

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675867	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Kerens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 NE 4th St Kerens, TX 75144	
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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on interview, and record review the facility failed to implement a policy that is in accordance with the State Medicaid Plan to allow a resident to return to his previous room upon discharge from the hospital for 1 of 1 resident reviewed for discharges. The facility failed to ensure Resident #1 received the services required when they failed to allow Resident #1 to return to the facility after his hospitalization and they failed to appropriately notify the resident, his representative, and the LTC Ombudsman of the discharge. This failure placed residents at risk of an extended, unnecessary hospitalization and a traumatic psychosocial adjustment to a new facility. Findings include: Record review of Resident #1's undated face sheet, reflected he was an [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of Alzheimer's, Urinary Tract Infection, Muscle Weakness, Bipolar (mental illness), and Restlessness and Agitation. He was discharged to the hospital on 6/23/24 to be evaluated for urinary tract infection and behavior. Record review of Resident #1's Quarterly MDS reflected a BIMS score of 4, which indicated the resident's cognition was severely impaired. Record review of Resident #1's Care Plan, reflected a Focus area was initiated for potential for delirium or an acute confusion episode on 12/18/23. In an interview on 7/29/24 at 11:05 a.m., the ADM stated, Resident #1 was not at the facility because he went to the hospital. The ADM stated that she discussed with his family member that it would be best if he did not come back to the facility because she did not want a pattern of abuse from resident to resident. The resident had been aggressive twice with other residents. The ADM stated, the facility would have taken him back; however, his family member understood and found another place. In a telephone interview on 7/29/24 at 3:54 p.m. Resident #1's family member stated, she was told by the ADM that Resident #1 could not return to the facility from the hospital, due to his aggressiveness. She also stated the discharge planner at the local hospital was also told that the facility would not allow the resident to return. (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

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 7/29/24 at 4:03 p.m. with the local hospital discharge planner stated there were multiple notes documented at the hospital stating that the emergency room , the family member and the case managers were told that the resident could not return to the nursing facility. She agreed to provide the notes to the state. In an interview on 7/30/24 at 12:01 pm DON stated, 'We told the daughter we would lie to place the resident elsewhere, but we would take him back. There is no paperwork (discharge or bed release) because daughter agreed to find him another place. In an interview with OM the business office manager on 7/30/24 at 1:00 pm, she stated there is no discharge paperwork for Resident #1. A record review of the hospital documentation on Resident #1, reflected that the facility refused to allow Resident 1 to return to the facility from the hospital: Note on 6/24/24 9:11 a.m. emergency room nurse reflected, Called the nursing home to update on plan of care - talked to Assistant Director of Nurses, Director of Nurses, and Administrator (ADM) and explained situation, The ADM said the pt has had two offenses for aggression and cannot return to facility. Informed that we would have to explore placement at another NH. Note on 6/24/24 10:19 a.m. by resident's doctor reflected, Nursing home reported that they could not take care of him anymore and refused to take him back. Patient is intermittently confused. Patient aggressive with staff at nursing home and was refused back there. Left in our ER. Note on 6/24/24 1:50 p.m. Discharge Planner's notes reflected, Resident's family member is aware that the facility has stated Resident #1 cannot return the facility he came from. Note on 6/24/24 2:13 p.m. Case Manager's notes reflected, Received call from another local nursing home; they are able to accept patient and report he can come today Resident was discharge to an alternate facility on 6/25/24 (2-days hospitalization). A record review of the facility policy named, Nursing Facility Resident Rights dated November 2021 reflects on page 3 of 4, residents have the right to receive a 30-day written notice sent to them, their legally authorized representative or a family member for transfers or discharges.		

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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** 49065 Based on interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 1 resident (resident #2) reviewed for care plans. The facility failed to ensure Resident #2 had a care plan to reflect the accurate diet she was on. Resident #2 was care planned for pureed textured diet when she was receiving regular diet. This failure could place residents at risk of getting insufficient nutrition with the wrong diet order which could have diminished her physical and psychosocial well-being. Findings include: Review of Resident #2's undated face sheet reflected that she was a [AGE] year-old female admitted with diagnoses of Malnutrition, Encephalopathy, Chronic Ulcer of Right Calf, Chronic Kidney Disease, Dementia and Anemia. Review of 7/29/24 of Resident #2's Quarterly MDS reflected her BIMS score was 99, which indicates they could not fully evaluate her cognitive abilities. Review of resident #2's 7/5/24 Care Plan reflected she was on a pureed texture diet order with a goal to maintain weight and proper nutrition. The care plan also reflected in the Activities of Daily Living section that on 5/31/24 an intervention was initiated that she required one staff assisting her for eating. Review of Resident #2's orders reflected a diet order on 6/8/24 of a Regular Diet, Pureed Texture, Regular Consistency. The order was signed by PCP on 6/10/24. In an interview on 7/30/24 at 12:20 pm, the LVN stated that on 7/27/24 resident #2 ate whole pieces of shrimp that her family had brought to her. She stated that she thought the resident was on a regular soft diet and that she had never seen the resident eat a pureed diet. In an interview on 7/30/24 at 12:55 with the DS, she stated that resident #2 has received a Regular diet with regular texture (not pureed) for the whole time she has been at the facility. She further stated that she thinks the pureed diet order was an error and that the resident can also feed herself without assistance. In an interview on 7/30/24 at 1:15 pm with PCP regarding the Regular pureed diet order signed on 6/10/24 by PCP, he stated that he was not familiar with the patient as he has so many patients, he can't remember them all. He was not sure if he had seen the resident. He referred surveyor to speak to his Nurse Practitioner. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/30/24 at 1:48 pm the NP stated, the pureed diet was not a diet she would have ordered and that it must have come from when the resident was in the hospital. She further stated that she had seen the resident eating and the correct order for this resident would have been a regular diet with regular texture (not pureed). She also stated the resident was able to feed herself without assistance. In an interview on 7/30/24 at 2:12 pm with the CNA, she stated on 7/27/24 at 3:00 pm resident #2 was eating rice with bite size shrimp. She further stated that she had never seen the resident eat anything, but regular texture diet and she had no problem feeding herself. In an interview on 7/30/24 at 2:30 pm with the ADM she stated, the policy was to serve the diet as ordered by the physician. She also stated that now she was aware that Resident #2 had a Regular pureed diet ordered but was getting a Regular diet with regular texture instead. The ADM stated the negative outcome to an incorrect diet can be as severe as death. In an interview on 7/30/24 at 2:59 pm with the DON she stated, the policy was to serve the diet as ordered and to check the food against the diet order. She further stated that she knew Resident #2 had a pureed diet order but didn't know until now that she wasn't getting that diet. She stated the negative outcome to an incorrect diet can be choking and aspiration (food going into the lungs). In an interview on 7/30/24 at 3:10 pm with the ADON he stated, the policy on serving the diet was that the food should be checked and verified when passing the food to the residents. He stated that he knew resident #2 had a pureed diet ordered but he was not sure what was served to her. He stated the negative outcome to an incorrect diet can be aspiration (food going into the lungs). Record Review of the facility policy titled, Diet Orders/Diet Manual and dated 2012, reflect The Physician will prescribe diets in accordance with the approved Diet Manual and a written order must appear on the medical record before the resident can be served.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on interview, and record review the facility failed to ensure medical records were complete and accurate in accordance with accepted professional standards and practices when the facility to maintain a correct medical record for 1of 1 resident (resident #2) reviewed for diet orders. Evidence supports the resident medical record was not accurate. The facility failed to ensure Resident #2 had an accurate medical record when the physician signed an incorrect diet order for a pureed diet that the resident wasn't getting and did not need. This failure could place residents at risk of getting insufficient nutrition with the wrong diet order which could have diminished her physical and psychosocial well-being. Findings include: Review of Resident #2's undated face sheet reflected that she was a [AGE] year-old female admitted with diagnoses of Malnutrition, Encephalopathy, Chronic Ulcer of Right Calf, Chronic Kidney Disease, Dementia and Anemia. Review of 7/29/24 of Resident #2's Quarterly MDS reflected her BIMS score was 99, which indicates they could not fully evaluate her cognitive abilities. Review of resident #2's 7/5/24 Care Plan reflected she was on a pureed texture diet order with a goal to maintain weight and proper nutrition. The care plan also reflected in the Activities of Daily Living section that on 5/31/24 an intervention was initiated that she required one staff assisting her for eating. Review of Resident #2's orders reflected a diet order on 6/8/24 of a Regular Diet, Pureed Texture, Regular Consistency. The order was signed by PCP on 6/10/24. In an interview on 7/30/24 at 12:20 pm, the LVN stated that on 7/27/24 resident #2 ate whole pieces of shrimp that her family had brought to her. She stated that she thought the resident was on a regular soft diet and that she had never seen the resident eat a pureed diet. In an interview on 7/30/24 at 12:55 with the DS, she stated that resident #2 has received a Regular diet with regular texture (not pureed) for the whole time she has been at the facility. She further stated that she thinks the pureed diet order was an error and that the resident can also feed herself without assistance. In an interview on 7/30/24 at 1:15 pm with PCP regarding the Regular pureed diet order signed on 6/10/24 by PCP, he stated that he was not familiar with the patient as he has so many patients, he can't remember them all. He was not sure if he had seen the resident. He referred surveyor to speak to his Nurse Practitioner. (continued on next page)		

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