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	04/24/2024

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. 42190 Based on interview and record review, the facility failed to ensure residents were informed orally, of their rights, for 8 of 8 residents interviewed during a group meeting. Resident #s #15, #16, #25, #29, #31, #40 and #303. Residents were not provided on going communication of their rights, during their stay in the facility. This failure could place the residents at risk of a decreased quality of life, decreased awareness of their right and decreased execution of their rights. Findings include: During record review of monthly resident council meeting minutes, on 04/23/2024 at 8:50AM, revealed resident rights were not reviewed, over the past five months; April, March, February and January 2024 and December 2023. During interview on 04/23/2024 at 10:00AM, Residents #15, #16, #25, #26, #29, #31, #40 and #303 said, the Activity Director had not reviewed or explained resident rights to them . During interview on 04/24/2024 at 10:55AM, the Activity Director said she never reviewed the list of resident rights with the residents. She said she did not know she should have been reviewing the rights. She said if a resident brought up an issue that involved a right, she would discuss that right for that particular situation. She said she will start reviewing the list of resident rights at future resident council meetings. During interview on 04/24/2024 at 4:30PM, the Administrator said the resident receive a copy of the resident rights, when they receive their admission packet, upon admission. She said she has not reviewed the list of resident rights with the residents. Review of a document titled Resident Right, with a revised date of 2016, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation #1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include . The policy does not addressng, orally explaining the resident rights to the residents.

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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screening for 2 of 12 residents reviewed for PASRR (Residents #33 and #35). The facility failed to ensure Residents #33 and Resident #35 had accurate PASRR Level 1 Screenings indicating diagnoses of mental illness and refer the residents to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Resident #33 Record review of a face sheet dated 04/24/2024 indicated Resident #33 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included major depressive disorder with behaviors (a mental illness indicated by a persistent feeling of sadness and loss of interest with symptoms of irritability, restlessness, and /or angry outbursts). Record review of Section I of the Comprehensive (admission) MDS assessment, dated 12/04/2023, indicated Resident #33 had a diagnosis of depression. Section N of the same MDS assessment indicated Resident #33 had received antidepressant and antipsychotic medications for treatment of major depressive disorder during the 7 days of the assessment period. Record review of a physician's orders dated 11/29/2023 indicated Resident #13 was to receive Remeron (an antidepressant medication), Lexapro (an antidepressant medication), and Risperidone (an antipsychotic medication) for treatment of major depressive disorder with severe psychotic behaviors. Record review of Resident #33's PASRR Level 1 Screening completed on 11/27/2023 indicated in section C0100 there was no evidence of this individual having mental illness. Resident #35 Record review of a face sheet dated 04/24/2024 indicated Resident #35 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included mood disorder (a disorder described by marked disruptions in emotions of severe lows called depression or highs called mania also called bipolar disorder). Record review of Section I of the Comprehensive (admission) MDS assessment, dated 11/20//2023, indicated Resident #35 had a diagnosis of bipolar disorder. Section N of the same MDS assessment indicated Resident #35 had received antipsychotic and antidepressant medications during the 7 days of the assessment period. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of physician's order dated 11/10/2023 indicated Resident #35 was receiving the medications, Lexapro (an antidepressant medication) and Seroquel (an antipsychotic medication) for treatment of mood disorder. Record review of Resident #35's PASRR Level 1 Screening completed on 11/09/2023 indicated in section C0100 there was no evidence of this individual having mental illness. During an interview on 04/24/2024 at 09:50 AM with the DON, she said the MDS Nurse was responsible for tasks associated with the MDS and PASRR. During an interview on 04/24/2024 at 11:10 AM, the MDS Nurse said her department was responsible for reviewing the Level I PASRRs to ensure accuracy and appropriate follow-up actions. She said she was training a second MDS nurse at the time Resident #33 and Resident #35 admitted to the facility and the MDS Nurse Trainee was responsible for reviewing PASRR I screenings. The MDS Nurse said she did not know why the inaccurate PASRR I was not addressed. The MDS Nurse said the LA should have been notified of Resident #33's and Resident #35's inaccurate PASRR Level 1 screenings. The MDS Nurse said she was the only MDS Nurse currently and was responsible for reviewing PASRR Level I Screenings. The MDS Nurse said it was important for the PASRR Level 1 Screenings to be accurate because the facility needed to make sure the residents were getting the correct resources and services.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47204 Based on observation, interview, and record review the facility failed to post accurate daily information that included the total number and actual hours worked by registered nurses and licensed practical or licensed vocational nurses directly responsible for resident care per shift for the 6-2 shift on 3 of 3 days reviewed for posted nursing staff information. The facility did not post the accurate actual number and hours worked by registered nurses and licensed practical nurses directly responsible for resident care per shift on 04/22/2024, 04/23/2024, and 04/24/2024. This failure could place all residents, their families, and facility visitors at risk of not having access to accurate information regarding staffing data. Findings included: Observation on 04/22/2024 at 08:50 AM of the DAILY NURSE POSTING REPORT dated for the day of 04/22/2024 and posted at the nurse station at the south entrance of the facility indicated there was 1 RN for a total of 8 hours and 5 LVNs for a total of 21 hours directly responsible for resident care on the 6 AM-2 PM shift. Observation on 04/23/20244 at 08:35 AM of the DAILY NURSE POSTING REPORT dated for the day of 04/23/2024 and posted at the nurse station at the south entrance of the facility indicated there was 1 RN for a total of 8 hours and 5 LVNs for a total of 21 hours directly responsible for resident care on the 6 AM-2 PM shift. Observation on 04/24/20244 at 08:35 AM of the DAILY NURSE POSTING REPORT dated for the day of 04/24/2024 and posted at the nurse station at the south entrance of the facility indicated there was 1 RN for a total of 8 hours and 5 LVNs for a total of 21 hours directly responsible for resident care on the 6 AM-2 PM shift. During an interview with the DON on 04/23/2024 at 11:45 AM, she said she was the only RN in the facility. She said the 1 RN for 8 hours on the 6-2 shift listed on the posted Daily Nurse Posting Reports observed was for herself. She said she did not provide direct resident care. The DON said the 5 LVNs on the 6-2 shift included her ADON and MDS Nurse. She said the ADON worked 2-3 hours a day doing treatments and the remaining 5-6 hours performing other duties unrelated to direct resident care. She said the MDS Nurse did not perform direct resident care. The DON said she included herself, the MDS Nurse, and the ADON in the count of nurses because that was how she was taught to do it. A review of the nursing schedule for 04/22/2024 indicated there were 2 LVNs assigned to Halls 200, 300, and 400 on the north side of the facility and 1 LVN assigned to Halls 800 and 900 on the south side of the facility for the 6-2 shift. There was no RN assigned to provide direct resident care for the 6-2 shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of the nursing schedule for 04/23/2024 indicated there were 2 LVNs assigned to Halls 200, 300, and 400 on the north side of the facility and 1 LVN assigned to Halls 800 and 900 on the south side of the facility for the 6-2 shift. There was no RN assigned to provide direct resident care for the 6-2 shift. A review of the nursing schedule for 04/24/2024 indicated there were 2 LVNs assigned to Halls 200, 300, and 400 on the north side of the facility and 1 LVN assigned to Halls 800 and 900 on the south side of the facility for the 6-2 shift. There was no RN assigned to provide direct resident care for the 6-2 shift. A review of the facility's policy titled Staffing included the following: 2. Staffing numbers and the skill requirements are determined by the census, needs of the residents This will be posted prominently inside the facility entrance and shows .direct care staff with titles and hours.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 27140 Based on observation, interview, and record review, the facility failed to ensure the menu was followed for 2 of 2 meals reviewed for menus and nutritional adequacy. (Lunch meals 04/22/24, 04/23/24). Resident # 21 did not receive pureed bread on her lunch tray on 04/22/24. Incorrect utensils were used for serving food during lunch on 04/23/24 resulting in improper portion sizes. Cook A served the lunch meal on 04/23/24 in a haphazard manner inadequately filling the serving utensils with food and did not deliver the required amount of foods consistently. Pureed diets did not receive pureed bread during lunch on 04/23/24. Regular and mechanical diets received a half portion of bread during lunch on 04/23/34. These failures could place residents who eat foods from the kitchen at risk of not having their nutritional needs met. Findings included: A review of the dietary spreadsheet dated Day: 30 Monday (04/22/24) for the noon meal indicated a pureed diet should receive a #20 dip (1.52 oz.) of pureed buttered white bread. During an observation on 04/22/24 at 1:15 PM Resident #21 was eating in her room and being fed by staff a pureed diet. The divided plate contained pureed soup, corn, and rice. A pureed ice cream sandwich was in a separate bowl. There was no pureed bread served. During an interview on 04/23/24 at 1:07 PM, the DM said the pureed bread was placed in a small black plastic cup on the tray because the divided plates did not have room for the bread on the plate but on 04/22/24 the bread was probably in the vegetables. When asked if the vegetable serving size had been adjusted by the RD to include the pureed bread she said no. A review of the planned menu dated Week 1 Tuesday (04/23/24) for the noon meal was smoked sausage, sauerkraut, breaded okra, Texas toast, and apple crisp. The dietary spreadsheet indicated a regular diet should receive 3 oz. of sausage, 1/2 cup of sauerkraut, 3/4 cup of breaded okra, 1 slice of Texas toast, and 1/2 cup of apple crisp. The dietary spreadsheet indicated a pureed diet should receive 1/3 cup of sausage, 3/8 cup of sauerkraut, 1/2 cup fried okra, 1/3 cup Texas toast, 3/8 cup of apple crisp. During observations and interviews in the kitchen on 04/23/24 the following was noted: *at 11:25 AM it was noted regular sliced bread was being used instead of Texas toast and cake with frosting was substituted for apple crisp. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*at 11:35 AM the DM was pureeing fried okra but found the consistency could not be smoothed to the proper consistency. She threw it way and had Cook A get a can of black beans from the pantry to heat up as a substitute for the okra. She said she was substituting creamed corn for the sauerkraut. She said she had 5 residents receiving the pureed diets. She attempted to puree chopped ham instead of sausage for the meat item but could not get it to puree to the proper consistency. She threw the pureed ham away. *at 11:45 AM Cook A took 4 full sized baking trays of sliced/buttered bread from the oven that had been toasted. The DM instructed her to cut the slices into halves, which she did and placed in a stainless steel pan on the griddle area of the stove for service. One tray of toast was not sliced and prepared for service. *at 11:50 AM the DM took 2 dessert dishes containing a serving of cake with frosting and placed them in the food processor. She added 1% milk to the processor and processed to a smooth consistency. She was asked how many desserts she needed to prepare and she said the residents receiving pureed foods were on low concentrated sweets diets and only received a half portion. She pureed 2 servings for 5 residents. She said there were 5 residents receiving pureed diets. She did not use any utensil to measure the amount of processed cake poured into a serving dish. She did not follow a recipe for preparation of the pureed dessert. *at 12:00 PM Cook A mechanically chopped about 4-5 scoops of sausage slices for the mechanical meat. She said there was not enough sausage slices to make 12 mechanically chopped servings and still have enough whole slices for the regular residents. She placed the chopped sausage on the steam table. DM said she had 10 pounds of smoked sausage to be prepared for the lunch meal. Cook A ignored any questions directed towards her regarding how much mechanical sausage she was preparing for service. *at 12:12 PM DA B was frying breaded chicken breasts to be used for the pureed meat instead of ham. *at 12:17 PM DA B prepared the pureed chicken in the food processor using cold 1% milk as a thinning agent. There was no recipe being used. The chicken was cooled by using cold milk from the refrigerator. Cook A was continuing to walk around the kitchen swinging her arms and talking loudly about everything being late but not assisting anyone with preparations. The chicken was placed in the oven to re-heat. *at 12:20 PM chopped ham was being heated in a pan on the stove with some BBQ sauce to add to the mechanical sausage that was on the steam table. The following the following serving utensils were used during meal service:: Sausage slices 3 oz; fried okra /2 cup (should be 3/4 cup); sauerkraut 1/2 cup; creamed corn 6 oz (should be 4 oz); mechanical sausage/chopped ham mix 6 oz. (should be 3 oz); puree meat 8 oz (should be 1/3 cup); (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	puree corn 6 oz (should be 4 oz); puree black beans 6 oz (should be 4 oz); half slices of buttered toast were in a stainless steel pan on the griddle area of the stove (should be full slice) no puree bread was prepared. *at 12:45 PM tray line service started and Cook A began serving the food by scooping food into the utensils, the utensil was not always full of food. *at 12:47 PM DA B plated a half piece of toast with her gloved hand and covered the plate with an insulated lid. *at 12:52 PM pureed items were served using the 6 oz scoops placed in the containers of beans and corn. The utensils were filled partially with an indeterminate amount of food and placed on the plates. Using an 8 oz scoop for the meat the utensil was partially filled and an undetermined amount was placed on the plates. No pureed bread was prepared and placed on the plate or tray during this meal service. *at 12:55 PM the last pureed plates were served using partially filled scoops. Cook A and DA B were scraping the puree containers on the steam table to get a little bit of food into the serving utensils and placed that on the last plate. They were laughing about having to scrape so hard to get some food to place on the plate. *at 1:00 PM DA C came to the kitchen from delivering a tray cart and she said the nurse said Resident #308 was to get large portions and he did not receive them. Cook A said no one was getting large portions or double portions today because there was not enough food. She said all the residents were just going to get regular portions. A review of the dietary roster dated 04/22/24 indicated there were 5 residents receiving pureed diets and 5 residents receiving large portions, double entrees, or double meat/protein portions. There were 2 residents that did not receive food from the kitchen. The DM said she had not checked the utensils used for service or made sure the foods served was appropriate. When asked about the lack of serving utensils she said she tried to order one on each order. During an interview on 04/23/24 at 1:20 PM the DM said residents should have received a whole slice of bread. She said the cook must have misunderstood her when she told her to cut the toast slices in half. She said she meant for them to be cut in half so they could be placed on the plates easier. The DM seemed resigned to the type of staff she had and said she was just lucky to have anyone that would work.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27140 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen observed for kitchen sanitation. The microwave had food debris and splatters. The bulk flour bin had a measuring cup inside. The DM dropped a thermometer into the pureed meat and served the food. Cook A touched the inside of the plates and food with her gloved hands. She was not wearing an apron and used her body to keep the plates with food on the tray line. DA B touched the inside of the plates with her bare hand and placed bread on top of the food using her hand and not a utensil. Cook A returned food that had spilled onto the prep area to the pan of food on the steam table. These failures could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During observations and interviews on 04/22/24 of the kitchen the following was noted: *at 10:00 AM Microwave had food debris and liquid splatters inside. *at 10:20 AM the bulk flour bin had a measuring cup stored inside product. The DM removed the cup from the flour and said that wasn't supposed to be in there. During observations and interviews on 04/23/24 of the kitchen the following was noted: *at 12:40 PM the DM was taking the holding temperature of the pureed chicken breasts and dropped the thermometer into the food. She dipped the thermometer out of the pureed meat with another utensil, wiped off the face of the dial with her bare hand, and continued to try and get a temperature reading. She said the steam was hot on her arm. *at 12:45 PM the tray line service started. Cook A placed 9-10 plates at a time in their insulated bottoms on the prep area beside the steam table and along the tray line on the steam table. She placed her gloved hands in the bottom of the plates. She began serving the food and scooping the food into the utensils and dumping it on the plates. She contained the food to the plate using her hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*at 12:47 PM DA B was placing the sauerkraut and bread on the plates, picking the plates up and placing them on the delivery cart. She was wearing a glove on her right hand but not her left hand. She picked up the plates using her left hand and her thumb was inside the plate. Using her gloved hand, instead of tongs, she picked up a half a piece of toast and placed it on top of the food and covered the plate with a lid. *at 12:50 PM Cook A kept rapidly tossing food onto plates using her gloved hands to scoot the food around on the plates because it had been so forcefully placed. Sausage slices came out of the serving utensil and landed on the prep area around the steam table and she picked up the slices and returned them to the container of sausage on the steam table. *at 12:55 PM Cook A was using her body to keep plates on the steam table tray line. She was not wearing an apron, just her street clothes, and was bumping the plates of food with her stomach area. During the observation the DM was not observing food service and was not aware of what activities were taking place on the serving line. She had not checked the utensils used for service or made sure the foods were served appropriately. Food Code 2013 - Hands and Arms 2-301.11 Clean Condition. The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the Code. Even seemingly healthy employees may serve as reservoirs for pathogenic microorganisms that are transmissible through food. Staphylococci, for example, can be found on the skin and in the mouth, throat, and nose of many employees. The hands of employees can be contaminated by touching their nose or other body parts. 2-301.12 Cleaning Procedure. Handwashing is a critical factor in reducing fecal-oral pathogens that can be transmitted from hands to RTE food as well as other pathogens that can be transmitted from environmental sources.