STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676173	A. Building B. Wing	06/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenedy Health & Rehabilitation	7882 South Highway 181 Kenedy, TX 78119

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan, meet professional standards of quality for 1 of 5 residents (Residents #1) reviewed for following physician orders.The facility failed to obtain a specialty care follow up appointment to the urologist for Resident #1 ordered post hospitalization on 1/7/26 after the insertion of a supra pubic catheter. Resident #1 was transferred to the hospital on 6/23/26 related to a change in condition and was diagnosed with sepsis and a urinary tract infection while at the hospital.These failures could place the residents at risk of not having their individual needs met and of not receiving adequate care and medical interventions to maintain their health and prevent worsening health conditions.The findings included: Record review of Resident #1's face sheet, dated 6/27/26, reflected an [AGE] year-old male admitted to the facility on [DATE], re-admitted on [DATE], and discharged to an acute care hospital on 6/23/26 with diagnoses that included cerebral infarction (an area of brain tissue that has been permanently damaged because its blood supply was blocked; stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or partial loss of strength on one side of the body) following cerebral infarction affecting right dominant side, acute cystitis without hematuria (sudden infection and inflammation of the bladder that does not cause blood in the urine), presence of urogenital implants (a medical device that has been surgically placed in the urinary system), obstructive and reflux uropathy (condition in which the normal flow of urine is impaired because of blockage, backward flow of urine, or both), retention of urine, benign prostatic hyperplasia (a non-cancerous enlarged prostate gland) with lower urinary tract symptoms, gastrostomy status (an active, functioning surgical opening in the stomach which holds a feeding tube), dementia with agitation, and urinary tract infection. Record review of Resident #1's most recent quarterly MDS assessment, dated 5/22/26, reflected the resident was cognitively intact for daily decision-making skills, required substantial/maximal assistance with ADLs and mobility, had an indwelling urinary catheter, and was always incontinent of bowel. Record review of Resident #1's June 2026 Order Summary report, dated 6/27/26, reflected the following:- Cleanse supra pubic catheter site with normal saline, pat dry, cover with drainage sponge twice daily for preventative wound healing with order date 1/8/26 and no end date.- Empty (urine) drainage bag every shift with order date 11/29/25 and no end date.- Ensure catheter strap in place every shit change and as needed with order date 11/29/25 and no end date.- Monitor supra pubic catheter every shift for leakage, blockage, sediment buildup, or low output every shift for preventative with order date 1/8/26 and no end date.- Supra pubic 16 French/10 ml to gravity drainage every day and night shift related to neuromuscular dysfunction of bladder (condition in which the nerves or muscles that control the bladder do not function normally), obstructive and reflux uropathy with order date 1/8/26 and no end date. Record review of Resident #1's comprehensive care plan, with revision date 6/26/26, reflected the resident had an indwelling urinary catheter related to neurogenic bladder (condition in which the bladder does not function normally because of damage to the nerves that control bladder storage and emptying) and on 1/8/26 had a supra pubic catheter with interventions that included to cleanse the supra pubic catheter site. Record review of the hospital records, dated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Actual harm Residents Affected - Few	1/1/26, reflected Resident #1 was seen for acute kidney injury related to urine retention, hyperkalemia (condition in which the level of potassium in the blood is higher than normal), sepsis (the body's response to an infection becomes dysregulated, causing widespread inflammation that can lead to organ dysfunction and if untreated septic shock and death), and obstruction of urinary catheter. Resident #1's hospital record reflected, may need urology consult for potential suprapubic catheter placement. Resident #1's hospital records reflected in part, 1/6 plans for IR SPT (suprapubic tube by Interventional Radiology [IR]) insertion today. Will monitor for output and anticipate discharge this afternoon if no hematuria or complications. Record review of Resident #1's Patient Depart Summary, with disharge date of 1/7/26, revealed, Your suprapubic catheter may need to be changed every 4-6 weeks, or as often as recommended by your health care provider. Record review of Resident #1's clinical record reflected the following:- 2/1/26 Description of the behaviors: Resident #1 pulls on supra pubic catheter tubing- 2/13/26: Resident #1 transferred to the hospital on 2/13/26 at 3:40 p.m. related to unresolving gross hematuria, and low-grade fever- 2/13/26: Resident #1 re-admitted /returned from emergency room via ambulance. Diagnosis urinary tract infection and one new order for antibiotic therapy for 7 days. Family member, MD and DON notified.- 2/15/26: Weekly Summary. Description of behaviors: continues to pull on suprapubic catheter/tubing at insertion site, will attempt to bite/nibble on squishy toy that he keeps in hand. MD and family member aware of the behaviors. Record review of the progress note dated 2/19/26 with time stamp 3:39 p.m., and authored by LVN A reflected in part, call placed to urologist to set up a follow-up appointment at this time. Urology office notified this nurse. Resident #1's current Medicare Part A does not cover appointment. Record review of Resident #1's hospital records, dated 6/23/26, revealed diagnoses of septic shock and a UTI. Further review revealed imaging showed, showed partially decompressed urinary bladder with suprapubic foley catheter in place. There is persistent perivesicular and presacral edema. Enlarged prostate gland. Further review revealed the resident had neurogenic bladder and was referred for consultation related to bilateral hydronephrosis (swelling of the kidneys r/t buildup of urine.) An attempt at a telephone interview on 6/27/26 at 7:01 a.m. with Resident #1 was unsuccessful. The hospital operator indicated they did not have a Resident by that name in the hospital. During an interview on 6/27/26 at 9:30 a.m., the DON stated she submitted an allegation of neglect to State Office related to a social media post she had seen posted by Resident #1's family member on 6/25/26 alleging the facility was not properly treating the resident's urinary tract infection which resulted in the resident having sepsis which resulted in being admitted to the hospital intensive care unit. The DON stated, on 6/23/26 at approximately 3:30 p.m. or 4:00 p.m., Resident #1 was lethargic, or tired, didn't want to get up so we put him in bed, administered fever reducing medication and obtained his vital signs. The DON stated Resident #1's blood pressure began to decrease and the family member and MD were notified. The DON stated that the MD ordered a urinalysis but as the evening progressed Resident #1's condition declined and the MD ordered the resident to be transferred to the hospital for evaluation and treatment on 6/23/26 at approximately 7:30 p.m. The DON stated Resident #1 continued at the hospital but was no longer in the intensive care unit and was awaiting transfer to a regular hospital room. The DON stated, Resident #1 had a long history of chronic urinary tract infections and had been treated in the facility with IV antibiotics. The DON stated, Resident #1 admitted to the facility with an indwelling urinary catheter, but because the resident had a history of pulling on the urine tube and had at times dislodged it, the indwelling urinary catheter was discontinued, and the supra pubic catheter was inserted on 1/7/26 related to trauma. The DON stated, Resident #1 also had a feeding tube and would often pull on the feeding tube as well. The DON stated that when the supra pubic catheter was inserted for Resident #1 on 1/7/26, the resident was discharged from the hospital with a discharge order to follow up with the urologist. The DON stated that when LVN A tried to schedule a follow up appointment with the urologist, the urologist office declined to see Resident #1 because of payor source. The DON stated since then, the nurses had been monitoring the supra pubic site for signs of infection but did not know when the (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	change out the supra pubic catheter there could be adverse effects. The MDS nurse stated, I was not aware the resident (Resident #1) never made it to the urologist for a follow-up. An attempt at a telephone interview on 6/27/26 at 1:41 p.m. was made with the BOM. A voicemail message was left requesting call-back. During an interview on 6/27/26 at 2:03 p.m., RN B stated she was aware Resident #1 had chronic issues with urinary tract infections and the resident pulled on the catheter tubing causing trauma. RN B stated she was not aware there were orders for Resident #1 to follow-up with the urologist and the floor nurses who admitted the resident to the facility post hospitalization were responsible for obtaining the orders. RN B stated, catheter care included monitoring for infection, emptying the catheter urine bag, and instruction on when to change out the catheter, and assumed that was just standard procedure for infection control. An attempt at a telephone interview with the Urologist on 6/27/26 at 4:32 p.m. was unsuccessful. A voicemail message was left requesting call-back. During a follow-up interview on 6/27/26 at 4:36 p.m., the DON stated the floor nurses could change out a supra pubic catheter in the facility. The DON stated the MD had seen Resident #1 since he had the supra pubic catheter had been inserted but the MD never gave orders to change it out. The DON stated, urinary catheters, including supra pubic catheters, were changed out if there was blockage or leakage per facility policy. The DON stated, not to say the MD would never write that order, it's just that during this time it was not indicated to change it (the supra pubic catheter) out. That is what I assume. During an interview on 6/27/26 at 4:51 p.m. LVN C stated there were residents in the facility who had indwelling urinary catheters and one resident who had a supra pubic catheter. LVN C stated that the nursing staff in the facility could change out supra pubic catheters. LVN C stated she was aware from Resident #1's discharge hospital orders that the resident was supposed to go back to the urologist for a follow-up appointment but was not sure if the appointment was made. LVN C stated to change out a supra pubic catheter there had to be a physician's orders in place. LVN C stated, if there was no physician's order to change out the supra pubic catheter, then we would have called the doctor to get an order. During an interview on 6/28/26 at 10:25 a.m., RN D stated, for residents with indwelling urinary catheters, including supra pubic catheters, care included an order that indicated the size of the catheter, monitoring for infection and patency, and orders to have the catheter changed out in case of dislodgement or as needed. RN D stated there were residents in the facility with catheters and had orders to change them out monthly, every two months, or as needed, it just depends on the individual resident. During an interview on 6/28/26 at 10:41 a.m., LVN E, who was also the Treatment Nurse stated, for urinary catheters, including supra pubic catheters care, you do what the doctor's orders say. LVN E stated the nurse should be contacting the doctor to obtain orders for changing out the catheter and notification should be made to the doctor when the catheter had sediment, there was poor urine output, the urine looked cloudy, or the catheter was clogged. LVN E stated, if the urologist refused to see the resident because of payor source, the appointment should have been paid for by the facility because the follow up to the urologist was a doctor's order, and that is following doctor's orders. During an interview on 6/28/26 at 11:03 a.m., the Administrator stated he was aware Resident #1 was not seen for a follow-up appointment by the urologist due to payment issues and, we realize that was an issue now. The Administrator stated medical payment to the specialist was the responsibility of the facility and the appointment should have been expedited regardless. The Administrator stated the facility priority should have been to notify the doctor when Resident #1 did not get the appointment to the urologist because say he has an infection; it could get worse and you want to address it immediately. During a telephone interview on 6/28/26 at 3:27 p.m., the BOM stated she was not directly involved in scheduling appointments and could not recall the exact specifics with the urology follow-up appointment for Resident #1. The BOM stated she worked on securing benefits for Resident #1 but, the Administrator should have stepped in and arranged for payment (to the urologist). He (Resident #1) is a resident of the facility, and we are responsible for him. Record review of the facility document titled, Catheter Care, undated reflected in part, .Review the resident's plan of care daily for (continued on next page)

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