

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455855	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Kennedy Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for 2 of 16 residents (Resident #4 and Resident #5) observed for resident environment. The facility failed to ensure the baseboard in the room of Resident #4 and #5 was attached to the wall from 12/9/2024-12/11/2024. This failure could place residents at risk for an unsafe environment. The Findings included: 1. Record review of an Admission Record for Resident #4 dated 12/10/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, hypertension, and scoliosis (curve in the spine). Record review of a Quarterly MDS Assessment for Resident #4 dated 10/30/2023 indicated she had severe impairment in thinking with a BIMS score of 6. She required substantial/maximal assistance with transfers and used a wheelchair. Record review of a care plan for Resident #4 dated 11/17/2023 indicated she was at risk for falls and used a wheelchair. Interventions included to keep areas free of clutter. 2. Record review of an Admission Record for Resident #5 dated 12/10/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of schizophrenia (a mental illness that affects the way a person thinks feels and behaves), dementia, Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements) and hypertension. Record review of a Quarterly MDS Assessment for Resident #5 dated 11/18/2024 indicated she had severe impairment in thinking with a BIMS score of 6. She required substantial/maximal assistance with transfers and used a wheelchair. Record review of a care plan for Resident #5 dated 1/2/2020 indicated she was at risk for falls and used a wheelchair. Interventions included to keep areas free of clutter. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: Facility ID: 455855
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/9/2024 at 9:43 AM, in the secured unit, Resident #4 was sitting in the common area in a wheelchair, alert to person and place and thought the year is nineteen something. She wheeled herself to her room and said she lived in the room by herself but there were other residents' pictures on the other side of the room. The baseboard on the wall by the front door had about three feet that was not attached to the wall. During an observation and interview on 12/9/2024 at 9:55 AM, in the secured unit, Resident #5 was sitting in the common area in a wheelchair. She was alert to person only. She said she was not sure who lived in the room with her. She said she had just been at the facility for a couple of days. During an observation on 12/10/2024 at 4:00 PM, in the secured unit the room of Residents #4 and #5 still had the baseboard detached from the wall. The residents were not in the room at that time. During an observation on 12/11/2024 at 8:30 AM, in the secured unit the room of Residents #4 and #5 still had the baseboard detached from the wall. The residents were not in the room at that time. During an observation and interview on 12/11/2024 at 8:31 AM, in the secured unit CNA K said she had worked at the facility for [AGE] years. She entered the room of Resident #4 and 5 who were not in the room and said she had noticed the detached baseboard sometime last month. She said she told a housekeeper about it and the housekeeper informed her she would notify the Maintenance Supervisor. She said residents could trip or fall over the baseboard that was not attached to the wall. She said when they noticed any maintenance concerns, they were told to inform housekeeping and they would tell the Maintenance Supervisor. Record review of a maintenance log dated 7/2/2024-11/19/2024 for the secured unit indicated on 10/4/2024 room of Residents #4 and #5 had a problem with the wall/floor [codebase] coming off and had not been completed by the Maintenance Supervisor as indicated by his signature. During an interview on 12/11/2024 at 8:38 AM, the Maintenance Supervisor said he was responsible for repairs in the facility and was aware of the baseboards in the room of Resident #4 and #5. He said he was notified about it one day last week and was meaning to repair it. He said he had not repaired it because he had other things in the building that took priority. He said he did not see any risks to the residents if the baseboard were not attached to the wall and did not think they would trip or fall. The administrator had recently resigned from her position and was not available for interview. Record review of a facility policy revised April 2021 indicated, .Residents are provided with a safe, clean, comfortable and homelike environment .		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 2 of 3 residents (Resident #1 and Resident #4) reviewed for accidents. The facility failed to keep Resident #1 in a safe environment to prevent an elopement on 4/26/2024 when he climbed out of a window in the secured unit. The facility failed to keep Resident #2 in a safe environment to prevent an elopement on 8/23/2024 when he walked out an unlocked door in the secured unit. An Immediate Jeopardy (IJ) situation was identified on 12/10/2024 at 1:32 PM. While the IJ was removed on 12/12/2024 at 1:27 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for serious injury and accidents. Findings included: 1. Record review of an Admission Record dated 5/08/2024 for Resident #1 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Major Depressive Disorder and mild cognitive impairment. Record review of an admission Elopement/Wandering Evaluation dated 4/10/2024 for Resident #1 indicated he admitted to the facility on [DATE]. He had diagnoses of dementia/cognitive impairment, ambulated without assistance, could communicate, and had a history of wandering in the last month. He was indicated as a high risk for elopement with a score of 11. Score ranges: low risk 0-8, at risk 9-10 and high risk 11 or above . Record review of a Quarterly MDS assessment dated [DATE] for Resident #1 indicated he had moderate impairment in thinking with a BIMS score of 8. Resident had history of rejecting care, and dangerous wandering that intruded on the privacy and activities of others. Record review of an Elopement/Wandering Evaluation dated 4/19/2024 for Resident #1 indicated he admitted to the facility on [DATE]. He had diagnoses of dementia/cognitive impairment, ambulated without assistance, could communicate, and had a history of wandering in the last month. He was indicated as a high risk for elopement with a score of 12. Score ranges: low risk 0-8, at risk 9-10 and high risk 11 or above . (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of a care plan dated 4/25/2024 for Resident #1 indicated he had secure unit placement and was an elopement risk/wanderer related to dementia. History of wandering, elopement attempts, previous elopement on 4/19/24. Interventions included identify and document wandering behavior and attempted diversional interventions. Record review of a witness statement dated 5/03/2024 by LVN F indicated she observed Resident #1 sitting on the couch in the TV room talking to CNA H approximately 10 minutes before the incident. LVN F reported Resident #1 had not exhibited any elopement attempts this shift. LVN F reported when Resident #1 was returned to the unit he was alert and oriented to person and place and told her he pulled a nail out of the wall and used it to open the window and crawled out to go to the store and buy smokeless tobacco. LVN F reported there were no injuries and resident was placed on 1-1 staff observation for safety . Record review of a witness statement dated 5/03/2024 by CNA H indicated he was sitting on the sofa talking to Resident #1 when Resident #1 said he wanted to go to the store to buy Skoal and diet Mt. Dew. CNA H reported he told Resident #1 the store was closed right now, but someone would get it for him when it opened. CNA H reported Resident #1 went into his room and closed the door, which was Resident #1's usual behavior. Record review of a witness statement in provider investigation report dated 5/03/2024 by CNA G indicated she was returning from break and observed Resident #1 walking through the parking lot of the facility. CNA G asked Resident #1 if he was okay and he said he was trying to go to the store for snuff. CNA G redirected Resident #1 back into the facility and reported the incident to the charge nurse. Record review of a Q 15-minute observation form for Resident #1 indicated Q 15-minute monitoring started at the facility on 4/26/24 at 5:15 PM and ended on 4/27/2024 at 1:15 PM when resident was transferred out of the facility. Record review of an elopement/wandering evaluation post incident on 5/08/2024 indicated he had diagnoses dementia/cognitive impairment, ambulated without assistance, could communicate, and had a history of wandering in the last month, and had eloped twice in one week. He was indicated as a high risk for elopement with a score of 18. Score ranges: low risk 0-8, at risk 9-10 and high risk 11 or above. 2. Record review of a facility face sheet dated 8/22/24 for Resident #2 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Major Depressive Disorder. Record review of a Quarterly MDS assessment dated [DATE] for Resident #2 indicated he had a BIMS score of 12, which indicated he had moderate cognitive impairment. He had no wandering behaviors during assessment period, had delusions (misconceptions or beliefs that are firmly held, contrary to reality), ambulated without assistance, and was dependent with most ADLs. Record review of a comprehensive care plan dated 9/27/24 for Resident #2 indicated he was an elopement risk/wanderer related to history of attempts to leave facility unattended and he wandered aimlessly. Focus included secure unit placement on 8/29/2024. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of a facility form titled Elopement/Wandering Evaluation dated 8/22/24 for Resident #2 indicated he was an elopement risk/wanderer related to history of attempts to leave facility unattended, he wandered aimlessly, and has medical diagnose of dementia/cognitive impairment. Record review of Provider Investigation Report dated 8/30/2024 indicated Resident #2 opened secure unit door and walked outside when door failed to lock. During an observation and interview on 12/09/24 at 9:05 a.m., Resident #2 was observed lying in his bed in his room on secured unit. He said he told the nurse he was going to the red light and then walked out of the secured unit doors. Resident #2 said he wanted to go to a local city . He said facility staff found him at a building next door (approximately 300ft away and next to a busy road) and gave him a ride back to the facility. During an interview on 12/9/24 at 9:10 AM with CNA K, she said she works day shift and usually works on the secured unit. She said she thinks the Maintenance Man checks door locks and alarms, but she does not know how often. She said she checks all doors on secured unit when she was rounding. During an interview on 12/9/24 at 9:15 AM with LVN A, she said she works day shift on hall 900, which was the secured unit. She said she has not had an elopement on her shift. She said Resident #1 was transferred to another facility and Resident #2 will pack up his belongings and ask to leave, but he was easy to redirect. She said all staff were expected to verify door locks and alarms were functioning each shift. She said there was no documentation to record security checks. She said the Maintenance Man also was responsible for checking door locks and alarms, but she does not know the schedule. Attempted telephone interviews with LVN D, LVN F, CNA H, left voice mail messages requesting return call. During a telephone interview on 12/9/24 at 12:10 PM, CNA G said the night Resident #1 eloped, she was coming back from break and saw Resident #1 walking through the facility parking lot. She said he told her he was going to buy snuff and asked her for a ride. She said he got into her car, and she drove him back to the facility entrance where she could see staff members outside. An observation on 12/09/2024 at 1:00 PM of the sunroom, which leads to the secured unit smoking exit door, revealed 1 of 5 windows checked did not have safety locks and opened fully. The volume of the alarm on the exit door was low, alarm was activated and monitored for approximately 10 minutes with no staff response. The exit door in sunroom exited into a fenced smoking area, which had a wooden gate that was unlocked and standing open. During an interview on 12/9/24 at 1:48 PM, the Maintenance Man said he checked all doors, windows, and alarms weekly. He said he had not been told of any problems with the doors or alarms on secured unit. He said staff turned off the alarm on the exit door to the secured smoking area, and he had to reset it with the key. He said he had trained all staff on proper securement of doors and alarms, and he had installed safety locks to keep the windows on secured unit from opening fully to prevent any resident from climbing out. He said he does not keep any maintenance logs. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 12/9/24 at 2:00 PM, CNA E said she works day shift and usually works on the secured unit. She said all staff were responsible for checking doors and alarms. She said alarms were loud enough for staff can hear them on the unit. During a telephone interview on 12/9/24 at 2:30 PM, LVN F said she was not working the night Resident #1 eloped, but it was reported to her he was able to disable the safety lock on his bedroom window and climb out. She said following the incident he was placed on 1 to 1 observation and staff tried to keep his room door open as much as he would allow them. She said the Maintenance Man installed safety locks on all windows on the secured unit following the incident. She said all staff were responsible for checking doors and alarms to make sure the unit is secured. She said risks for a resident who eloped were injuries or getting lost. An observation on 12/10/2024 at 8:35 AM of secured unit smoking area revealed the wooden gate was unlocked and standing open. An observation on 12/10/2024 at 8:50 AM of secured unit revealed a window in the dining room did not have a safety lock and opened fully. During an interview on 12/10/24 at 9:30 AM, LVN B said she works day shift and always works the secured unit. She said the unit was staffed with one dedicated nurse and two dedicated CNAs. She said nurses were responsible for checking door locks and alarms at the start of every shift and then every few hours during shift. She said CNAs on unit also assist with checking doors and alarms. She said maintenance man was responsible for ensuring all secured unit door locks and alarms were functioning properly, but she does not know how often he checks them. She said she has told the maintenance man the wooden gate in the secured smoking area does not stay locked and he told her the wind was probably blowing it open. During an interview on 12/10/24 at 12:15 AM, the DON said it was the Maintenance Man's responsibility to ensure all locks and alarms are in working order by performing weekly maintenance. She said she doesn't know if he keeps any records of work performed. She said nurses working on the secured unit were also responsible for checking door locks and alarms every shift. She said no one should be using the wooden gate in the secured smoking area except for Maintenance Man, but other staff probably uses it as well. She said it was the expectation of staff to immediately notify DON and Administrator if a resident was missing. She said staff should search the unit, perform a headcount of residents, and expand the search outside if resident isn't found. She said risks for a resident who elope from the facility were hyperthermia, heat exhaustion, or injuries. Attempted telephone interviews with LVN D and Administrator, left voice mail messages requesting return call. During a telephone interview on 12/10/24 at 4:00PM, CNA H said he was working the night of both elopements involving Resident #1 and Resident #2. (continued on next page)		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 6 residents (Resident #3) reviewed for clinical records. The facility failed to ensure the medication administration records (MAR) for Resident #3 reflected discontinuation of medications on 10/09/2024 and non-administered medications when Resident #3 was out of the facility on 10/10/24 and 10/14/2024. This failure could place residents at risk of improper care due to inaccurate records. Findings: Record review of Resident #3's facility face sheet dated 12/09/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE] with diagnosis of major depressive disorder (mood disorder that causes persistent feelings of sadness and loss of interest). Record review of Resident #3's comprehensive care plan dated 9/07/2024 revealed she refused medications at intervals. Record review of Resident #3's significant change MDS dated ,d+[DATE] revealed a BIMS of 9 indicating moderately impaired cognition. Record review of Resident #3's MDS list revealed a discharge MDS was completed on 10/10/2024. Record review Resident #3's order summary report revealed on 10/09/2024, Depakote 250mg 1 tab three times a day and Paroxetine 30mg 1 tab daily was discontinued. Record review of Resident #3's MAR dated October 2024 revealed the Depakote 250mg 1 tab three times a day and Paroxetine 30mg 1 tab daily was not discontinued on 10/09/24. Record review of Resident #3's nurses notes from 10/09/2024 to 10/15/2024 revealed she was discharged from the facility on 10/10/2024 at 12:55 pm and returned on 10/12/2024 at 12:35 pm and again on 10/13/2024 at 3:00 pm and returned 10/14/2024 at 12:11 am. Record of Resident #3's medication administration record dated October 2024 revealed [NAME] in the hospital the MAR did not indicate her hospitalization and nurses were initialing that medications were administered. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/24 at 3:31 p.m., LVN A stated she had worked at the facility since April 2024. She said when a doctor gave a new order the nurse was responsible for entering the new order into the computer, placing the new order on the MAR, notifying the pharmacy and family. She said if a medication was discontinued the medication would be removed from the orders, the MAR would reflect the order was discontinued and the card should be pulled and placed in the discontinued box for destruction. She said she was not the nurse that received the order changes for Resident #3 but did administer her medications while she was at the facility. She said she was not sure why she initialed that she administered Resident #3's medications when she was out to the hospital, and it was a data entry error. She said when Resident #3 was discharged to the hospital she was the nurse that sent her on 10/13/2024 but not 10/10/2024 and she should have flagged the MAR indicating the resident was out of the facility but was not sure why that was not done. She said that inaccurate medical records could cause improper care of a resident. During a phone interview on 12/9/24 at 3:50 p.m., LVN B said she had worked at the facility for 1 year and had been an LVN since 1986. She said she remembered caring for Resident #3. She said when receiving a new or discontinued medication order the order was placed in the computer, the MAR was updated, the medication that was discontinued was pulled from the cart and the pharmacy and family were notified of the order. She said she was the nurse that took the order to discontinue Depakote 250mg three times a day and Paroxetine 30mg daily for Resident #3 on 10/09/2024. She said she pulled the medications from the cart for destruction but failed to indicate on the MAR the medication was discontinued. She said that Resident #3 no longer received the discontinued medications effective 10/09/2024. She said she was the nurse that sent Resident #3 to the hospital on 10/10/2024 and she should have flagged her MAR indicating resident was out of the facility. She said she could not remember why she did not do that and was off work on the days Resident #3 was in the hospital. She said if the MAR was not accurate it could cause the residents to receive or not receive accurate medications. Attempted phone interview on 12/09/2024 at 3:55 p.m., with LVN D. LVN D worked night shift the days Resident #3 was in the hospital and initialed Resident #3's MAR as if medications were administered. During an interview on 12/10/24 at 10:12 am LVN C said she had worked at the facility for [AGE] years. She said the process for new orders were to transcribe the order in the computer, place in the nurses notes, notify the pharmacy and family and then update the MAR with the new order and place a dc out in front of any medication that was discontinued. She said if a medication was discontinued then that medication was to be removed from the cart. She said if a resident is out of the facility for any reason the MAR should be flagged and there should not be initials next to an order that was carried out. She said inaccurate recording of medications could result in medication error or inaccurate resident care. During an interview on 12/11/2024 at 10:00 am the DON said all the nurses had received training on proper charting and recording of resident orders. She said the nurses should be placing discontinued in front of any order on the MAR, flagging the MAR when the resident was out of the facility and reflecting accurately when an order is not performed and why. She said she expected all nurses to chart correctly and accurately to prevent a resident negative outcome. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Medication Administration dated 5/2017 indicated, .medications will be documented as ordered by the physician. 10. If a dose of regularly scheduled medication is withheld or refused the space provided on the MAR for that dosage administration is initialed and circled . Record review of a facility policy titled Charting and Documentation dated July 2024 indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relayed the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities for 1 (Hall 400) of 4 hallways (Hall 100 and 300 and 400 hallways) and 11 of 11 (Residents #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16) residents reviewed for call light response. The facility failed to ensure hallway 400's call lights were visible and audible to staff. This failure could place residents at risk of injury, pain, hospitalization , and a diminished quality of life. Findings include: 1. Record review of a facility face sheet dated 12/11/24 for Resident #6 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with acute kidney failure (condition where your kidneys stop working suddenly). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #6 had a BIMS score of 15, which indicated that he was cognitively intact. He required partial to moderate assistance with most ADLs. He was frequently incontinent of bowel and bladder. Record review of a comprehensive care plan for Resident #6 dated 9/18/24 indicated that he had an ADL self-care performance deficit, and he had the following intervention: .encourage the resident to use bell to call for assistance . 2. Record review of a facility face sheet dated 12/11/24 for Resident #7 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with dementia (decline in cognitive function). Record review of a quarterly MDS dated [DATE] for Resident #7 indicated that she had a BIMS score of 11, which indicated that she had moderate cognitive impairment. She required substantial/maximal to total assistance with most ADLs. She was always incontinent to bowel and bladder. Record review of a comprehensive care plan for Resident #7 dated 8/23/24 indicated that she had an ADL self-care performance deficit and had the following intervention: .encourage the resident to use bell to call for assistance . 3. Record review of a facility face sheet dated 12/11/24 for Resident #8 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of age-related cognitive decline (normal and subtle deterioration of thinking and memory abilities that occur during aging). Record review of a quarterly MDS assessment for Resident #8 dated 10/28/24 indicated that he had a BIMS score of 15, which indicated that he was cognitively intact. He was independent with most all ADLs. He was always continent of bladder and frequently incontinent of bowel. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a comprehensive care plan for Resident #8 dated 10/2/24 indicated that he had an ADL self-care performance deficit and had the following intervention: .encourage the resident to use bell to call for assistance . 4. Record review of a facility face sheet dated 12/11/24 for Resident #9 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of dementia (decline in cognitive function). Record review of a quarterly MDS assessment dated [DATE] for Resident #9 indicated that she had a BIMS score of 15 indicating that she was cognitively intact. She was independent with most all ADLs. She was always continent of bowel and bladder. Record review of a comprehensive care plan for Resident #9 dated 10/8/24 indicated that she had an ADL self-care performance deficit and had the following intervention: .encourage the resident to use bell to call for assistance . 5. Record review of Resident #10's facility face sheet dated 12/11/2024 revealed Resident #10 was an [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of psychotic mood disorder (mental illness). Record review of Resident #10's annual MDS assessment dated [DATE] revealed Resident #10 was independent with cognitive skills for daily decision making and needed supervision setup for activities of daily living. Record review of Resident #10's comprehensive care plan dated 10/17/2024 revealed Resident #10 had an ADL self-care deficit and to encourage the use of call bell for assistance. 6. Record review of Resident #11's facility face sheet dated 12/11/2024 revealed Resident #11 was a [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of cerebral infarction (lack of blood flow to the brain). Record review of Resident #11's annual MDS assessment dated [DATE] revealed Resident #11 had a BIMS of 15 indicating intact cognition and was dependent on staff for all activities of daily living. Record review of Resident #11's comprehensive care plan dated 10/24/2024 revealed Resident #11 was a t risk for fall and injuries and to assist with ADL's and had an ADL self-care deficit and to encourage the use of call bell for assistance. 7. Record review of Resident #12's facility face sheet dated 12/11/2024 revealed Resident #12 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis systolic (Congestive) and diastolic (Congestive) Heart Failure (chronic condition in which the heart doesn't pump blood as well as it should). Record review of Resident #12's annual MDS assessment dated [DATE] revealed Resident #12 had a BIMS of 13 indicating intact cognition and was independent on most activities of daily living. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's comprehensive care plan dated 09/18/2024 revealed Resident #12 was to be monitored for dizziness and falls and to assist with ADL's and had an ADL self-care deficit and to encourage the use of call bell for assistance. 8. Record review of Resident #13's facility face sheet dated 12/11/2024 revealed Resident #13 was a [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing problems.). Record review of Resident #13's annual MDS assessment dated [DATE] revealed Resident #13 had a BIMS of 13 indicating intact cognition and required staff supervision for all activities of daily living. Record review of Resident #13's comprehensive care plan dated 10/03/2024 revealed Resident #13 was at risk for fall and injuries and used a rollator to ambulate, assist with ADL's and had an ADL self-care deficit and to encourage the use of call bell for assistance. 9. Record review of Resident #14's facility face sheet dated 12/11/2024 revealed Resident #14 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #14's annual MDS assessment dated [DATE] revealed Resident #14 had a BIMS of 12 indicating intact cognition and was independent for all activities of daily living. Record review of Resident #14s comprehensive care plan dated 12/03/2024 revealed Resident #14 was at risk for fall and injuries and used a walker to ambulate, assist with ADL's and had an ADL self-care deficit and to encourage the use of call bell for assistance. 10. Record review of Resident #15's facility face sheet dated 12/11/2024 revealed Resident #15 was an [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of sepsis, unspecified organism (inflammation throughout the body). Record review of Resident #15's annual MDS assessment dated [DATE] revealed Resident #15 had a BIMS of 06 indicating impaired cognition and was dependent on staff for all activities of daily living. Record review of Resident #15's comprehensive care plan dated 10/29/2024 revealed Resident #15 was at risk for fall and injuries and to assist with ADL's and had an ADL self-care deficit and to encourage the use of call bell for assistance. 11. Record review of Resident #16's facility face sheet dated 12/11/2024 revealed Resident #16 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of Schizophrenia. Record review of Resident #16's annual MDS assessment dated [DATE] revealed Resident #16 had a BIMS of 15 indicating intact cognition and was independent for all activities of daily living. Record review of Resident #16's comprehensive care plan dated 10/24/2024 revealed Resident #16 was at risk for fall and to encourage the use of call light for assistance. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/24 at 3:30 p.m., the MDS Nurse said the facility was working on a plan to move some of the residents from hallway 100 and 300 to the 500-hall due to the call light system being unmanned. During an observation on 12/11/24 at 3:50 p.m., the bathroom emergency call light was activated by this surveyor in vacant room [ROOM NUMBER]. The audible alarm sounded at the Central monitoring station but there was no staff present. The call light bulb was not functioning above the doorway of unoccupied room [ROOM NUMBER]. During an observation on 12/11/24 at 3:55 p.m., the bathroom emergency call light was activated by this surveyor in occupied room [ROOM NUMBER] for Resident #7. During an observation on 12/11/24 at 4:05 p.m., CNA L and CNA Q went to room [ROOM NUMBER] and checked on Resident #7 and deactivated the bathroom call light. They left the hallway without deactivating the bathroom call light in the unoccupied room. The MDS Nurse went into room [ROOM NUMBER] and deactivated the call light. During a phone interview on 12/11/24 at 4:11 p.m., the Corporate Maintenance Man said he came to the facility every 2-3 weeks, and he was responsible for training the local maintenance man. He said he kept no logs of facility needs or what he did when he was in the facility, but he would be at the facility in the next two weeks to correct any outstanding facility environmental needs. During an observation on 12/11/24 at 4:15 p.m., the Maintenance Man replaced the bulb in the call light above the doorway of unoccupied room [ROOM NUMBER]. During an observation on 12/11/24 at 4:20 p.m., of the 100/300 nurses' station there was no alarm or light for monitoring the call system for the residents on the 400 hallway. The audible alarm on 400 hall was not heard at the 100/300 nurses' station after activation by this surveyor but was activated and audible at the 400/500 nurses' station. During an interview on 12/11/24 at 4:25 p.m., LVN O said she had worked at the facility for 2 months and was assigned the 100 hallway and right side of 400 hallway. LVN O said the call light monitoring station for hallway 400 was located at the unoccupied nurse's station. Monitoring of 400 hallway was completed by random visual checks of the call lights above the doorways. She said the staff were unable to hear the audible alarm sounding at the 400/500 nurses' station. She said the nurses' aides would sit near the hallway between rounds so they could see the 400 hallway lights above the doors' indicating assistance was needed. She said the risk to the resident was not knowing the call light had been activated and the resident would have to wait for longer periods of time for assistance. During an interview on 12/11/24 at 4:29 p.m., RN P said he has worked at the facility since October 2024. He said he sometimes served as the weekend RN, and he was not aware that the call light for the residents on the 400 hallway were not audible at the 100/300 station. He said he rounded regularly, and the nurse aides took turns keeping hall 400 in eyesight between rounds. He said the risk to the residents was injury if the call light was not seen or heard when activated by the resident. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/24 at 4:35 p.m., CNA L said she had worked at the facility for almost two years. She said she normally rounded every two hours on hallway 400, most residents were independent on hall 400 except for Residents #7, #10 and #11 but they were able to use the call light. CNA L said the audible alarms for the call light was very faint and the staff check the call light by looking above the doors for the activated red light. She said the staff take turns looking down the hallway between rounds, but there were times when it might be 15 to 20 minutes before someone noticed an activated light. She said the residents could be at risk for falls and there were times when another resident would hear the alarm or see the light and go get assistance. During an interview on 12/11/24 at 4:45 p.m., CNA Q said she had worked at the facility for one year and was assigned the 300 and 400 hall. She said the residents were mainly independent except three residents that were incontinent, but they could use the call light for assistance. She said the ambulatory residents would let the staff know if they saw a call light on or heard the alarm going off. She said the risk to the resident was falls or injury if she could not hear the call light. She said the staff took turns monitoring the hallway between rounds by watching for the activated red light above the doorways since the alarm was not always heard due to the noise on the unit and it was too far away to be heard. During an interview and observation on 12/12/24 at 08:00 a.m., CNA R was sitting at the nurses' station for the 400/500 hallways. She said she had been assigned to sit and monitor the station for the call lights and notify the staff on the 100/300 hallway if assistance was needed. During an interview on 12/12/24 at 9:25 a.m., the DON said residents that were currently on Hall 400 were going to be moved to halls 100 and 300 today, 12/12/2024. She stated the move was being discussed with all residents. She said this would allow staff to better monitor the call system. She stated currently staff makes rounds every two hours. She said all staff are instructed to answer call lights. The DON said staff that are not direct care staff are instructed to communicate any needs to the CNAs or nurses. She said staff was stationed at the end of the hallway so that the hall call lights can be easily monitored. During an interview on 12/12/24 at 9:35 a.m., Resident #7 said she rarely uses her call light, and she likes to do things on her own. She said the staff come when she uses her light, and she has never waited over a few minutes. During an interview on 12/12/24 at 9:45 a.m., Resident #6 said he uses his walker to ambulate and needs his urinal emptied a few times a day. He said he like to be as independent as he can and does not use his call light often. Resident #6 said he has not been injured since being on the 400 hall and it has never taken longer than 30 minutes for staff to come and that was only once that he remembered. During an interview on 12/12/24 at 9:55 a.m., Resident #9 said she rarely uses her call light, and she likes to do things on her own. She said the staff come when she uses her light, and she has never waited over a few minutes. Resident #9 said if she saw a one of her friends (Residents on hallway 400) needing assistance she would go get a nurse. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/24 at 10:05 a.m., Resident #10 said she rarely uses her call light, and she likes to do things on her own. She said the staff come when she uses her light, and she has never waited over a few minutes. Resident #9 said if she saw another resident needing assistance, she would go get a nurse, but they come by to check on them often. She said she has never had a fall since being on the 400 hall. During multiple interviews with residents on the 400 hallways from 12/09/2024 10:00 am to 12/12/2024 11:00 am residents denied waiting for long periods of time for assistance or any falls due to unanswered calls for assistance . During multiple observations from 12/09/2024 10:00 am to 12/12/2024 11:00 am staff were observed sitting at the 100/300 nurses' station with view of 400 hall and multiple staff were up and down 400 hall and near the hall with the rooms visible. There were no observed unanswered call lights during these observations. Record review of incidents and accidents from 01/01/24 to 12/09/24 indicated no falls with injuries or other incidents for the 400 hallways caused by unanswered call lights. Record review of a facility policy dated May 2017, Nursing Policy and Procedure- Call Light- Use of .3. For bedside call lights, a light and or sound will appear, and be heard. This alarm will sound until the call light is tuned off.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 1 of 2 entrance foyers (foyer for 800/900 hallways) shower room on the 100 hallway, 300 hallway, 500 hallway and 800/900 hallways reviewed for physical environment. The facility failed to maintain the 800/900 foyer entrance ceiling. The facility failed to clean the 100 hall shower room and maintain the hall 100 shower room door. The facility failed to secure cleaning agents in the shower room on the 100 hallway. The facility failed to maintain walls, doors and doorways on the 300 hallway. The facility failed to secure nursing supply storage rooms on the 500 hallway and 800/900 hallway. Findings included: During an observation on 12/09/24 at 8:45 am, the sheetrock ceiling in the entrance foyer, had three large areas that appeared to have old water damage. The areas were sagging and crumbling. The foyer was open to the public and residents. During an observation on 12/09/24 at 09:30 am, shower room [ROOM NUMBER] hallway has out of order sign on door, the wood around the knob is broken and splintered with sharp edges. A supply cabinet in the shower room was open and had a 16-ounce container of disinfectant cleaner concentrate accessible to residents. Hair was covering the drainage hole on the floor and a sticky yellow substance was around the edges of the shower floor. Residents are ambulating up and down the hallway. During an observation on 12/09/24 at 09:50 am, of the 300 hallway there were chips in the paint on the walls, doors and doorways throughout hallway 300. The wall opposite the nurses' station is unpainted with bare sheetrock exposed. During an observation on 12/09/24 at 10:16 a.m., the 500 unit had no residents, there was an unlocked open storage room with sterile supplies including trach care supplies, including sterile trach kits and holders, suction supplies, sterile water and sterile saline, catheter care supplies, and gloves. The door is open and accessible to visitors and residents sitting in the area. During an observation on 12/09/24 at 5:00 p.m., observation of supply room on 500-hallway, the door remains open. During an observation on 12/10/24 observation at 8:45 am the 500-hallway supply room door is open and accessible to residents and visitors. During an observation on 12/10/24 at 10:00 a.m., the 800/900 hallway supply room door containing feedings and supplements is open and accessible to resident or visitors with no lock. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455855	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Kennedy Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/10/24 at 10:15 a.m., the MDS Nurse said not locking the supply rooms allow access to supplies by residents and visitors. The MDS Nurse said sterile supplies could be tampered with and contaminated. During an interview on 12/09/24 at 2:45 p.m., the Maintenance Man said he had worked at the facility for 2 years. He said he had been aware for some time that the door on the 100 halls to the shower room would have to be replaced and he was currently trying to locate a replacement but having trouble due to the size and specifications of the door. During an interview on 12/10/24 at 10:30 a.m., the Maintenance Man said that the supply rooms on the 500 hallways and the 800/900 hallways had no locks. He said the risk to the residents could be the supplies could be tampered with and contaminated. He said nursing services would have to relocate the supplies, or he would apply a lock to secure the supplies if needed. He said the facility had many maintenance needs and he was trying to get the most serious taken care of first. During an interview on 12/10/24 at 10:45 a.m., the DON said the supply rooms for nursing supplies and feeding did not have locks and she was not aware they needed locks. She said the supplies could be tampered with and contaminated if they were not secured. During an observation and interview on 12/10/24 at 11:30 am the disinfectant cleaner concentrate remains in the shower room. Housekeeper said she had worked here [AGE] years and cleaning products are kept on a locked cart or a locked supply area. She said she would remove the disinfectant cleaner from the shower room. She said the risk to the resident would be poisoning if the cleaner was consumed by a resident During a phone interview on 12/11/24 at 4:11 p.m., the Corporate Maintenance Man said he had worked for the corporation for [AGE] years. He said he was responsible for training of the maintenance staff, and he did not maintain a log of outstanding facility needs. He said he came to the facility every 2-3 weeks, and he would be coming to the facility in two weeks to complete any tasks that needed to be addressed and resolve any outstanding issues. He said the risk to the residents was injury if the facility was not maintained. The administrator had recently resigned from her position and was not available for interview. Record review of a policy dated 2001 .Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.		