

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 05/01/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</p> <p>Based on interview, and record review the facility failed to ensure residents had the right to be free from verbal abuse by staff for 2 (Resident #1 and Resident #2) of 10 residents reviewed for abuse.</p> <p>The facility failed to prevent verbal abuse by CNA A. On [DATE] CNA A told Resident #1 She was stinky and needed to take a shower.</p> <p>The facility failed to prevent verbal abuse by the Cook. On [DATE] the [NAME] cussed Resident #2 in a verbal altercation.</p> <p>This failure could place all residents in the facility at risk for severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with the most recent admission on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (progressive lung disease that makes breathing difficult), pseudobulbar affect (neurological condition), and major depressive disorder (persistent feelings of sadness).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated no cognitive impairment.</p> <p>Record review of Resident #1's care plan revealed she had an ADL self-care performance deficit with interventions that included: The resident is totally dependent on ,d+[DATE] staff to provide bath/shower.</p> <p>Record review of psychiatric assessment completed on [DATE] indicated: Patient states one of the nurse aides told her she was stinky and needed to shower. She says she was offended by this and feels sad. She verbalizes she will be okay though and is grateful for the concerns. She states she gets regular showers from the hospice nurse every MWF. Patient says she eats and sleeps okay/good. Anxiety: Patient denies symptoms of excessive worry.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's nursing progress note dated [DATE] at 12:36 AM, written by RN C indicated Resident #1 expired in the facility.</p> <p>Record review of witness statement provided by Hospice CNA B dated [DATE] indicated: On [DATE] she was taking Resident #1 to the shower room and was told that someone was in the shower room and to go around to the 200 hall, on the way around CNA A started saying out loud that time does not go on her time and she needed to wait her turn. CNA A made the statement a few times before Resident #1 turned around and said never mind she was not going to shower if she (CNA A) was going to keep saying stuff. Resident #1 headed back to her room when CNA A told her no go ahead go take the shower because she stinks and needed it. CNA A said you know what let me go get Resident #1's roommate up to that room stinks she needs to get up too so we can air out that and strip the beds. Resident #1 got back to her door she turned around and decided to go ahead and go take the shower on her hall.</p> <p>Record review of witness statement provided by CNA A on [DATE] indicated: I [CNA A] don't recall what happen Monday beside me telling [another resident] I am not his auntie and am not married to that. I don't think I cussed anyone.</p> <p>Record review of the facility new hire/status change form indicated CNA A was terminated on [DATE].</p> <p>During an attempted interview on [DATE] at 2:00 p.m. the DON had left the facility and was no longer employed at the facility.</p> <p>During an interview on [DATE] at 9:24 AM, the Activity Director said CNA A talked a little hateful to the residents but not to a point that it was abuse. She said CNA A was a good CNA and her residents were taken care of.</p> <p>During an interview on [DATE] at 1:49 PM, CNA A said all she said to Resident #1 was that she smelled really bad, and she needed to take a shower. She said she never cussed Resident #1.</p> <p>2. Record review of Resident #2's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included type 2 diabetes (high blood sugar), insomnia (sleep disorder), and depression (persistent feelings of sadness).</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, which indicated no cognitive impairment.</p> <p>Record review of Resident #2's care plan dated [DATE] revealed he had the potential to be verbally aggressive with interventions that included: When the resident becomes agitated; intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later.</p> <p>Record review of witness statement dated [DATE] written by the BOM indicated: was sitting in my office when I heard screaming from dietary went to dietary [Cook] was screaming at [Resident #2] I then told her to stop she begin yelling louder stating she is sick of the way he talks to her that we need to do something with his fucking ass cause he ain't going to talk like that no more to her. I asked him to go outside and calm down she keep on screaming back and forth with [Resident #2]. [sic]</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:04 AM, Resident #2 said when he gets upset, he cusses that was just who he was. He said the staff was there to work for him. He said he did remember the incident in the kitchen, but he was over it and that [NAME] no longer worked at the facility. He said he was over that incident, and it was in the past.</p> <p>During an interview on [DATE] at 9:24 AM the Activity Director said Resident #2 is mean and a smart [NAME]. She said he cusses the staff and tells them that he signs their paycheck. She said Resident #2 had called the kitchen staff fat sloppy [NAME]. She said he was very hateful over the TV and food. She said she was not here the day the argument took place with the Cook.</p> <p>During an interview on [DATE] at 10:39 AM, the BOM said she heard the [NAME] being loud then she heard Resident #2, so she went to the kitchen. She said Resident #2 was in the doorway and the [NAME] was screaming at Resident #2. She said Resident #2 was yelling calling the staff names. She said the [NAME] was saying she was not in the pen with him, and she told the [NAME] to stop screaming at the Resident #2. She said the [NAME] called her supervisor on the phone and she kept screaming. The BOM said she told the [NAME] she was suspended to leave the building. She said Resident #2 does talk to the staff and call them names when he gets upset. She said she did not feel like the incident affected the resident in anyway.</p> <p>During an interview on [DATE] at 1:54 PM the [NAME] said Resident #2 came to the kitchen and there was a new girl in the kitchen, and she did not know Resident #2 was not supposed to get beef. The [NAME] said she had hot dogs for him but in the meantime, Resident #2 came down and started cussing them and calling them names. She said the BOM did not try stop him from doing all the cussing of the staff. She said she did not cuss Resident #2, but she did tell the BOM person that she was motherfucking wrong for letting him get away with everything. She said the facility suspended her and then about a week later they called her and let her know she was terminated.</p> <p>Record review of the facility's New Hire/Status Change Form indicated: the [NAME] was terminated on [DATE] for verbal abuse.</p> <p>Record review of the facility's Abuse-Reportable Events policy dated ,d+[DATE] indicated: It is the policy of this home to prohibit resident abuse or neglect in any form, and to report in accordance with the law and incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person.5. Investigation: a. When an employee becomes aware of an allegation or suspicion of abuse or reportable event the employee should: Immediately report the allegation or suspicion to the charge nurse on the unit on which the resident resides immediately to ensure immediate safety of the resident. B. The charge nurse will: Assess the resident or resident(s). Notify the Administrator or the person on-call, if after hours. The person on-call will notify the Administrator, if unavailable, the Director of nurses will be notified. Nursing facility but the above immediately but not later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the event that caused the allegation do not involve abuse and do not result in serious bodily injury .</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>47339</p> <p>Based on observation, interview, and record review, the governing body failed to appoint an Administrator licensed by the state who was responsible for management of the facility for 1 of 1 facility reviewed for governing body.</p> <p>The governing body failed to designate a person in the role of an Administrator from 3/25/2025, through surveyor exit on 5/1/2025.</p> <p>This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents.</p> <p>The findings included:</p> <p>During an observation and interview on 4/29/2025 at 8:30 AM, an entrance conference was conducted with the DON only being present. She said the facility did not have a full time Administrator, but the MDS nurse had recently gotten her license and the plan was for her to be the Administrator. The DON said the MDS nurse does not come to the facility daily because she had permission to work from home some days. The DON called the MDS Nurse to come to the facility due to surveyor entrance.</p> <p>During an interview on 4/29/2025 at 12:05 PM, the MDS Nurse said she had been employed at the facility for about 8 years. She said the facility had been without an Administrator since 3/25/2025. She said she had just received her administrator license and the plan was for her to take the administrator position. She said she was just waiting on an offer letter and then she would possibly be taking over as the administrator on 5/1/2025. She said after the previous Administrator left; the staff were reporting things to the DON.</p> <p>During an interview on 5/1/2025 at 10:39 AM, the BOM said the previous Administrator's last day was 3/25/2025. She said the facility currently did not have an administrator. She said the MDS nurse had just received her license and the plan was for her to take the position.</p> <p>During a follow-up interview on 5/1/2025 at 11:00am, the MDS Nurse said she was still waiting on an offer letter and had not officially accepted the administrator position at this time.</p> <p>During an interview on 5/1/2025 at 12:05 PM, the RDO said the last time the facility had a full-time administrator was 3/25/2025. She said the plan was for the MDS Nurse to take the administrator position. She said the offer letter had to be revised and that was why MDS Nurse had not officially accepted the administrator position.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of a facility policy titled Administration dated 3/2020 indicated, .It is the policy of this home to follow TAC rule for Nursing Home Administrator. The facility must have a governing body, or designated persons functioning as a governing body that is legally responsible for establishing and implementing polices regarding the management and operation of the facility. 3. The governing body appointed, and the facility must operate under supervision of a nursing facility administrator who is: 1) Licensed by the Texas Board of Nursing Facility Administrators. 2) Responsible for management of the facility .</p>		