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	12/03/2025

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 - Actual harm 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
	455855	A. Building B. Wing	12/03/2025

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 - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 3 of 11 residents (Resident #1, Resident #2 and Resident #3) reviewed for abuse and neglect. 1. The facility failed to protect Resident #2 from abuse from Resident #1 on 11/1/2025 when Resident #1 hit Resident #2 twice on the shoulder while cussing him. 2. The facility failed to protect Resident #2 from abuse from Resident #1 on 11/10/2025 when Resident #1 hit Resident #2 on the lower legs while cussing him. 3. The facility failed to protect Resident #3 from abuse from Resident #1 on 11/25/2025 when Resident #1 hit Resident #3 on the right thigh with his fists. The reasonable person concept was applied in determining the psychosocial outcomes. These failures could place residents at risk for severe negative psychosocial outcomes such as fear and anxiety, crying, depression, post-traumatic stress symptoms, and loss of sense of safety in their own home. Findings include: 1. Record review of Resident #1's electronic face sheet indicated Resident #1 was a [AGE] year-old male who originally admitted to the facility on [DATE] with the most recent readmission on [DATE]. Resident #1 had diagnoses which included: cerebral infarction (stroke with right side weakness), vascular dementia (decline in cognitive function), schizophrenia (affects thinking, feelings and behaviors), schizoaffective disorder (hallucinations and delusions), conduct disorder (aggression/impulsivity/lack of remorse characteristics), and cerebral palsy (affects body movement and muscle coordination). Record review of Resident #1's quarterly MDS assessment, dated 9/28/2025, indicated a BIMS of 15, which indicated no cognitive impairment. Resident #1 used a wheelchair and was not assessed for walking 10 feet due to medical condition or safety concerns. Record review of Resident #1's care plan, dated 11/22/2023, indicated: 1. Resident #1 had traumatic brain injury and made statements at times that may be inappropriate with interventions that included: .Redirect Resident when he has inappropriate behaviors. 2. Resident #1 had aggressive behavior toward another resident dated 4/8/2024 with interventions that included: .B. Monitor resident. C. Remove resident from situation . Resident #1's care plan was updated on 11/12/2025 to include the incident that occurred on 11/10/2025. Record review of the facility incident report, dated 11/1/2025 at 3:45 PM, written by LVN E, indicated: Resident #1 rolled by Resident #2 hit him twice on his shoulder. Resident #2 had not said anything to Resident #1 and while he was hitting Resident #2 he was cursing him. Record review of the facility incident report, dated 11/10/2025 at 4:00 PM, written by LVN A, indicated: CNA reported to this nurse the [Resident #1] and [Resident #2] were in a verbal altercation, when [Resident #2] stated to [Resident #1] you want to fight. [Resident #1] hit [Resident #2] with his fist in his legs. Record review of the facility incident report, dated 11/25/2025 at 2:45 PM, written by LVN E, indicated: I heard a little loudness from [Resident #1] voice and when I turned and look out from the nurse's station [Resident #1] was rolling toward [Resident #3] and hit him on his right thigh with his fists while I tried to stop him. The only thing that I saw [Resident #3] was trying to push his fist back to keep [Resident #1] away from him. [Resident #3] appears to be astonished and didn't say anything. During an attempted interview on 12/1/2025 at 9:40 AM, Resident #1 was not able to answer questions appropriately due to cognition. Resident #1 did not have any visible injuries or bruising from the incident. 2. Record review of Resident #2's electronic face sheet indicated Resident #2 was a [AGE] year-old male who originally admitted to the facility on [DATE] with the most recent readmission on [DATE]. Resident #2 had diagnoses which included: severe intellectual disabilities (delayed motor, language, and social accomplishments within the first 2 years of life), schizoaffective disorder (hallucinations and delusions), and cerebral palsy (affects body movement and muscle coordination). Record review of Resident #2's significant change in status MDS assessment, dated 11/10/2025, indicated a BIMS of 03, which indicated severe cognitive impairment. Resident #2 used a wheelchair and was not assessed for walking 10 feet due to medical condition or safety concerns. Record review of Resident #2's care plan, dated 9/23/2024, indicated: Resident #2 received aggressive behavior from another resident with interventions that included: A. Assess resident for injuries. B. Monitor resident. C. Remove resident from situation. During an attempted interview on 12/1/2025 at 2:30 PM, Resident #2 was not able to answer questions appropriately due to cognition. 3. Record review of Resident #3's electronic face sheet indicated Resident #3 was a [AGE] year old male who admitted to the facility on [DATE]. Resident #3 had diagnoses which included: anxiety (feeling of fear, dread, and uneasiness), unspecified dementia (confusion or mild cognitive impairment), and cognitive communication deficit (trouble participating in conversations). Record review of Resident #3's

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	12/03/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	12/03/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 11 (Resident #1) residents reviewed for supervision. The facility failed to ensure the secured unit, 800 hall, door alarm and door lock was functioning properly. On 10/30/2025 Resident #1 eloped from the facility and was found in the parking lot. An Immediate Jeopardy (IJ) situation was identified on 12/02/2025. While the IJ was removed on 12/03/2025, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of harm, serious injuries, and death due to lack of supervision and failure to follow protocols.Findings include: Record review of Resident #1's electronic face sheet indicated Resident #1 originally admitted to the facility on [DATE] with the most recent readmission on [DATE]. Resident #1 had diagnoses included: cerebral infarction (stroke with right sided weakness), vascular dementia (decline in cognitive function), schizophrenia (affects thinking, feelings and behaviors), schizoaffective disorder (hallucinations and delusions), and cerebral palsy (affects body movement and muscle coordination). Record review of Resident #1's quarterly MDS assessment, dated 9/28/2025, indicated a BIMS of 15, which indicated no cognitive impairment. Resident #1 used a wheelchair and was not assessed for walking 10 feet due to medical condition or safety concerns. Record review of Resident #1's care plan, dated 8/7/2023, indicated: The resident is an elopement risk. 8/6/2023 resident exited the facility and left premises. Resident was found on highway. 10/30/2025 Resident was found outside by shower tech of facility near an entrance door. interventions included: .5. Monitor resident 1:1. Document wandering behavior and attempted diversional interventions in behavior log. 6. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Every 15-minute monitoring for 72 hours. Record review of Resident #1's elopement risk assessment, dated 9/7/2025, indicated a elopement score of 16 which was high risk to wander. Record review of Resident #1's elopement risk assessment, dated 10/30/2025, indicated a elopement score of 11 which was high risk to wander. Record review of the facility incident report for Resident #1, dated 10/30/2025 at 12:00 PM, completed by LVN A indicated: 2 CNAs reported to this nurse patient was found outside in the facility parking lot. During an observation and interview on 12/01/2025 at 9:20 AM, CNA F pushed the secured unit 800 hall back door and the door opened, and the alarm sounded. She said the nurse had to check all the secured unit doors every day to ensure all the doors were locked and the alarms were functioning properly. She said she did not know why the secured unit 800 hall door was not locked. During an interview on 12/01/2025 at 9:25 AM, LVN E said she was the nurse for the secured unit. She said the nurses on the secured unit were supposed to check all the secured unit doors every shift to ensure they were locked, and all door alarms were functioning properly. She said she checked the secured unit 800 hall door on 12/1/2025 when she got to work at 6:00 AM and it was locked, and the alarm was functioning properly. She said she did not know why the door was unlocked on 12/1/2025 during the state surveyor observation at 9:20 AM. During an interview on 12/1/2025 at 9:35 AM, CNA G said the secured unit 800 hall door was supposed to be locked, with the alarm functioning at all times. She said she did not know why the door was unlocked on 12/1/2025 at 9:20am. During an attempted interview on 12/1/2025 at 9:40 AM, Resident #1 was not able to answer questions appropriately due to cognitive communication deficit. During an interview on 12/1/2025 at 11:30 AM, the DON said 12/1/2025 was her first day working at the facility and did not know anything about the elopement on 10/30/2025 prior to her employment. During an interview on 12/1/2025 at 11:41 AM, the Maintenance Director said she did not know why the secured unit 800 hall door was not locked on 12/1/25 at 9:20 AM, but it was not supposed to be unlocked. She said she checked the secured unit 800 hall door when she got to work on 12/1/2025 and the door was locked. She said she checked all facility doors daily to ensure all door locks and door alarms were functioning properly. She said the secured unit 800 hall door had to be locked from the outside and the key stayed in the lock on the outside of the door. She said she did not know why they kept the key in the lock on the door on the outside, but it had always been kept there since she worked at the facility. She said after Resident #1 eloped, on 10/30/2025, she added another alarm to the fire doors that were on the secured unit 800 hall as an intervention for the elopement. During an interview on 12/1/2025 at 11:50 AM, the Administrator said on

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	12/03/2025

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 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. (continued on next page)

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	12/03/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 3 entrances (south lobby entrance) and for the dining room chairs in 1 of 2 dining areas reviewed for environmental concerns. 1. 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 12/01/25, 12/02/25 and 12/03/25. 2. The facility failed to ensure the dining room chairs in Hall 900 (secured unit) were in good repair and without damage to the cushions. 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 include: During multiple observations on 12/01/25, 12/02/25 and 12/03/25 between 8:00 AM to 4:30 PM the ceiling at the south lobby entrance was leaking water and there were towels and buckets under the leaks catching the water. During an observation on 12/01/2025 at 8:00 AM revealed a section of pink insulation approximately 1 feet by 2 feet was noted hanging from the ceiling. During an observation on 12/01/2025 at 10:00 AM, the insulation had been removed and the hole repaired. The area of repair continued to leak water with a bucket and towel located under the area of the leak . During multiple observations on 12/01/25, 12/02/2025 and 12/03/2025 between 8:30 AM and 4:00 PM, the chairs located in the dining room of the secured unit, hall 900, were noted to have rips, tears and holes in 14 chairs observed. 6 chairs were noted to have inner cushion exposed. Residents observed sitting in chairs during observations. During an interview on 12/01/2025 at 9:30 AM, the Maintenance Supervisor said the roof was an ongoing problem and when it rained it leaked. She said she sealed the roof twice, but it was not working. She said the corporate maintenance personnel was actively evaluating and working on the issue. She said a ceiling that leaked and was in disrepair could cause falls, changes in resident condition and overall affect their health and dignity. During an interview on 12/02/25 at 8:15 AM, CNA C said she routinely worked on hall 900 and the ceiling in the lobby entrances leaked anytime it rained. She said she was unable to recall how long there had been a hole in the south entrance ceiling. She said the staff knew to place towels and buckets to catch the water. She said the maintenance supervisor worked on the roof regularly to remove the water, but nothing had fixed the problem. She said the housekeepers also regularly emptied the buckets as needed and cleaned daily. She said the leaking could cause falls and injuries. She stated the chairs located in the dining room for hall 900 were in poor condition for a long period of time, she was unable to give an approximate time. She stated housekeeping staff cleaned the chairs daily. She said the residents deserved to have chairs that were in nice condition and not torn up. During an interview on 12/03/25 at 2:00 PM, LVN A said she routinely worked on hall 900 and the ceiling in the lobby entrances leaked anytime it rained. She said she was not sure how long there had been a hole in the south entrance ceiling. She said the maintenance supervisor worked on the roof regularly. She said the residents and visitors were at risk for falls and injuries. She stated the chairs located in the dining room for hall 900 were in poor condition for many months, she was unable to provide an approximate timeline. She stated housekeeping staff cleaned the chairs daily. She said the residents should have a nice environment as well as any visitors and chairs should not have rips or tears. During an interview on 12/03/25 at 2:00 PM, the Administrator said maintenance was responsible for the repairs of the facility and assessed the roof, applied sealant but despite the repair the roof continued to leak. She said a local contractor was scheduled to evaluate the roof next week and provide an estimate for repairs needed. She stated she communicated with corporate management on multiple occasions regarding the roof leaking and sent photos of the current leaks. She stated the insulation that was observed on 12/01/25, was a recent occurrence and the night shift staff notified her the night before of the insulation exposed. She said she notified corporate management of the ceilings condition. 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 that repairs were completed. The administrator stated she was aware of the conditions of the chairs located in the dining room of hall 900. She said the chairs had been in the facility for over 5 years. She said the materials used on the chairs peeled and became worn very quickly. She said the chairs could present a cleaning and disinfecting problem due to cloth and foam materials being exposed. She stated the residents had a right to a clean environment and furniture that was without holes and tears. Record review of the facility's 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