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	10/22/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 6 of 11 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6) reviewed for abuse and neglect. The facility failed to protect Resident #1 from abuse when on 9/19/25 Resident # 3 hit Resident #1. The facility failed to protect Resident #5 from abuse when on 9/24/25 Resident # 4 grabbed, pulled, and scratched Resident #5's hand. The facility failed to protect Resident #2 from abuse when on 10/3/25 Resident #6 pushed Resident #2 to the ground, resulting in a lumbar vertebral fracture. The facility failed to protect Resident #1 from abuse when on 10/8/25 Resident #2 punched Resident #1 in the face causing a non-displaced nose fracture.On 10/21/2025 at 12:35 PM, an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/22/2025 at 04:30 PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.The facility Administrator was notified on 10/21/2025 at 12:35 PM that an Immediate Jeopardy situation had been identified due to the above failures and the IJ template was given at that time.These failures could place residents at risk for continued abuse, and severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being. Findings include:Resident #1:Record review of Resident #1's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease (progressive neurodegenerative disorder that affects memory, thinking, and behavior), anxiety (excessive worry, fear, and nervousness), and psychotic disorder with hallucinations (disconnect from reality, may see, hear, smell, taste or feel things that are not there). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, which indicated Resident #1 was unable to complete the interview. Resident #1's cognitive skills for daily decision making were severely impaired and never or rarely made decisions. Record review of Resident #1's care plan dated 9/09/2024 revealed Resident #1 had the potential to be physically aggressive with interventions that included: 1. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. 2. Assess and address for contributing sensory deficits. 3. Assess and anticipate residents' needs: food, thirst, toileting needs, comfort level, body positioning, and pain.Record review of Resident #1's progress note dated 9/19/2025 at 10:15 PM written by LVN J indicated Resident #3 hit Resident #1 in the back.Record review of Resident #1's progress note dated 10/08/2025 at 8:48 AM written by LVN C indicated on 9/19/25, Resident #1 was pushing the dining room table while Resident #2 was eating. Resident #2 asked Resident #1 not to push the table. Resident #1 continued to push the table. Resident #2 stood up and started punching Resident #1 in the face. Resident #1 had epistaxis (bleeding from the nose). LVN C notified the DON, Administrator and the Nurse Practitioner and sent Resident #1 to the hospital for x-rays of the face.Record review of Resident #1's progress note dated 10/08/2025 at 12:28 PM written by LVN C indicated she received report from the hospital RN that Resident #1 did have a non-displaced fracture to his nose (also known as a hairline fracture, occurs when the bone cracks but remains aligned without shifting).Record review of an incident report dated 9/19/2025 written by LVN J indicated: CNA reported to this nurse that she was taking [Resident #1] past [Resident #3] when [Resident #3] hit [Resident #1] in the back.Record review of an incident report dated 10/08/2025 at 8:30 AM written by LVN C indicated: This [Resident #1] was sitting at the dining room table across from [Resident #2]. This [Resident #1] was moving the table when [Resident #2] asked him to stop moving the table. This [Resident #1] continued to move the table. [Resident #2] stood up and started hitting [Resident #1] with closed fists.Resident #2:Record review of a facility face sheet dated 10/20/25 for Resident #2 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (progressive neurodegenerative disorder that affects memory, thinking, and behavior) and dementia. Face sheet also indicated a discharge date of 10/8/25 to a psychiatric hospital.Record review of a Quarterly MDS assessment dated [DATE] for Resident #2 indicated a BIMS score of 3, indicating a severe cognitive impairment. He exhibited no behavioral symptoms directed toward others. He was independent with most ADLs. Record review of a comprehensive care plan dated 10/3/25 for Resident #2 indicated he was pushed by another resident on 10/3/25. Record review of an incident report dated 10/3/25 for Resident #2 indicated he was pushed by another resident and landed on the floor on his left side.

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 6 of 11 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) reviewed for abuse policies. 1. The facility failed to follow their policy by not reporting abuse within the 2-hour required time frame when on Resident # 3 hit Resident #1, on 9/19/25. The facility did not report the incident to the state agency until 9/22/25. 2. The facility failed to follow their policy by not reporting abuse within the 2-hour required time frame when on Resident # 4 scratched and held Resident #5's hand, on 9/24/25. The facility did not report the incident to the state agency until 9/26/25. 3. The facility failed to follow their policy by not reporting an incident of abuse on 10/8/25 when Resident #2 punched Resident #1 in the face which caused a non-displaced nose fracture. 4. The facility failed to gather written statements for incidents that occurred on 9/19/25, 9/24/25 or 10/8/25, as per facility policy. 5. The facility failed to complete the State Provider Investigation Report (5-day report) for incidents of resident-to-resident abuse on 9/19/25, 9/24/25, 10/3/25 and 10/8/25, per facility policy. 6. The facility failed to review corrective actions for incidents of resident-to-resident abuse on 9/19/25, 9/24/25, 10/3/25, and 10/8/25, per facility policy. 7. The facility failed to analyze the occurrence to determine what changes, if any, were needed to the policies and procedures to prevent further occurrences for incidents of resident-to-resident abuse on 9/19/25, 9/24/25, 10/3/25, and 10/8/25, as per facility policy. 8. The facility failed to refer all occurrences to the QAPI committee to be analyzed to determine what change or changes were needed, if any, to the facility's policies and procedures to prevent further occurrences for incidents of resident-to-resident abuse on 9/19/25, 9/24/25, 10/3/25, and 10/8/25 as per facility policy. An Immediate Jeopardy (IJ) situation was identified on 10/21/2025. While the IJ was removed on 10/22/2025, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse which could lead to further abuse and neglect of other residents. Findings included: 1. Record review of Resident #1's electronic face sheet indicated a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease (progressive neurodegenerative disorder that affects memory, thinking, and behavior), anxiety (excessive worry, fear, and nervousness), and psychotic disorder with hallucinations (disconnect from reality, may see, hear, smell, taste or feel things that are not there). Record review of Resident #1's quarterly MDS assessment, dated 06/23/2025, indicated a BIMS score of 99, which indicated Resident #1 was unable to complete the interview. Resident #1's cognitive skills for daily decision making were severely impaired and never or rarely made decisions. Record review of Resident #1's care plan dated 9/09/2024 indicated Resident #1 had the potential to be physically aggressive with interventions which included: 1. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. 2. Assess and address for contributing sensory deficits. 3. Assess and anticipate residents' needs: food, thirst, toileting needs, comfort level, body positioning and pain. Record review of Resident #1's progress note, dated 9/19/2025 at 10:15 PM, written by LVN J, indicated Resident #3 hit Resident #1 in the back. Record review of Resident #1's progress note, dated 10/08/2025 at 8:48 AM, written by LVN C, indicated Resident #1 was pushing the dining room table while Resident #2 was eating. Resident #2 asked Resident #1 not to push the table. Resident #1 continued to push the table. Resident #2 stood up and started punching Resident #1 in the face. Resident #1 had epistaxis (bleeding from the nose). LVN C notified the DON, Administrator and the Nurse Practitioner and sent Resident #1 to the hospital for x-rays of the face. Record review of Resident #1's progress note, dated 10/08/2025 at 12:28 PM, written by LVN C, indicated she received report from the hospital RN that Resident #1 had a non-displaced fracture to his nose. Record review of an incident report, dated 9/19/2025, written by LVN J, indicated: CNA reported to this nurse that she was taking [Resident #1] past [Resident #3] when [Resident #3] hit [Resident #1] in the back. Record review of an incident report, dated 10/08/2025 at 8:30 AM, written by LVN C, indicated: This [Resident #1] was sitting at the dining room table across from [Resident #2]. This [Resident #1] was moving the table when [Resident #2] asked him to stop moving the table. This [Resident #1] continued to move the table. [Resident #2] stood up and started hitting [Resident #1] with closed fists. Resident #1 was not able to be interviewed due to Resident #1 being in the behavioral hospital. 2. Record review of Resident #2's facility face sheet

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility had evidence that all alleged violations were thoroughly investigated and prevented further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 6 of 11 residents (Residents #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6) reviewed for abuse/neglect. 1.The facility failed to investigate abuse when Resident # 3 hit Resident #1, on 9/19/25. 2. The facility failed to investigate abuse when Resident # 4 grabbed, pulled, and scratched Resident #5's hand, on 9/24/25. 3. The facility failed to investigate abuse when Resident #6 pushed Resident #2 to the ground, on 10/3/25. 4. The facility failed to investigate abuse when Resident #2 punched Resident #1 in the face which caused a non-displaced nose fracture, on 10/8/25. 5. The facility failed to gather written statements for incidents that occurred on 9/19/25, 9/24/25, or 10/8/25 as per facility policy. 6. The facility failed to complete the State Provider Investigation Report (5-day report) for incidents of resident-to-resident abuse on 9/19/25, 9/24/25, 10/3/25, and 10/8/25 as per facility policy. 7. The facility failed to review corrective actions for incidents of resident-to-resident abuse on 9/19/25, 9/24/25, 10/3/25, and 10/8/25 as per facility policy. 8. The facility failed to analyze the occurrence to determine what changes, if any, are needed to the policies and procedures to prevent further occurrences for incidents of resident-to-resident abuse on 9/19/25, 9/24/25, 10/3/25, and 10/8/25 as per facility policy. An Immediate Jeopardy (IJ) situation was identified on 10/21/2025. While the IJ was removed on 10/22/2025, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for abuse, physical harm, psychosocial harm, trauma, unrecognized abuse and emotional distress. Findings Included: 1.Record review of Resident #1's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included alzheimers disease (progressive neurodegenerative disorder that affects memory, thinking, and behavior), anxiety (excessive worry, fear, and nervousness), and psychotic disorder with hallucinations (disconnect from reality, may see, hear, smell, taste or feel things that are not there). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, which indicated Resident #1 was unable to complete the interview. Resident #1's cognitive skills for daily decision making were severely impaired and never or rarely made decisions. Record review of Resident #1's care plan dated 9/09/2024 revealed Resident #1 had the potential to be physically aggressive with interventions that included: 1. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. 2. Assess and address for contributing sensory deficits. 3. Assess and anticipate residents' needs: food, thirst, toileting needs, comfort level, body positioning, and pain. Record review of Resident #1's progress note dated 9/19/2025 at 10:15 PM written by LVN J indicated Resident #3 hit Resident #1 in the back. Record review of Resident #1's progress note dated 10/08/2025 at 8:48 AM written by LVN C indicated Resident #1 was pushing the dining room table while Resident #2 was eating. Resident #2 asked Resident #1 not to push the table. Resident #1 continued to push the table. Resident #2 stood up and started punching Resident #1 in the face. Resident #1 had epistaxis (bleeding from the nose). LVN C notified the DON, Administrator and the Nurse Practitioner and sent Resident #1 to the hospital for xrays of the face. Record review of Resident #1's progress note dated 10/08/2025 at 12:28 PM written by LVN C indicated she received report from the hospital RN that Resident #1 did have a non-displaced fracture to his nose. Record review of an incident report dated 9/19/2025 written by LVN J indicated: CNA reported to this nurse that she was taking [Resident #1] past [Resident #3] when [Resident #3] hit [Resident #1] in the back. Record review of an incident report dated 10/08/2025 at 8:30 AM written by LVN C indicated: This [Resident #1] was sitting at the dining room table across from [Resident #2]. This [Resident #1] was moving the table when [Resident #2] asked him to stop moving the table. This [Resident #1] continued to move the table. [Resident #2] stood up and started hitting [Resident #1] with closed fists. Resident #1 was not able to be interviewed due to Resident #1 currently in the behavioral hospital. 2. 2. Record review of Resident #2's facility face sheet, dated 10/20/25, indicated an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Alzheimer's disease and dementia (decline in cognitive abilities such as memory, thinking, and problem solving). Resident #2 was discharges to a psychiatric hospital on [DATE]. Record review of a Quarterly MDS

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Record review and interview, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System within 14 days after a facility completes the resident's assessment for 1 (Resident #4) of 6 residents reviewed for MDS transmission, in that: The facility failed to complete and transmit an Entry and Discharge MDS assessment for Resident #4 within 14 days of completion.These failures could place residents at risk of not having their assessment and care plan completed timely, which could result in denial of services and/or payment for services.Findings include: Record review of a facility face sheet dated 10/20/25 for Resident #4 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Bipolar disorder (a mental health condition characterized by extreme mood swings, including emotional highs (mania or hypomania) and lows (depression) and Epilepsy (seizures). Face sheet indicated also indicated a discharge date of 9/25/25 to a psychiatric hospital. Record review of an MDS tab in Resident #4's electronic medical record indicated there had been no MDS assessments completed. MDS tracking tab in PCC indicated an entry MDS was due with an ARD of 9/9/25, a discharge MDS was due with an ARD of 9/11/25, an entry MDS was due with an ARD of 9/23/25, and a discharge MDS was due with an ARD of 9/23/25. None had been completed, nor transmitted. During an interview on 10/21/25 at 2:43 pm MDS nurse said she started as the MDS nurse on 9/29/25 and she had no prior experience with MDS assessments. She said she had had a little bit of training with the previous MDS nurse where she would show her regulations in RAI, but she had received no formal training. She said all residents should have an entry MDS on admission and a discharge assessment with discharged . She said she did remember reading that in the RAI manual. She said she was not doing MDSs when Residents #2 and #4 were admitted and discharged . She said the Administrator did tell her yesterday (10/20/25) that there were a lot of MDSs that had not been done, completed, or transmitted. She said she was trying to get them completed now and able to submit. She said if MDSs are not completed timely, accurately and not submitted as required, the facility would not receive payments. She said care plans may not be completed accurately, and staff would not know how to take care of the residents. During an interview on 10/22/25 at 3:23 pm DON said the MDS coordinator was responsible for completing and transmitting MDS assessments. She said the care plans may not be up to date if MDSs are not completed timely. She said going forward she would be responsible for monitoring and ensuring timely completion and submissions. During an interview on 10/22/25 at 4:19 pm the Administrator said she would be responsible for MDS being completed and transmitted going forward. She said care plans could be missed if MDSs were not completed timely and transmitted as required and residents could be at risk of harm. Record review of a facility policy titled Electronic Transmission of the MDS dated September 2010 read: .All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed for 1 of 6 residents (Resident #4)reviewed for care plans . The facility failed to complete baseline care plans within 48 hours of admission for Residents #4. This failure could place residents at risk of not receiving care and services to meet their needs.Findings included:Record review of a facility face sheet dated 10/20/25 for Resident #4 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental health condition characterized by extreme mood swings, including emotional highs (mania or hypomania) and lows (depression) and Epilepsy (seizures).Record review of an MDS tab in an electronic medical record for Resident #4 indicated there had been no MDS assessment completed.Record review of a care plan tab in an electronic medical record for Resident #4 indicated there had been no comprehensive care plan completed.Record review of an assessments tab in an electronic medical record for Resident #4 indicated there had been no baseline care plan completed.During an interview on 10/21/25 at 2:43 pm MDS Coordinator said she had started doing MDSs on 9/29/25 and had no prior experience. She said the floor nurses should be responsible for completing the baseline care plan, but she said she did not know how long the facility had to complete the baseline care plan. She said if they were not completed the staff may not know how to take care of the residents. During an interview and observation on 10/21/25 at 3:15 pm LVN J said she was a floor nurse but said she did not complete the baseline care plans. She said she thought the ADON did them. She said she thought they must be done by an RN. She gave me a checklist from a book at the nurses' station that she said the floor nurses use to complete admissions. Baseline care plan was not included on the checklist. During an interview on 10/21/25 at 3:50 pm LVN J brought another list that she said came out with the checklist in July or August and baseline care plans were included on that list. She said she was not aware that they were to be completing them.During an interview on 10/22/25 at 10:45 am ADON said she had worked at the facility since July 2024, but she had been ADON since 10/1/25. She said she did not know baseline care plans were supposed to be done on admission until yesterday (10/21/25). She said she did not know how long the facility had to do a baseline care plan. She said moving forward her and the DON would be checking over new admissions to make sure baseline care plans were done. She said staff would not know how to take care of the residents without the baseline care plan.During an interview on 10/22/25 at 3:23pm DON said the admission nurse would be responsible for baseline careplans going forward. She said going forward her and the ADON would be responsible for making sure those are being completed. She said residents potentially would not be cared for properly without a baseline care plans. During an interview on 10/22/25 at 4:19pm Administrator said the MDS coordinator would be responsible for baseline care plans. She said care could be missed if baseline care plans were not completed and residents could be at risk of harm. Record review of a facility policy titled Care Plans - Baseline dated December 2016 read: .A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. and .To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.

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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 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. Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 1 of 9 resident hallways (Hallway 900 secured unit) and 2 of 3 entrances (north and south lobby entrance) reviewed for environmental concerns, in that:1. The facility failed to ensure the ceiling on the 900 hall was in good repair and did not leak water on 10/20/25, 10/21/25 and 10/22/25.2. The facility failed to ensure the lobby ceiling located at the south entrance (near the secured unit) was in good repair and did not leak water on 10/20/25, 10/21/25 and 10/22/25.3. The facility failed to ensure the lobby ceiling located at the north entrance was in good repair and did not have a hole and missing sheet rock exposing the frame and insulation on 10/20/25, 10/21/25 and 10/22/25.These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.Findings included: During multiple observations on 10/20/25, 10/21/25 and 10/22/25 between 9:00 am to 4:00 pm the ceiling on 900 hall and the ceiling at the south lobby entrance were leaking water and there were towels and buckets under the leaks catching water. The north entrance lobby ceiling had missing sheet rock exposing the frame and insulation. During an interview on 10/22/25 at 9:15 am CNA A said she had worked at the facility almost 2 1/2 years and the ceiling on 900 hall and the ceiling in the lobby entrances leak anytime it rains. She said she was not sure how long there had been a hole in the north entrance ceiling. She said the staff know to place towels and buckets to catch the water. She said the maintenance supervisor works on the roof regularly to remove the water, but nothing has fixed the problem. She said the housekeepers also regularly empty the buckets as needed and clean daily. She said the residents deserved better and the leaking could cause falls and injuries. During an interview on 10/22/2025 at 10:50 am the Maintenance Supervisor said that the roof was the problem and when it rains it leaks. She said she had sealed the roof twice already, but it was not working. She said she had been in contact with her corporate maintenance personnel, and he instructed her to continue to seal the roof. She said the area at the north entrance was better and was now dry and she was going to replace the sheet rock in the next week or so. She said the area on 900 hall and the south lobby continued to leak despite repairs. She said a ceiling that leaks and was in disrepair could cause falls, changes in resident condition and overall affect their health and dignity. During an interview on 10/22/25 at 11:00 am the Administrator said maintenance was responsible for the repairs of the facility and had been on the roof, applied sealant but despite the repair the roof continued to leak. She said they had reached out to corporate and was instructed to seal the roof as needed. She said a leaking ceiling and ceiling in disrepair could affect the residents overall health, safety and dignity. She said she expected the environment to be free of hazards and would continue to work to see the repairs were completed. Record review of a facility policy titled Quality of Life - Homelike Environment dated June 2024 indicated, .Residents are provided with a safe, clean, comfortable and homelike environment. 2. the facility staff and management shall maximize to the extent possible the characteristics of the facility that reflect a personalized setting; a. clean, sanitary, and orderly environment; daily cleaning and monthly deep cleaning .