

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 09/16/2025
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 - Immediate jeopardy to resident health or safety</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>(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident had the right to be free of abuse for 1 of 6 (Resident #1) residents reviewed for abuse. The facility failed to prevent LVN A from physically abusing Resident #1 on 9/9/2025 witnessed by CNA B and CNA C. An IJ was identified on 9/12/25. The IJ template was provided to the facility on 9/12/25 at 3:34 p.m. While the IJ was removed on 9/13/25 the facility remained out of compliance at a scope of Isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ due to ongoing need for in-services on abuse and neglect, abuse coordinator and notification of abuse process. This failure could place residents at risk for physical and verbal abuse, psychosocial harm, and decreased quality of life. Findings included: Record review of the face sheet dated 9/11/2025 indicated that Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including severe intellectual disability which was below average intelligence, anxiety disorder which was intense, excessive, and persistent worry and fear about everyday situations, schizoaffective disorder which was a lifelong pattern of social withdrawal and limited emotional expression, ADHD which was a chronic condition including attention difficulty, hyperactivity and impulsiveness, cerebral palsy which was a congenital disorder of movement, muscle tone or posture, and cognitive communication deficit which was a group of disorders that affect a person's ability to communicate effectively due to underlying cognitive impairments. Record review of the MDS dated [DATE] indicated that Resident #1 had a BIMS score of 03 (severe cognitive impairment). His score indicates that he had difficulty communicating some words or finishing thoughts but was able if prompted or given time and that he missed parts or intent of conversation but comprehends most conversation. Record review of the care plan dated 9/7/25 which showed that Resident#1 was last admitted to the facility on [DATE] and was receiving services at the facility. Record review of a progress note dated 9/10/2025 indicated that Resident #1 was on the floor of his bedroom fighting with his roommate and LVN A documented attempting to soothe Resident #1 by rubbing his back and his chest and his hand getting caught in the shirt of Resident #1. It indicated that LVN A instructed CNA B and CNA C to take Resident # 1 into the hallway. LVNA indicated that he assessed Resident # 1 and noted no injury. During an interview on 9/11/25 at 4:11 p.m. CNA B said that on 9/9/25 she worked with CNA C on the evening shift. She said that at around 7:30 p.m. they were assisting Resident #1 to bed and he was being combative, hitting them and not cooperating. She said that she went to get LVN A, and he said that there was nothing he could do. She said that when she went back to the room, Resident #1 was still being combative and trying to fight with his roommate. She said that she and CNA C separated the residents and placed Resident #1 back in his wheelchair. She said that around 10:30 p.m. she and CNA C attempted to put Resident #1 in bed and he stood up and was cooperative at first but then became combative again and yelling at his roommate. Resident #1 was sitting in his chair with nothing but his shirt on and was still attempting to hit CNA B and CNA C. CNA B said that she went to get assistance from LVN A. LVN A was outside of the room and Resident #1 said you want to fight, N word?. She said that LVN A came in the room and said, you got one now and grabbed Resident #1 by the shirt up by his neck and Resident #1 was making a choking noise and crying. CNA B said that when LVN A let him go, Resident #1 sat crying in his wheelchair. Record review of the voice recording provided by CNA B on 9/11/25 at 4:30 p.m. that was recorded on 9/10/25 sometime after 6:00 p.m. and included the voice of LVA A, CNA B and CNA C as identified by CNA B. A summary of the recording was that LVN A approached CNA B and CNA C letting them know that he had to complete an incident report after being accused of abusing Resident #1. LVN A asked them what occurred in the bedroom and said that he was not confirming nor denying what occurred, but he did not remember. Both CNA B and CNA C told him that he had grabbed Resident #1 by the shirt around his neck and got into Resident #1's face when Resident #1 used a racial slur toward his roommate. LVN A then excused himself to go fill out the incident report. During an interview on 9/11/25 at 3:18 p.m. Resident #1 said that LVN A had choked him and that he was scared of LVN A. Resident #1 cried and left the interview. During an interview on 9/11/25 at 3:57 p.m. LVN A said that on 9/9/2025 he worked at the facility. He went into Resident #1's bedroom when he was fighting with his roommate. LVN A said that he was trying to calm Resident #1 down by rubbing his back and trying to talk to him. LVN A said that Resident #1 was on the floor and he was assisting him back to his chair and his hand got caught in Resident #1's t-shirt and when he pulled it out his hand went up toward Resident# 1's neck. LVN A said that Resident #1</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the administrator of the facility and to other officials including to the State Survey Agency in accordance with State law through established procedures for 1 of 6 (Resident #1) residents reviewed for abuse. The facility failed to ensure an allegation of abuse was immediately reported to the abuse coordinator. The facility failed to report the allegation of abuse within 2 hours. An IJ was identified on 9/12/25 The IJ template was provided to the facility on 9/12/25 at 3:34 p.m While the IJ was removed on 9/13/25 the facility remained out of compliance at a scope of Isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ due to ongoing need for in-services on abuse and neglect, abuse coordinator and notification of abuse process. This failure could place residents at risk for physical and verbal abuse, psychosocial harm, and decreased quality of life. Findings included: Record review of the face sheet dated 9/11/2025 indicated that Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including severe intellectual disability which was below average intelligence, anxiety disorder which was intense, excessive, and persistent worry and fear about everyday situations, schizoaffective disorder which was a lifelong pattern of social withdrawal and limited emotional expression, ADHD which was a chronic condition including attention difficulty, hyperactivity and impulsiveness, cerebral palsy which was a congenital disorder of movement, muscle tone or posture, and cognitive communication deficit which was a group of disorders that affect a person's ability to communicate effectively due to underlying cognitive impairments. Record review of the MDS dated [DATE] indicated that Resident #1 had a BIMS score of 03 which was indicative of severe cognitive impairment. Record review of the care plan dated 9/7/25 which shows that Resident#1 was last admitted to the facility on [DATE] and was receiving services at the facility. Record review of progress note dated 9/10/2025 indicated that Resident #1 was on the floor of his bedroom fighting with his roommate and LVN A documented attempting to sooth Resident#1 by rubbing his back and his chest and his hand getting caught in the shirt of Resident #1. It indicated that LVN A instructed CNA B and CNA C to take Resident # 1 into the hallway. LVNA indicated that he assessed Resident # 1 and noted no injury. During an interview on 9/11/25 at 4:11 p. m. CNA B said that on 9/9/25 she worked with CNA C on the evening shift. She said that at around 10:30 p. m. she observed LVN A grab Resident #1 by the shirt near his neck and that she heard Resident #1 make a choking noise and cry once released. She said that she would consider the actions she witnessed LVN A carry out to be abuse. She said she sent a text to the DON at 10:39 p.m. and 10:46 p.m. letting the DON know about the incident and that she did not know what to do. She said she did not contact anyone else and did not try to call the DON. CNA B said she did not know who the abuse coordinator was at the time of the incident and did not recall being trained on abuse and neglect. She said she got a text the next morning at 6:38 a.m. from the DON asking her to call her. She said that the risk of not reporting abuse immediately was that LVN A could have gone back and carried out more abuse or abused other residents before his shift ended. Record review of the voice recording provided by CNA B on 9/11/25 at 4:30 p.m. that was recorded on 9/10/25 sometime after 6:00 p.m. and included the voice of LVA A, CNA B, and CNA C as identified by CNA B. A summary of the recording was that CNA B and CNA C acknowledged that they observed LVN A grab Resident #1 by the shirt and around his neck on 9/9/25. Both CNA B and CNA C told him that they had observed him grab Resident #1 by the shirt around his neck and got into Resident #1's face when Resident #1 used a racial slur toward his roommate. During an interview on 9/11/25 at 3:18 p.m. Resident #1 said that LVN A had choked him and that he was scared of LVN A. Resident #1 cried and left the interview. During an interview on 9/11/25 at 3:57 p.m. LVN A said that on 9/9/2025 he worked at the facility. He went into Resident #1's bedroom when he was fighting with his roommate. LVN A said that he was trying to calm Resident #1 down by rubbing his back and trying to talk to him. LVN A said that Resident #1 was on the floor and he was assisting him back to his chair and his hand got caught in Resident #1's t-shirt and when he pulled his hand out of Resident #1's shirt and it went up toward Resident #1's neck. LVN A said that Resident #1 was one of his favorite residents and that he would never abuse him. He said that residents have called him the N word before and he was not one so it does not bother him. LVN A said that he did not choke Resident #1 LVN A said that there were two CNAs in the room with him when his hand got caught in</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to in response to allegations of abuse, neglect, exploitation, or mistreatment, prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress for 1 of 6 (Resident #1) residents reviewed for abuse. LVN A physically abused Resident #1 on 9/9/25 and the facility failed to protect residents from further potential abuse when LVN A returned to the facility on the night shift of 9/10/2025 after being suspended at 7:50 a.m. on 9/10/25. An IJ was identified on 9/12/25. The IJ template was provided to the facility on 9/12/25 at 3:34 pm. While the IJ was removed on 9/13/25 the facility remained out of compliance at a scope of Isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ due to ongoing need for in-services on abuse and neglect, abuse coordinator and notification of abuse process. This failure could place residents at risk for physical and verbal abuse, psychosocial harm, and decreased quality of life. Findings included: Record review of the face sheet dated 9/11/2025 indicated that Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including severe intellectual disability which was below average intelligence, anxiety disorder which was intense, excessive, and persistent worry and fear about everyday situations, schizoaffective disorder which was a lifelong pattern of social withdrawal and limited emotional expression, ADHD which was a chronic condition including attention difficulty, hyperactivity and impulsiveness, cerebral palsy which was a congenital disorder of movement, muscle tone or posture, and cognitive communication deficit which was a group of disorders that affect a person's ability to communicate effectively due to underlying cognitive impairments. Record review of the MDS dated [DATE] indicated that Resident #1 had a BIMS score of 03 which was indicative of severe cognitive impairment. Record review of the care plan dated 9/7/25 which showed that Resident#1 was last admitted to the facility on [DATE] and was receiving services at the facility. During an interview on 9/11/25 at 4:11 p.m. CNA B said that on 9/10/25 she worked with CNA C on the evening shift. She said that they were outside smoking around 9:40 p.m. when LVN A approached them and asked them about the incident the night before between LVN A and Resident #1 and that he did not remember but was at the facility to document an incident report about it. She said that she did not know that LVN A was under investigation and that if she had she would have reported it. She said that the risk of not knowing that he was under investigation was that he could have come to the facility for retaliation which placed the staff and residents at risk of abuse. She said that LVN A got onto the computer and went onto the secured unit but she did not see him interact with any residents. CNA A said that the incident the night before that she was referring to was LVN A grabbing Resident # 1 by the shirt and making him choke. Record review of the voice recording provided by CNA B on 9/11/25 at 4:30 p.m. that was recorded on 9/10/25 sometime after 6:00 p.m. and included the voice of LVA A, CNA B, and CNA C as identified by CNA B. A summary of the recording was that CNA B and CNA C acknowledged that they observed LVN A grab Resident #1 by the shirt and around his neck on 9/9/25. LVN A admitted that he had returned to the facility to document the incident from last night with Resident #1. LVN A said that he got allegations for beating up on [unintelligible]. During an interview on 9/11/25 at 3:18 p.m. Resident #1 said that LVN A had choked him and that he was scared of LVN A. Resident #1 cried and left the interview. During an interview on 9/11/25 at 3:57 p.m. LVN A said that on 9/9/2025 he worked at the facility. He went into Resident #1's bedroom when he was fighting with his roommate. LVN A said that he was trying to calm Resident #1 down by rubbing his back and trying to talk to him. LVN A said that Resident #1 was on the floor and he was assisting him back to his chair and his hand got caught in Resident #1's t-shirt and when he pulled his hand out of Resident #1's shirt and his hand went up toward Resident #1's neck . LVN A said that Resident #1 was one of his favorite residents and that he would never abuse him. He said that residents have called him the N word before and he was not one so it does not bother him. LVN A said that he did not choke Resident #1. LVN A said that there were two CNAs in the room with him when his hand got caught in Resident #1's t-shirt. LVN A confirmed that the CNA's in the room were CNA B and CNA C. LVN A said that he was informed by DON that he was suspended pending an investigation on the morning of 9/10/25 and was told that he could likely return to work on Saturday if everything looked good. During an interview on 9/12/25 at 1:18 p.m. CNA C said that she worked on the night shift on 9/10/2025 alongside CNA B. She said around 9:30 p.m. LVN A came up to her and CNA B and started talking to them about the incident that had occurred the night before with LVN A grabbing Resident #1 by the shirt and throat and making him make a</p>		