 at 11:50 am LVN C said she had been employed at the facility for approximately 4 months. She said during the trach care provided to Resident #1 this morning, she was not sure what she did wrong, just maybe would have changed her gloves more. She said she thought that she had done all the correct steps. During an interview on 10/16/24 at 3:40 pm Administrator was asked for the policy on enhanced barrier precautions. She said she had already given it to this surveyor, it was the one titled MDRO When informed that CNA A and B both said they had not been trained on enhanced barrier precautions, her reply was They probably haven't, if that is what they said. She said Resident #2 did not have an MDRO and did not need enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/26/24 at 3:45 pm DON said she had not considered Resident #2's wound chronic. She said it was open and he had had it for about 2 months. She said they would train staff on enhanced barrier precautions. She said they had now printed out the provider letter and they would have a meeting and would also be training new staff. She said both CNA A and CNA B were new. During an interview on 10/31/24 at 12:20 pm DON said trach care was a sterile technique. During an interview on 11/1/24 at 9:57 am the Administrator said she had started at the facility in August 2024. She said she had in serviced staff on EBP. DON was the Infection Preventionist and was responsible for training staff on infection control. The ADON was new and would be responsible for training staff on hire and once a year. Record review of a facility form titled CNA Proficiency Audit for CNA A and dated 10/3/24 indicated that CNA A had been trained on infection control. Record review of a facility form titled CNA Proficiency Audit for CNA B and dated 9/11/24 indicated that CNA B had been trained on handwashing and infection control. Record review of a competency evaluation for LVN C indicated that on 6/5/24 she was satisfactory with trach care. Record review of a facility policy titled Tracheostomy Care dated 5/2017 read .Aseptic technique must be used/sterile gloves must be worn: during tracheostomy tube changes (non-disposable and disposable); during cleaning and sterilization of non-disposable tracheostomy tubes; .and .during endotracheal suctioning . Record review of a facility policy titled Hand Washing dated 5/2017 read .Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: .after removing gloves . Record review of a facility policy titled Infection Control - Multidrug Resistant Organisms (MDROs) dated 5/2017 read .Staff will use Standard Precautions as the primary approach to preventing transmission of MDROs . Record review of a facility policy titled Infection Control - Precautions - Categories and Notices dated 5/2017 read .Standard Precautions will be used in the care of all residents regardless of their diagnosis, or suspected or confirmed infection status .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility was free of pests for 2 of 2 hallways, 1 of 1 nurses station, 2 of 8 residents (Resident #1 and Resident #8), and 1 of 1 ice chest reviewed for pest control. The facility failed to ensure the 100 and 300 hallways and the common nurse's station between the 2 hallways were free of gnats and pests on 10/30/31 through 11/2/24. The facility failed to ensure Resident #8's room was free on gnats on 10/30/24. The facility failed to ensure the Ice Chest located at nurses' station for 100 and 300 hallway residents did not have a gnat inside it on 10/30/24. The facility failed to ensure Resident #1's room was free of gnats on 10/31/24. This failure could place residents at risk of a diminished quality of life due to an unsanitary environment. Findings include: Record review of a facility face sheet dated 10/26/24 for Resident #1 indicated that he was a [AGE] year-old male originally admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: quadriplegia (a symptom of paralysis that affects all limbs and body from the neck down)., Record review of a comprehensive MDS assessment dated [DATE] for Resident #1 indicated Section C (cognitive patterns) indicated that he was independent with cognitive skills for daily decision making. He had a tracheostomy (an opening in the front of the throat allowing resident to breath. During an observation on 10/31/24 at 9:25 am LVN C was observed performing tracheostomy care and suctioning on Resident #1 in his room. She had to swat at gnats during the provision of tracheostomy care and suctioning. Gnats were observed flying around Resident #1's open tracheostomy. During an observation on 10/31/24 at 4:10 pm Resident #1's chair was observed with multiple gnats flying and landing all over the chair cushion. Record review of a facility face sheet dated 11/2/24 for Resident #8 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of dementia. Record review of a comprehensive MDS assessment dated [DATE] for Resident #8 indicated that she had a BIMS score of 9, which indicated that she had moderately impaired cognition. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 10/30/24 at 12:30 pm Resident #8's Family Member said they had brought Resident #8 chicken for lunch yesterday (10/29/24) and the box was still in her trash can in her room. Chicken box observed in residents' trash can with gnats flying all around and inside can. He said Resident #8 could not even eat in peace. During observations on 10/26/24 between the hours of 2:15 pm and 3:10 pm gnats were observed flying on hallway 300. During an observation on 10/28/24 at 12:20 pm gnats were observed flying on hallway 100. During an observation on 10/29/24 at 9:47 am a CNA was observed sitting at the nurse's station between hallways 100 and 300 swatting at gnats. During an observation on 10/30/24 at 4:32 pm an ice chest was observed at the nurse's station for 100 and 300 hallways. Ice in chest was observed with a gnat in the ice. During a joint interview on 10/26/24 at 3:45 pm the DON and Administrator both said that pest control company was coming next week to spray for the gnats. During an interview on 10/29/24 at 3:40 pm LVN K said there were always gnats in the facility, and someone was at the facility now to spray for them. During an interview on 10/30/24 at 11:30 am Family Member of Resident #8 said the facility had had gnats for about a month and a half. He said he had told the facility, and they just came in the room and mopped with bleach. Resident #8 observed sitting up in bed trying to eat lunch with gnats flying around food while she tried to eat. During an interview on 10/30/24 at 12:19 pm the Maintenance Man said they had had problems with gnats for about 2 to 3 weeks and pest control sprayed weekly. He said he did not have documentation of this nor of what they sprayed because they do not give that to him unless they were called out special like they were yesterday. He said as far as he was aware, yesterday (10/29/24) was the first time they had sprayed for gnats. During an interview on 10/30/24 at 4:00 pm the Housekeeping Supervisor said her staff emptied resident room trash cans daily. During an interview on 10/31/24 at 3:25 pm the Pest Control representative said her company provided pest control for the facility. She said the facility was set up as a commercial customer and they provide them with a monthly service which included spraying for ants, roaches, and spiders. She said she did not have any documentation of her company providing any spraying for flies or gnats until 10/29/24. She said flies and gnats were not included in their monthly service for commercial customers. During an interview on 11/1/2024 at 9:30 am the DON said they had noticed gnats a few weeks ago in the facility and they were scattered throughout. She said they had notified maintenance and had pest control come out. She said they came this week and sprayed foam down the drains and not sure what drains were treated. She said it was much improved the next day. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/1/24 at 9:57 am the Administrator said she was hired at the facility in August 2024. She said pest control come on a regular basis, but they came out special and treated the drains this week. She said they shot some foam down them. She also said food left out was a problem. She said she planned to continue to see the underlying cause of the gnats and get the housekeeping department to make sure they are doing their jobs and emptying the trash daily. Record review of an invoice from [Company name] pest control dated 10/29/24 indicated that facility drains were treated for ants, cockroaches, beetles, gnats, fruit flies, drain flies, acrobat ants, little black ants, odorous house ants, flies, sugar ants, and fungus. Invoice read .foamed all floor drains in facility. Also foamed sinks of some bathrooms . Record review of a facility policy titled Pest Control dated 2001 and revised in October 2023 read .Our facility shall maintain an effective pest control program . and .Garbage and trash are not permitted to accumulate and are removed from the facility daily .