

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/05/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure a bag of biscuits was properly sealed in the reach in freezer. This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 12/02/2025 at 11:35 AM in the reach-in freezer in the kitchen revealed a clear plastic bag of frozen biscuits. The bag was closed at the top with two knots and there was an opening between the knots, exposing the contents of the bag to the ambient air in the freezer and potential contamination by pathogens and bacteria and a deterioration in food quality. During an interview on 12/02/2025 at 11:36 AM, the DFN stated the bag of biscuits was not sealed properly and should have been. Staff was trained on how to properly store food in the freezer and she would conduct additional training. The DFN stated food stored in the freezer should be completely sealed to ensure it did not deteriorate. Record review of the facility's policy IC 00-5.0 Food Safety, Dietary Policy & Procedures Manual 2012, revealed, 2. Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated and stored properly. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-302 Preventing food and ingredient contamination. 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) Food shall be protected from cross contamination by: (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings. (6) Protecting food containers that are received packaged together in a case or overwrap from cuts when the case or overwrap is opened. 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676173
		If continuation sheet Page 1 of 8

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review for one of one PASRR positive resident (Resident #47) who had a significant change in mental or physical condition. The facility failed to notify the LMHA of Resident #47's significant change in mental and physical status after submitting a significant change MDS on 10/22/2025. This failure could potentially result in PASRR positive residents receiving services of not having their needs evaluated to determine if additional services were required. The findings included: Record review of Resident #47's electronic face sheet dated 12/04/2025 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a chronic mental health condition characterized by symptoms of both schizophrenia and mood disorders, affecting how individuals think, feel, and behave), psychotic disorder with delusions (a severe mental health condition characterized by a loss of touch with reality, often manifesting as delusions) and mild intellectual disabilities. Record review of Resident #47's significant change MDS dated [DATE] revealed a BIMS score of 07/15, indicating severe cognitive impairment. Section GG - Functional Abilities, revealed a decline in the resident's eating, toileting, and walking abilities from his quarterly MDS dated [DATE]. The resident also changed from always continent of bladder and bowel to frequently incontinent of both. Record review of Resident #47's comprehensive care plan revealed the resident was identified as PASRR positive for mental illness and intellectual disability. Record review of Resident #47's EHR revealed the resident was assessed by the Local Mental Health Authority for both MI and IDD on 01/10/2023. During an interview on 12/04/2025 at 1:45 PM, the MDS LVN C stated she did not notify the state mental health authority or state intellectual disability authority promptly after a significant change in Resident #47's physical condition for a review. MDS LVN C stated the lack of contact was an oversight, and it was important the LMHA was notified of the significant change so they could evaluate the resident to see if he required additional services. During an interview on 12/04/2025 at 1:50 PM, the MDS LVN Regional Director stated the LMHA authority was not notified of Resident #47's significant change in condition, and should have been notified so they could assess the resident to determine if additional services were necessary. During an interview on 12/05/2025 at 11:15 AM, the DON stated she was unaware of the requirement to notify the local state mental health or intellectual disability authority when a resident who was PASRR positive had a significant change and a significant change MDS was submitted. The DON stated she contacted the LMHA and was told she just needed to inform them of the resident's election for hospice, discharge to the hospital for over 30 days, or death. Record review of the facility's policy, PASRR Level 1 Screen Policy and Procedure revised 03/06/2013, stated only, Submission by the NF of the MDS SCSA (Significant Change in Status Assessment) Long Term Care Medicaid Information (LTCMI) on the LTC Online Portal will notify the LIDDA that the designated resident has elected hospice care and that a resident review is required and did not address notification of a significant change in mental or physical status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's mental, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment, for 1 of 18 residents (Residents #5) reviewed for comprehensive care plans. The facility failed to develop a comprehensive care plan that addressed Resident #5's self-care of his indwelling catheter. This failure could place residents at risk of infections from inadequate care and lack of staff supervision. The findings included: Record review of Resident #5's face sheet dated 12/03/2025 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Chronic respiratory failure with hypercapnia (a condition where patients experience prolonged respiratory issues that lead to an accumulation of carbon dioxide in the blood), retention of urine, and obstructive and reflux uropathy (conditions that impede normal urine flow and can lead to kidney damage, often requiring medical intervention). Record review of Resident #5's admission MDS assessment dated [DATE] revealed in Section C - Cognitive Patterns, a BIMS score of 15/15, indicating the resident was cognitively intact. Section H, Bowel and Bowl, H0100. Appliances, A. Indwelling catheter was checked, indicating Resident #5 had this type of catheter. Record review of Resident #5's comprehensive care plan, updated 12/02/2025, had a focus area indicating, The resident has Indwelling Catheter. Date initiated: 11/04/2025, Revision on: 11/05/2025. The goal was for the resident to remain free from catheter-related trauma through the review date. Target date: 02/22/2026. Interventions included the size of the catheter bag and tubing and bag placement, changing the catheter as ordered by physician, checking tubing for kinks and maintaining drainage bag off the floor, ensuring tubing was anchored to the resident's leg or linens so it was not pulling on the urethra, monitoring/documenting intake and output per facility policy, monitoring/documenting pain or discomfort, and monitoring/recording/reporting to the physician signs and symptoms of UTI. There was no mention in this focus area of the resident's self-maintenance of his catheter and emptying of his drainage bag. During an interview on 12/02/2025 at 2:30 PM, Resident #5 stated he performed 100% of his catheter care himself and had been doing so since his admission. He was happy he was able to ambulate from his bed to the bathroom to empty the drainage bag and has had no issues with his catheter since admission. During an interview on 12/04/2025 at 8:50 AM, the DON stated Resident #5 performed his own catheter care, his comprehensive care plan did not indicate the resident did his own catheter care and should have this information. The DON stated Resident #5 was a private individual who was capable of performing this care, but his ability should have been properly assessed and noted in his care plan. During an interview on 02/04/2025 at 10:22 AM, MDS LVN C stated she should have noted Resident #5's performed his own catheter care in his comprehensive care plan. It was an oversight on her part that it was omitted. MDS LVN C stated it was important this information was included in the care plan for staff awareness. Record review of the facility's policy GP MC 03-18.0 Comprehensive Care Planning, undated, revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. Care plans will be person-centered and reflect the resident's goals for admission and desired (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outcomes. Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 18 residents (Residents #7) reviewed for care plans, in that: The facility failed to revise Resident #7's comprehensive care plan to reflect the resident's change in hearing status. This deficient practice could place residents with a decline at risk of receiving proper care. The findings included: Record review of Resident #7's electronic face sheet dated 12/05/2025 revealed the resident was an [AGE] year-old male with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), chronic obstructive pulmonary disease (a progressive lung disease that blocks airflow, causing breathing difficulties, persistent cough (often with mucus), wheezing, and chest tightness) and chronic atrial fibrillation (a fast, irregular heartbeat that's long-lasting or constant, causing symptoms like palpitations, fatigue, shortness of breath, dizziness, and weakness, significantly raising stroke risk). Record review of Resident #7's Significant Change MDS dated [DATE] revealed a BIMS score of 07/15, indicating severe cognitive impairment. Section B - Hearing, Speech, and Vision revealed the code 1 was checked, indicating the resident had minimal difficulty with his ability to hear (difficulty in some environments, such as when a person speaks softly or the setting is noisy). Record review of Resident #7's comprehensive care plan, updated 10/24/2025, revealed there was no focus area addressing communication or the resident's hearing deficiency. During an interview on 12/05/2025 at 1:30 PM, MDS LVN C stated Resident #7's comprehensive care plan should have addressed his hearing difficulty, and it was omitted in error. MDS LVN C stated it was important to include this information in the comprehensive care plan so staff would know how to adjust their methods when communicating with the resident. During an interview on 12/05/2025 at 1:35 PM, the DON stated the Resident #7's hearing difficulty was not noted in his comprehensive care plan and should have been so that appropriate accommodations could be made for this deficiency. Record review of the facility's policy GP MC 03-18.0, undated, revealed, The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions. Review of the CMS RAI Version 3.0 Manual dated October 2019 revealed .to evaluate the information gained through both the comprehensive assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems .the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths and problems.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's environment was free from accident hazards over which the facility had control and provided supervision and assistive devices to each resident to prevent avoidable accidents for 1 of 6 residents (Resident #3) whose care was reviewed for accidents and hazards, in that: The facility failed to complete quarterly smoking risk assessments for Resident #3. This deficient practice could affect residents who used tobacco and could result in avoidable accidents from improper supervision during tobacco use. The findings included: Record review of Resident #3's face sheet, dated 12/05/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia with agitation (a common behavioral symptom, appearing as increased restlessness, irritability, yelling, or physical aggression, often stemming from unmet needs, confusion, or environmental triggers), chronic obstructive pulmonary disease (a progressive lung disease that blocks airflow, causing breathing difficulties, persistent cough, wheezing, and chest tightness), and Parkinson's disease (a progressive brain disorder causing dopamine-producing cells to die, leading to movement issues like tremor, stiffness, slow movement, balance problems, and speech changes). Record review of Resident #3's annual MDS dated [DATE] revealed a BIMS score of 5, indicating severe cognitive impairment. Section J1300. Current Tobacco Use revealed the code 1 for Yes was marked. Record review of Resident #3's comprehensive care plan, updated 09/16/2025, revealed a focus area noting Resident #3 is a smoker and the resident also vapes with supervision, dated 07/04/2025. The goal was the resident will smoke or vape in designated areas without occurrence over the next 90 days. The first intervention was, Perform smoking assessment according to facility policy. Record review of Resident #3's electronic health record revealed his last safe smoking assessment was completed on 04/30/2024. The assessment noted the resident had a history of dropping cigarettes and burning his clothes. He was assessed as requiring direct supervision while smoking and requiring a fire-resistant smoking apron while smoking. During an interview on 12/05/2025 at 2:15 PM the DON stated all residents used vapes instead of smoking at present time. Resident #3 was supervised by the AD when he used his vape, and it was the AD's responsibility to do a smoking assessment on all residents who smoked or used a vape every quarter. During an interview on 12/05/2025 at 2:20 PM, the AD stated she supervised the residents who smoked and used a vape, and Resident #3 used a vape. The AD stated she was responsible for completing a safe smoking assessment on all residents who used tobacco in any form and must have missed completing assessments on this resident. The AD did not provide a reason the assessment was missed. Record review of the facility's policy, Smoking Policy revised 11/01/2017 revealed, 2. A safe smoking assessment will be done regularly for each resident who smokes. Smoking by residents is classified as unsafe and will be prohibited except when the resident will be directly supervised by facility personnel or visitors who are aware of the resident's limitations with smoking. The resident must be within direct view of the smoking supervisor, in reasonably close proximity of the supervisor, and the supervisor must be able to respond quickly in the event of an emergency. 5. Smoking or using an e-cigarette/vape is prohibited in any area flammable liquids, combustible gas, or oxygen are used or stored and in any other hazardous locations.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and service to prevent urinary tract infections and to restore continence to the extent possible for 1 of 5 (Resident #53) residents reviewed for incontinent care. The facility failed to ensure CNA A thoroughly cleaned Resident #53's buttocks and anal area during incontinent care. This deficient practice could place residents at-risk for infection and/or skin breakdown. The findings were: Record review of Resident #53's face sheet, dated 12/04/2025, revealed an admission date of 11/29/2024. Resident #53 had diagnoses which included: Cerebral infarction (Cerebral infarction is a type of stroke that results from the obstruction of blood flow to the brain), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Depression (mood disorder that causes a persistent feeling of sadness and loss of interest), Hypertension (High blood pressure), Irritant contact dermatitis due to incontinence (Irritant contact dermatitis is a form of skin inflammation caused by contact with substances and/or environmental factors that injure the skin, damaging the skin barrier). Record review of Resident #53's Skilled nurse note, dated 12/03/2025, revealed Resident #53 required reminders, cues, and supervision in planning, organizing, and correcting daily routines and had memory problems. Resident #53 was rarely understood. Record review of Resident #53's Skilled Section GG, dated 11/30/2025, revealed the resident required total care. Record review of Resident #53's care plan, dated 11/30/2025, revealed a problem of the resident has bowel incontinence and an intervention of Provide peri care after each incontinent episode. Observation on 12/04/2025 at 12:47 a.m. revealed while providing incontinent care for Resident #53, CNA A did not clean between the resident's buttock's and did not clean the anal area. During an interview on 12/04/2025 at 11:00 a.m., CNA A stated she did not fully separate Resident #53's buttocks to clean the anal area. She thought she had cleaned the buttock enough and did not need to go deeper. She stated she received incontinent care training from the DON. During an interview with the DON on 12/04/2025 at 11:45 a.m., she stated that the staff must clean the anal area and in the case of a male resident the underside of the perineal area to prevent skin irritation and prevent infection. She stated she provided incontinent care training to the staff within the year as well as checked their skills. Review of CNA proficiency audit for CNA A revealed she had passed proficiency for incontinent care and infection control on 05/04/2025. Record review of the facility's policy titled Perineal care, dated 05/11/2022, revealed, gently perform care to the buttocks and anal area.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to establish and 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 5 resident (Resident #53) reviewed for infection control, in that: 1.The facility failed to ensure CNA A washed her hands before starting to provide incontinent care for Resident #53. 2. The facility failed to ensure CNA A sanitized between her fingers while she provided incontinent care for Resident #53. These deficient practices could place residents at-risk for infection due to improper care practices.Record review of Resident #53's face sheet, dated 12/04/2025, revealed an admission date of 11/29/2024. Resident #53 had diagnoses which included: Cerebral infarction (Cerebral infarction is a type of stroke that results from the obstruction of blood flow to the brain), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Depression (mood disorder that causes a persistent feeling of sadness and loss of interest), Hypertension (High blood pressure), Irritant contact dermatitis due to incontinence (Irritant contact dermatitis is a form of skin inflammation caused by contact with substances and/or environmental factors that injure the skin, damaging the skin barrier). Record review of Resident #53's Skilled nurse note, dated 12/03/2025, revealed Resident #53 required reminders, cues, and supervision in planning, organizing, and correcting daily routines and had memory problems. Resident #53 was rarely understood. Record review of Resident #53's Skilled Section GG, dated 11/30/2025, revealed the resident required total care. Record review of Resident #53's care plan, dated 11/30/2025, revealed a problem of the resident has bowel incontinence and an intervention of Provide peri care after each incontinent episode. Observation on 12/04/2025 at 10:47 a.m. revealed CNA A did not change her gloves or sanitize hands after touching Resident #53's bed remote and before providing incontinent care for Resident #53. CNA A did not sanitize between the fingers of her hands between change of gloves. During an interview with CNA A, on 12/05/2025 at 11:00 a.m., she stated she had not sanitized her hands and change gloves before starting the care. CNA A stated she did not know the bed remote was considered dirty and that she had contaminated her gloves. CNA A stated she forgot to sanitize between her fingers while sanitizing her hands but knew how to practice hand hygiene and that it was important to prevent infection for the residents. She stated she received infection control training at least once a year. During an interview with the DON on 12/04/2025 at 11:45 a.m., she stated staff had to wash their hands before starting to provide care for a resident and had to use sanitizer or wash their hands between change of gloves and sanitize between their fingers to prevent the spread of infection. She stated she provided infection control training at least annually and the staff skills were checked annually and as needed. Review of CNA proficiency audit for CNA A revealed she had passed proficiency for incontinent care and infection control on 05/04/2025. Record review of the facility's policy, titled Fundamentals of Infection Control Precautions, dated 03/2024, revealed The following is a list of some situations that require hand hygiene: [.] after handling soiled equipment or utensils. [.] Include applying product to the palm of one hand and rubbing hands together, covering all surfaces of hand and fingers, until the hands are dry.		