

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/30/2024
NAME OF PROVIDER OR SUPPLIER  Kenedy Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7882 S Hwy 181 (No Mail Service) Kenedy, TX 78119	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy; personal privacy includes accommodations, medical treatment, written and telephone communications, and personal care, for 1 of 4 residents (Resident #40) reviewed for privacy, in that:</p> <p>CNAs A and B did not completely close Resident #40's privacy curtain while providing catheter/incontinent care.</p> <p>This deficient practice could place residents at-risk of loss of dignity due to lack of privacy.</p> <p>The findings include:</p> <p>Record review of Resident #40's face sheet, dated 08/30/2024, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Dementia (decline in cognitive abilities), Type 2 diabetes mellitus (high level of sugar in the blood), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Hypertension (high blood pressure) and, Peripheral vascular disease (abnormal narrowing of arteries reducing blood flow to the arms or legs).</p> <p>Record review of Resident #40's Quarterly MDS assessment, dated 08/20/2024, revealed the resident had a BIMS score of 15, indicating he had no cognitive impairment. Resident #40 was always incontinent of bowel and had a urinary catheter and, required extensive assistance with most of his ADLs.</p> <p>Record review of Resident #40's care plan, dated 11/02/2022, revealed a problem of ADLS: The resident has an ADL Self Care Performance Deficit Limited Mobility -Bilateral Below the Knee Amputation, with an intervention of TOILET USE: the resident is totally dependent on staff for toilet use. Incontinent of bowel - checked every 2 hours and as needed and incontinent/ perineal care rendered per nursing staff as needed</p> <p>Observation on 08/30/24 at 09:23 a.m. revealed CNA A and CNA B did not completely close the privacy curtains while they provided catheter/incontinent care for Resident #40, exposing the resident who could be seen from the room's door. Further observation revealed Resident #40's roommate was sitting on his bed and was ambulatory as indicated by the walker next to him. After finishing cleaning Resident #40, CNA B collected the soiled supply and opened the door to put it in the barrel outside the room while Resident #40 was still fully exposed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA A and CNA B on 08/30/2024 at 9:30 a.m., CNA A and CNA B stated the privacy curtain was not completely closed while they provided care for Resident #40 but it should have been. CNAs A and B stated Resident #40's roommate was ambulatory and could have stood up and seen Resident #40 exposed during care. CNA B stated opening the room's door while the resident was still exposed. CNAs A and B stated they had received resident rights training within the year.</p> <p>During an interview with the DON on 08/30/2024 at 9:39 a.m., the DON stated privacy must be provided during nursing care and Resident #40's privacy curtains should have been closed completely. The DON confirmed the staff had received training on resident rights within the year and the training was provided by herself, and they also checked the staff skills annually and as needed. The DON further stated that she, ADON, and the weekend RN supervisor did skills spot checks as well.</p> <p>Review of the facility's policy titled Perineal care, dated 5/11/2022, revealed, Procedure content [ .[ 7/ Provide privacy and modesty by closing the door and/or curtain.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents have a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely, for 1 of 2 shower rooms (Shower room [ROOM NUMBER]) and 2 of 26 resident rooms (Rooms #17 and #24) reviewed for safe, clean, and comfortable environment.</p> <p>The facility failed to repair missing and detached floor molding in a resident's room, replace a broken overhead light in a resident's shower room, and repair a scratched standing clothes closet in a resident's room.</p> <p>This deficient practice could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.</p> <p>The findings included:</p> <p>During an observation on 08/29/24 from 1:40 p.m. to 1:50 p.m. with the Maintenance Director. revealed the following:</p> <p>a. Resident room [ROOM NUMBER] had a 3.5 ft x 4 inch section of missing floor molding along the bottom surface of the wall adjoining to the floor surface. There was also a 4 x 4 inch section of floor molding in the bedroom proper that was detached from the wall.</p> <p>b. Resident Shower room [ROOM NUMBER] had 1 of 2 overhead lights which measured approximately 3 ft in length that was not working.</p> <p>c. Resident room [ROOM NUMBER] had a standing clothes closet that had an approximate 2 x 2 ft surface area on the front and side that contained multiple scratch marks that were ingrained into the wood surface.</p> <p>During an interview with the Maintenance Director on 08/29/24 at 1:55 p.m., the Maintenance Director stated that he had not been made aware by staff of the noted areas needing to be repaired. The Maintenance Director stated that fixing the noted repairs would promote a more positive home environment for the residents.</p> <p>During an interview with the Administrator on 6/5/24 at 2:00 p.m., the Administrator stated that fixing the floor molding in room [ROOM NUMBER], replacing the broken light in Shower room [ROOM NUMBER], and repairing the scratched clothes closet in room [ROOM NUMBER] would promote a more positive home environment for the residents.</p> <p>Record review of the facility's policy on Preventative Maintenance/Work-Order Request Section AD 03-12.0 dated 2003 stated The facility will repair or replace damaged/broken equipment or building amenities as needed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 2 shower rooms (Shower room [ROOM NUMBER]) reviewed for accidents and hazards, in that</p> <p>The facility failed to keep hazardous items out of reach of residents in a shower room.</p> <p>This deficient practice could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.</p> <p>The findings included:</p> <p>Observation on 08/27/24 at 11:30 a.m., revealed the door of Shower room was left open. Inside the room was a wall cabinet also left unlocked. Inside the cabinet were a razor, 3 bottle of shaving cream and a bottle of Micro kill one wipes.</p> <p>Review of the safety data sheet for micro kill one wipe revealed ACUTE TOXICITY - INHALATION - Category 4 FLAMMABLE LIQUIDS - Category 2 SERIOUS EYE DAMAGE /EYE IRRITATION - Category 2A SPECIFIC TARGET ORGAN TOXICITY (Single Exposure) - Category</p> <p>During an Interview with CNA A on 08/27/24 at 11:40 a.m., CNA A confirmed the door of the shower room and the wall cabinet were kept unlocked. CNA A confirmed the wipes, razor and shaving cream were in the cabinet. CNA A confirmed the cabinet should have been locked to prevent resident to get in contact with hazardous materials.</p> <p>During an interview with the DON on 08/27/24 at 12:05 p.m., the DON confirmed either the door of the shower room or the doors of the wall cabinet should remain locked. The DON confirmed the wipes, razor and shaving cream could be a hazard. The DON confirmed having several residents in the facility who are ambulatory but have mental illness diagnostics and/or dementia who could misuse the hazardous products and hurt themselves or others.</p> <p>Review of the facility policy, titled Hazardous communication program, dated 2003, revealed [.] The facility will provide adequate and appropriate space and equipment for safe handling and storage of hazardous materials and waste. The storage areas will have the capacity to be secured and meet the provision of the Life Safety Code.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34788</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #41) reviewed for incontinent care, in that:</p> <p>The facility failed to ensure CNA C thoroughly cleaned Resident #41 while providing incontinent care.</p> <p>This deficient practice could place residents at-risk for infection and skin break down due to improper care practices.</p> <p>The findings were:</p> <p>Record review of Resident #41's face sheet, dated 08/29/2024, revealed an admitted [DATE], with diagnoses which included: Hypothyroidism (under active thyroid), Anxiety disorder (A group of mental illnesses that cause constant fear and worry), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Dementia (decline in cognitive abilities), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Major depressive disorder(mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure) and, Hypertension (High blood pressure).</p> <p>Record review of Resident #41's Significant change MDS assessment, dated 05/28/2024, revealed Resident #41 has a BIMS score of 12, which indicated mild to moderate cognitive impairment. Further review revealed Resident #41 required limited to extensive assistance with ADLs and was indicated to occasionally be incontinent of bladder and frequently incontinent of bowel.</p> <p>Record review of Resident #41's care plan, dated 05/06/2024, revealed a problem of The resident has Urinary Tract Infection, with an intervention of Provide incontinence care as needed.</p> <p>Observation on 08/29/24 at 9:17 a.m. revealed, while providing incontinent care for Resident #41, CNA C did not clean between the buttocks' cheeks or the rectal area of the resident.</p> <p>During an interview on 08/29/2024 at 9:30 a.m. CNA C stated she did not clean between the resident's buttocks' cheeks area. CNA C stated she should have cleaned the rectal area. CNA C stated she had received training for infection control and incontinent care within the last year.</p> <p>During an interview with the DON on 08/29/2024 at 3:15 p.m., the DON stated the buttocks and rectal area had to be cleaned. The DON stated she was the one training the staff for infection control and incontinent care and that the ADON, weekend RN supervisor and herself would check the staff skills annually and as needed if a problem was noted.</p> <p>Record review of facility policy, titled Perineal care, dated 95/11/2022, revealed [ .] Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 3 residents (Resident #8) reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #8's oxygen concentrator was not dirty.</p> <p>That failure could place residents who required respiratory treatments at risk of receiving inadequate respiratory treatments and could result in a decline in health.</p> <p>The findings were:</p> <p>Record review of Resident #8's face sheet, dated 08/27/24, revealed Resident #8 was admitted to the facility on [DATE] and, readmitted on [DATE], with diagnoses that included: Dementia (decline in cognitive abilities), Aphasia (unable to comprehend or formulate language), Hypoxia (the body is deprived of adequate oxygen supply), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood)and, Hypothyroidism (under active thyroid).</p> <p>Record review of Resident #8's quarterly MDS dated [DATE] revealed a BIMS of 6, indicating the resident was severely cognitively impaired. Further review of this MDS revealed in Section O, Special Treatments and Programs, that the resident received oxygen therapy.</p> <p>Record review of Resident #8's physician orders for August 2024 revealed the following order: Continuous Oxygen via nasal cannula at 4 Liter Per Minute due to low O 2 saturation every day and night shift for Shortness of Breath related to RESPIRATORY FAILURE, UNSPECIFIED WITH HYPOXIA to begin on 4/19/2023.</p> <p>Observation on 08/27/2024 at 11:20 a.m. revealed Resident #8's oxygen concentrator's intake air grill was partially covered with gray dust and a sticky substance.</p> <p>During an interview on 08/27/2024 at 12:05 p.m., the DON revealed the concentrator did not require a outside filter since it had a filter inside that was changed every two years when the manufacturer does the maintenance. Th eDON the staff should have cleaned the concentrator outside.</p> <p>Record review of facility undated policy, Oxygen Administration,, dated 03/21/23 revealed: oxygen concentrator should be cleaned according to manufacturer recommendations.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34788</p> <p>Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 18 residents (Resident #8) observed for accuracy of medical records in that:</p> <p>The facility failed to have an appropriate order regarding the maintenance of Resident #8's oxygen concentrator.</p> <p>This deficient practice could place residents at risk for errors in care and treatment.</p> <p>The findings were:</p> <p>Record review of Resident #8's face sheet, dated 08/27/24, revealed Resident #8 was admitted to the facility on [DATE] and, readmitted on [DATE], with diagnoses that included: Dementia (decline in cognitive abilities), Aphasia (unable to comprehend or formulate language), Hypoxia (the body is deprived of adequate oxygen supply), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood)and, Hypothyroidism (under active thyroid).</p> <p>Record review of Resident #8's quarterly MDS dated [DATE] revealed a BIMS of 6, indicating the resident was severely cognitively impaired. Further review of this MDS revealed in Section O, Special Treatments and Programs, that the resident received oxygen therapy.</p> <p>Review of Resident #8's physician orders for August 2024 revealed the following order: Change or clean the filter of the O2 concentrator every night shift every Sunday started on 4/23/23.</p> <p>Review of Resident #8's Medication and Treatment administration record for August 2024, revealed the staff had signed on Sundays for changing or cleaning the filter as done.</p> <p>Observation of Resident #8's bedroom on 08/27/2024 at 11:20 a.m. revealed no apparent filter on the back air intake grill at the back of the oxygen concentrator.</p> <p>During an interview with the DON on 8/27/2024 at 12:05 p.m., the DON revealed the concentrator did not require a outside filter since it has a filter inside that is change every two years when the manufacturer does the maintenance. The order to change or clean the filter was incorrect. The staff should not have signed the filter [NAME] as done.</p> <p>Record review of facility's policy, titled purpose and requirements medical records, dated 2015, revealed The medical record is a legal document that serves the purpose of: 1. providing an accurate assessment of each resident's condition.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 4 residents (Resident #41) reviewed for infection control, in that:</p> <p>CNA C did not change her gloves or wash her hands after providing incontinent care for Resident #41.</p> <p>These deficient practices could place residents at-risk for infection due to improper care practices.</p> <p>The findings included:</p> <p>Record review of Resident #41's face sheet, dated 08/29/2024, revealed an admitted [DATE], with diagnoses which included: Hypothyroidism (under active thyroid), Anxiety disorder (A group of mental illnesses that cause constant fear and worry), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Dementia (decline in cognitive abilities), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Major depressive disorder(mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure) and, Hypertension (High blood pressure).</p> <p>Record review of Resident #41's Significant change MDS assessment, dated 05/28/2024, revealed Resident #40 has a BIMS score of 12, which indicated mild to moderate cognitive impairment. Resident #40 required limited to extensive assistance with hid ADLs and was indicated to occasionally be incontinent of bladder and frequently incontinent of bowel.</p> <p>Review of Resident #41's care plan, dated 05/06/2024, revealed a problem of The resident has Urinary Tract Infection, with an intervention of Provide incontinence care as needed.</p> <p>Observation on 08/29/24 at 09:17 a.m., revealed, while providing incontinent care for Resident #41, CNA C did not change her gloves or wash her hands after providing incontinent care for Resident #41 and before touching and fastening the clean brief to Resident #41.</p> <p>During an interview on 08/29/2024 at 09:27 a.m. CNA C confirmed she did not change her gloves or wash her hands prior to touch the clean brief. She confirmed she received infection control training with the year.</p> <p>During an interview with the DON on 08/29/2024 at 3:15 p.m., the DON confirmed gloves must be changed after cleaning and before touching clean brief to prevent cross contamination. The DON revealed she was the one training the staff for infection control and that the ADON, weekend RN supervisor and herself would check the staff skills annually and as needed if a problem was noted.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy, titled Fundamental of infection control precautions, dated 2019, revealed [ . ] the following is a list of some situations that require hand hygiene: [ . ] Before and after direct resident contacts (for which hand hygiene is indicated by acceptable professional practice) [ . ] after contact with a resident's mucous membranes and body fluids or excretions.</p>		