

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

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No. 0938-0391

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 02/26/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50042 Based on observations, interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 7 of 18 residents (Resident #5, #8, #9, #10, #11, #12, #14) reviewed for medications and pharmaceutical services, in that: The facility failed to ensure narcotic audits were properly conducted on or about [DATE], through [DATE], per the facility's policies and procedures, resulting in unaccounted for, misplaced, and/or misappropriated medications, including (2) tablets of Lorazepam 1mg, (1) tablet of Tylenol #3 (Codeine), (2) tablets of Lorazepam .5mg, (1) tablet of Phenobarbital 60mg, and (1) tablet of Amoxicillin 500mg. The facility failed to ensure medications, including controlled substances, were administered to Resident #5 and Resident #9 on [DATE], at 1800 (6:00 PM), as ordered or scheduled, resulting in the delayed administration of necessary medications. LVN A failed to follow the facility's Medication Administration Procedures policy on [DATE], in that LVN A withdrew and prepared scheduled medications, including narcotics, for Resident #8, #10, and #11, in anticipation of their future administration, but failed to administer the medications or properly dispose of these medications. LVN A also failed to sign residents' narcotic count sheets after removing the medications, thus creating discrepancies in the count for those medications. LVN A failed to completely and accurately document the administration of Resident #14's Fentanyl 12mcg Transdermal Patch in that LVN A signed the medication out on the resident's narcotic sheet prior to 10:55AM on [DATE] but post-dated the administration for [DATE] at 12:00 PM. LVN A did not withdraw the patch from the prescription box, administer or apply the medication, but documented a reduction in the count by 1 when 2 patches remained, causing a discrepancy in the count. These failures placed the residents at risk of not receiving the intended therapeutic benefits of their medications or care needed to maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675867	Facility ID: 675867 If continuation sheet Page 1 of 10

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's face sheet on [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses that include, but are not limited to Unspecified Dementia (dementia that is not specified by a doctor; a group of symptoms that affects memory, thinking, and interferes with daily life), Unspecified Glaucoma (an eye condition that damages the optic nerve), Schizoaffective Disorder, Bipolar Type (a form of mental illness that has the features of both schizophrenia and a mood disorder), Major Depressive Disorder (a mood disorder characterized by persistent feelings of sadness, loss of interest and changes in sleep and appetite), and anxiety disorder (a condition characterized by overwhelming worry or fear). Review of Resident #5's Quarterly MDS assessment dated [DATE], revealed a BIMS summary score of 12, indicating moderate cognitive impairment. Review of Resident #5's Physician's Orders dated February 26, 2025, reflected she was prescribed Lorazepam Tablet .5mg, Give 1 tablet by mouth at bedtime related to ANXIETY DISORDER, UNSPECIFIED. The start date on this medication was [DATE]. Review of Resident #8's face sheet on [DATE] reflected a [AGE] year-old male admitted to the facility originally on [DATE], with a most recent readmitted [DATE]. His diagnoses include, but are not limited to Atherosclerotic Heart Disease of Native Coronary Artery with Unspecified Angina Pectoris (a buildup of fats, cholesterol, and other substances in and on the artery walls), Infection and Inflammation Reaction Due to Other Cardiac and Vascular Devices, Implants and Grafts, Sequela (a complication or condition that follows a prior illness or disease), Methicillin Resistant Staphylococcus Aureus Infection (MRSA; a type of bacteria that is resistant to several antibiotics), Cellulitis of Left Upper Limb (a bacterial infection of the skin and the tissue beneath the skin), Bipolar Disorder (chronic mood disorder that causes extreme shifts in mood, energy levels and behavior), and Unspecified Psychosis (a mental health condition characterized by a disconnection from reality). Review of Resident #8's Quarterly MDS assessment dated [DATE], revealed a BIMS summary score of 7, indicating severe cognitive impairment. Review of Resident #8's Physician's Orders dated February 26, 2025, reflected he was prescribed Clindamycin HCl Capsule 300 MG, to be given as 1 capsule by mouth three times a day related to Cellulitis of the left upper limb. The start date of the medication was [DATE]. The end date of the medication was [DATE]. Review of Resident #9's face sheet on [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included, but are not limited to Eencephalopathy (any disease or disorder that affects the brain, leading to changes in thinking, behavior and overall brain function), Major Depressive Disorder (a mood disorder characterized by persistent feelings of sadness, loss of interest, and changes in sleep and appetite), and Anxiety Disorder (a condition characterized by overwhelming worry or fear). Review of Resident #9's Quarterly MDS assessment dated [DATE], revealed a BIMS summary score of 5, indicating severe cognitive impairment. Review of Resident #9's Physician's Orders dated 1/ ,d+[DATE], reflected he was prescribed Lorazepam .5 MG Tab, 1 tablet to be given by mouth every night at bedtime. The start date of this medication was [DATE]. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's face sheet on [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that include, but are not limited to Dementia (a group of symptoms affecting memory, thinking and social abilities), Poly osteoarthritis (osteoarthritis that affects five or more joints simultaneously), chronic pain, Psychotic Disorder with delusions (a mental health condition where a person has unshakable beliefs that are untrue), Anxiety Disorder ((a condition characterized by overwhelming worry or fear), and homicidal ideations (thoughts about homicide). Review of Resident #10's Quarterly MDS assessment dated [DATE], revealed a BIMS summary score of 3, indicating severe cognitive impairment. Review of Resident #10's Physician's Orders on [DATE] reflected she was prescribed Lorazepam 1 MG Tablet, 1 tablet to be given two times a day for agitation/anxiety, with a start date of [DATE], and Tylenol with Codeine #3 ,d+[DATE] mg Tablet (Acetaminophen-Codeine), t tablet to be given by mouth to times a day for pain related to poly osteoarthritis. Review of Resident #11's face sheet on [DATE] reflected a [AGE] year-old female admitted to the facility originally on [DATE] and readmitted to the facility most recently on [DATE]. Resident #11's diagnoses include Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills), limitation of activities due to disability, Parkinson's Disease (a movement disorder that affects the nervous system and causes tremor and stiffness), Post Traumatic Stress Disorder (a mental condition caused by a traumatic event), Bipolar Disorder (a chronic mood disorder that causes extreme shifts in mood, energy levels, and behavior), Major Depressive Disorder (a mood disorder characterized by persistent feelings of sadness, loss of interest and changes in sleep and appetite),, and chronic pain. Review of Resident #11's Quarterly MDS assessment dated [DATE], revealed a BIMS summary score of 10, indicating moderate cognitive impairment. Review of Resident #11's Physician's Orders on [DATE], reflected she was prescribed Phenobarbital Oral Tablet 60 MG, 1 tablet to be given by mouth two times a day related to seizures (other). The start date of this medication was [DATE]. Review of Resident #12's face sheet on [DATE] revealed a [AGE] year-old female admitted to the facility originally on [DATE] and readmitted to the facility on [DATE]. Resident #12's diagnoses include Schizoaffective Disorder (a mental health condition that combines schizophrenia and mood disorder symptoms), Depressive Type, Non Traumatic Ischemic Infarction of Muscle, Right Thigh (severely blocked blood flow), Hypothyroidism (underactive thyroid), Altered Mental Status, and Cognitive Communication Deficit. with no formal diagnoses listed. Review of Resident #12's Quarterly MDS assessment dated [DATE], revealed a BIMS summary score of 2, indicating severe cognitive impairment. Review of Resident #12's Physician's Orders on [DATE], reflected she was prescribed amoxicillin related to a tooth abscess. The order indicated Amoxicillin Tab 500 MG, 1 tablet to be given by mouth three times a daily for 7 days. The start date of this medication was [DATE]. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's face sheet on [DATE] revealed an [AGE] year-old male admitted the to facility on [DATE]. Resident #14's diagnoses include Malignant Neoplasm of Prostate (prostate cancer), Anemia (a blood condition characterized by not having enough healthy red blood cells or hemoglobin to carry to the body's tissues), Gout (a form of arthritis characterized by sudden and severe attacks of pain, swelling, redness and tenderness), and Restlessness and Agitation. Review of Resident #14's Physician's Orders on [DATE], reflected he was prescribed Fentanyl Transdermal Patch 72 Hour 12 MCG/HR, which was to be applied as 1 patch transdermal every 72 hours related to Malignant Neoplasm of Prostate and remove per schedule, The start date of this medication was [DATE]. Review of the initial Facility Reported Incident report submitted by ADM on [DATE] at 10:59AM via the web, revealed the date/time of the reported drug diversion incident to be [DATE] at 8:00PM. In the report it stated that the medication aide (MA A) was believed to be responsible for the reported drug diversion. The report stated the medication aide had already been suspended for an unrelated incident when the facility discovered the drug diversion and the Director of Nursing (DON) took over the medication pass at the time of MA A's suspension. Review of a supplemental report submitted by ADM on [DATE] at 11:59 AM, indicated none of the involved residents missed any doses of their medications, and none suffered any adverse effects. It also indicated a police report was filed. The following medications were reported to be missing: LORAZEPAM 1MG belonging to Resident #19, a Benzodiazepine. LORAZEPAM 1MG belonging to Resident #10, a Benzodiazepine. TYLENOL #3 belonging to Resident #10, a combination of acetaminophen and Codeine, an Opiate. PHENOBARBITAL 60MG belonging to Resident #11, a Barbiturate. LORAZEPAM .5MG belonging to Resident #5, a Benzodiazepine. LORAZEPAM .5MG belonging to Resident #9, a Benzodiazepine. AMOXICILLIN 500MG belonging to Resident #12, an antibiotic. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Provider Investigation Report submitted by the facility to HHS on [DATE] , revealed a reported incident of drug diversion which occurred on [DATE] at 6:30 PM at the facility. Resident #9, who is described as an interviewable resident with the capacity to make informed decisions, was listed as one of the residents involved in the incident. The report states that Resident #9 confirmed he was not given any medications on the evening of [DATE]. Resident #5 was also listed as an involved resident. Resident #5 was described as an interviewable resident without the capacity to make informed decisions whose diagnosis is unspecified dementia (a group of symptoms affecting memory, thinking and social abilities). Resident #5 also denied receiving her scheduled medication(s) on the evening of [DATE]. In total, 6 residents were found to have medications missing or unaccounted for. All residents were assessed, and no signs or symptoms of distress were noted. The residents reportedly didn't exhibit behaviors abnormal from their baseline. The medication cart was audited, and no other discrepancies were discovered. Facility staff believed MA A was responsible for the missing medication in that MA A was instigated and engaged in unprofessional verbal disagreements with other staff members on the day of the incident which led to the facility's DON returning to the facility to diffuse the situation and to suspend MA A pending investigation into an unrelated incident. Reportedly MA A refused to write a statement regarding the unrelated incident and refused to count the medication cart with the DON. MA A went home and DON took over med pass and assumed responsibility for the medication cart. MA A was ultimately terminated as the report stated that MA A admitted that she had made the errors by mistake, according to the facility (ADM). The responsible parties for the 6 residents involved were notified, the police were notified, and a report was made. The Medical Director was notified. The pharmacy was notified. The physician and pharmacy recommended no further treatment. Medication Carts were audited to ensure that no more medications were missing. All staff were in-serviced on Drug Diversion and Abuse, Neglect and Medication Administration. The DON was to have conducted random med cart audits, as well as follow along on random med passes. Safe surveys were conducted, which indicated no negative findings or confirmation of abuse or neglect. Review of Investigation Statement written by DM on [DATE] stated that DM observed MA A in the dining room at supertime and there seemed to be an argument going on. Review of Investigation Statement written by NB on [DATE] at 5:30PM stated that she observed MA A engaged in an argument with other staff members while other staff were feeding residents. Review of Investigation Statement written by LVN A on [DATE], from 5:45PM-6:00 PM, stated while LVN A was sitting at a dining room table, feeding a resident, when MA A came over and began talking about how tired she was and how she had worked 20 days straight. LVN A made the comment that she was tired of hearing MA A complain, which caused MA A to become upset and begin arguing loudly with other staff in front of resident. Review of Investigation Statement written by LVN A on [DATE] at 2200 (10:00 PM), in which it is which stated that she passed medications on the unit at approximately 2000(8PM). DON and LVN A counted narcotics at approximately ,d+[DATE] (9:15 PM-9:30 PM) on [DATE] when they noticed a discrepancy in the count on both carts. Review of Investigation Statement written by MA A on [DATE] (date deduced from information contained within the statement), stated MA A was in the dining room passing trays and she just started screaming at the employees for no reason. MA A stated that she refused to write a statement on the night of the incidentlast nite because she couldn't think. She ends the statement by writing, I do apologize on my behalf. MA A makes no admission to any conduct related to the missing medications. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 12 panel Drug Test Results Record for DON showed that DON submitted to a urinalysis drug test on [DATE] at 1030PM. The results were interpreted by DON at 10:35PM and confirmed by LVN A at 10:55PM. The results were negative. The substances tested for were Phencyclidine (PCP), Methylenedioxymethamphetamine (MDMA), Amphetamines, Methadone, Barbiturate, Buprenorphine (Opiate), Oxycodone (Opioid Analgesic), Methamphetamine, Benzodiazepine, Opiates, Marijuana and Cocaine. Review of the 12 panel Drug Test Results Record for LVN A showed that LVN A submitted to a urinalysis drug test on [DATE] at 10:50PM, which was received by DON. The results were interpreted by DON at 10:55PM. The results were negative. The substances tested for were Phencyclidine (PCP), Methylenedioxymethamphetamine (MDMA), Amphetamines, Methadone, Barbiturate, Buprenorphine (Opiate), Oxycodone (Opioid Analgesic), Methamphetamine, Benzodiazepine, Opiates, Marijuana and Cocaine. Review of the 12 panel Drug Test Results Record for MA A showed that MA A submitted to a urinalysis drug test on [DATE] at 11:35AM, which was received by DON. The results were interpreted by DON at 11:45AM. The results were negative. The substances tested for were Phencyclidine (PCP), Methylenedioxymethamphetamine (MDMA), Amphetamines, Methadone, Barbiturate, Buprenorphine (Opiate), Oxycodone (Opioid Analgesic), Methamphetamine, Benzodiazepine, Opiates, Marijuana and Cocaine. Review of the police report #,d+[DATE] filed by the facility on [DATE] with KPD revealed that a police officer was dispatched to the facility on [DATE] at 12:13PM in reference to a theft of narcotics. The officer met with DON who stated that MA A accidentally wrote the wrong date on several of the [patients] medicine logs. DON stated that instead of writing [DATE], MA A wrote [DATE] when she gave the [patients] their medicine on the previous day (Friday, [DATE]). DON said she was the one who caught the mistake, and that MA A is an elderly lady who just made a mistake but didn't take anything. DON stated that MA A had been drug tested and DON and LVN A counted the medicine and found that nothing was missing at all. DON stated that it was simply a mistake of MA A writing the wrong date. DON told the officer that she just needed to file a report in order to document the incident for the state. The officer cleared the scene at 12:38PM. Review of the facility's in-service records from [DATE] through [DATE] reflected facility staff were in-serviced on procedures regarding Medication Administration (specifically not to pre-pull medications), Abuse and Neglect, Medications to be Given as Ordered, Code of Conduct, and Drug Diversion. The in-service training attendance rosters for [DATE] do not indicate the time in which they were presented to staff, but MA A's signature was contained on each including Drug Diversion and Medication Administration. Review of the Controlled Drug Monitoring Record (audit) dated [DATE] through [DATE] stated, Does all count sheets on all med carts match remaining medication supply? Each date is separated into columns and in each column a date is recorded and the say of the week, as well as an option to circle Yes or No. If a No response is chosen instructions are given to describe and note corrective action. On each of the days listed all count sheets matched the remaining medication supply. Review of the Employee Disciplinary Report signed by MA A, DON, and ADM on [DATE], showed MA A was placed on investigatory suspension pending an investigation into resident rights due to MA A yelling in front of residents. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Employee Disciplinary Report signed by MA A, DON, and ADM on [DATE], stated it was discovered on [DATE], following MA A's suspension for raising her voice at other staff in front of residents, that there were medications missing from the medication cart. As a result, MA A was terminated. Review of the statement written by DON regarding the incident involving MA A. The statement is typed and not dated, but dated but stated in part that DON returned to the facility due to argument between several employees, including MA A. MA A refused to provide a statement and said she was going home instead. DON then took over the medication cart from MA A, who reportedly refused to count with DON at that time. Following her assumption of the medication cart, DON said she spoke with the hospice nurse and a resident's wife family member regarding hospice services and care, which she stated took some time. DON stated that she gave 2 residents their medications when the residents came to the desk asking for their nighttime medications. DON said that she and LVN A then counted the narcotics on the cart and did not notice any discrepancies at that time. DON said while giving scheduled narcotics to a resident at around 9:15 PM/9:30 PM, she noticed that the previous signed out medication was for [DATE]. Upon closer inspection of all of the narcotic count sheets, DON states she realized that there were multiple residents with medications signed out for [DATE] & [DATE] as given. DON states she immediately notified ADM. Review of Resident #5's Individual Patient's Controlled Substance Record reflected Resident #5 was prescribed 15 Lorazepam .5MG Tab on [DATE], with an order to give one tablet by mouth every night at bedtime. The administration documentation shows MA A documented the administration of 1 tablet on [DATE] at 2000 (8PM), and 1 tablet on [DATE] at 2000 (8PM). Review of Resident #9's Individual Patient's Controlled Substance Record reflected Resident #9 was prescribed 30 Lorazepam .5MG Tab on [DATE], with an order to give 1 tablet by mouth every night at bedtime. The administration documentation shows that MA A documented the administration of 1 tablet on [DATE] at 2000 (8PM), and 1 tablet on [DATE] at 2000 (8PM). Review of Resident #10's Individual Patient's Controlled Substance Record reflected Resident #10 was prescribed 30 Lorazepam 1mg tablets on [DATE], with administration directions to give 1 tab by mouth twice a day. The administration documentation shows MA A documented the administration of 1 tablet on [DATE] at 2000 (8PM) leaving 12 tablets remaining. LVN A documented the administration of 1 tablet on [DATE] at 800 AM leaving 11 tablets remaining. MA A documents the administration of 1 tablet on [DATE] at 2000 (8PM) leaving 10 tablets remaining, and 1 tablet on [DATE] at 2000 (8PM); leaving 9 tablets remaining. Review of Resident #10's Individual Patient's Controlled Substance Record reflected Resident #10 was prescribed 30 Tylenol #3 tablets on [DATE], with administration directions to give 1 tablet by mouth twice a day. The administration documentation shows LVN A documented the administration of 1 tablet on [DATE] at 800 AM leaving 11 tablets remaining. The administration documentation shows that MA A documented the administration of 1 tablet on [DATE] at 2000 (8PM) leaving 10 tablets remaining, and the administration of 1 tablet on [DATE] with no time indicated leaving 9 tablets remaining. Review of Resident #11's Individual Patient's Controlled Substance Record reflected Resident #11 was prescribed 60MG of Phenobarb on [DATE], with an order to give 1 tablet by mouth twice daily. The administration documentation shows MA A documented the administration of 1 tablet on [DATE] at 2000 (8PM) leaving 10 tablets remaining. But following this administration documentation, the administration of 1 tablet on [DATE] at 2000 (8PM) by DON leaving 9 tablets remaining. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's Individual Patient's Antibiotic Usage Record reflected Resident #12 was prescribed 21 Amoxicillin 500MG Tab on [DATE], with an order to take one tablet by mouth three times daily for 7 days. On [DATE], MA A documented the administration of one tablet given at 1800 (6:00 PM), which left 2 tablets remaining. DON made a handwritten note on the usage record that states, This was the med card on [DATE]. ,d+[DATE] charting was completed as given on [DATE]. In an interview with ADM on [DATE] at 8:40AM. ADM stated it's her belief that MA A was responsible for the missing medications on [DATE]. ADM stated that she doesn't believe MA A purposefully or intentionally misappropriated the missing medications. ADM stated that MA A had not been acting like herself that day and it's possible MA A was suffering from some sort of cognitive decline. ADM stated that MA A was arguing with staff and DON went to the facility to investigate. ADM said MA A's husband and son had to get her out of her car upon arriving home that evening. ADM said MA A did not remember driving home the next day. ADM stated that MA A was administered a drug test the next morning and the results were negative. ADM stated it is believed that MA A pre-dated her medication administrations. ADM said according to what was documented, the count was right, but further investigation revealed 7 pills were missing. The ADM stated that MA A worked the 2PM-10PM shift as a medication aide and had been employed with the facility since [DATE]. This was MA A's first incident. In an interview with DON on [DATE] at 8:40AM, DON stated that it was reported to her that MA A was arguing with staff and causing a disruption in front of the residents. Since DON lived practically next door to the facility, DON reported that she immediately presented to the facility to investigate. DON said MA A refused to write a statement or count the med cart with her and just wanted to go home. DON stated that she assumed responsibility for the medication cart without counting the medications on the cart to ensure all were accounted for. When the discrepancies were discovered, DON called MA A at 11:00PM on [DATE] to inquire about the missing medications. DON was unable to reach MA A. DON said MA A expressed to her prior to this event that she thought she was dying. No further details or explanation were provided by MA A or DON. In an interview with LVN A on [DATE], at 10:15AM, LVN A stated that she has been employed with this facility for 2 years. LVN A stated that medication aides typically administer medications from 2PM-10PM, but she switched shifts on this day. Observation of medication administration by LVN A on [DATE] at 10:15AM revealed 10 medications administered with 13 opportunities for error. LVN A administered all medications with no errors observed. The medications administered were Calcium 600+D, Cranberry, Fish Oil, Folic Acid, Guanfacine, Multi-Vitamin, Omeprazole, Risperidone, Sodium Chloride, and Vitamin D. Observation of medication cart audit with LVN A and review of the medication cards on the North Hall Treatment Cart on [DATE] at 10:34AM revealed 3 individual medication cups, labeled with Resident #8, #10, and #11's last names on the outside of each cup. The cups were stacked on top of each other and LVN A pushed the cups toward the back of the cart to conceal the medications. The cups contained 1 Clindamycin Cap 300MG belonging to Resident #8, 1 Lorazepam 1mg tablet, 1 Acetaminophen-Codeine #3 tablet belonging to Resident #10, 1 Phenobarbital Tab 60MG, and 1 Hydrocodone/APAP Tab ,d+[DATE]MG belonging to Resident #11. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and review of Resident #8's Individual Patient's Antibiotic Usage Record on [DATE] at 10:39AM revealed no documentation of the administration of 1 Clindamycin Cap 300MG on [DATE] by LVN A. Observation and review of Resident #10's Controlled Substance Record on [DATE] at 10:39AM revealed no documentation of Lorazepam 1mg tab on [DATE]. Observation and review of Resident #11's Individual Patient's Controlled Substance Record on [DATE] at 10:40AM revealed no documentation of the administration of 1 Hydrocodone/APAP Tab ,d+[DATE]MG on [DATE] by LVN A. Observation and review of the Med Cart Controlled Drugs-Audit Record for February 2025 on [DATE] at 10:49AM showed LVN A signed the audit record on [DATE] at 6AM which indicated the narcotic count was correct when she accepted the cart and assumed her shift. LVN A signed the audit record on [DATE] at 2PM which indicated the narcotic count was correct when she and accepted the cart from herself. LVN A signed the audit record on [DATE] at 10PM which indicated the count was correct. Observation and review of the Med Cart Controlled Drugs-Audit Record for February 2025 on [DATE] at 10:49AM showed LVN A failed to audit the Med Cart Controlled Drugs before she assumed her shift at 6AM in that LVN A failed to sign the audit record. LVN A was also observed to have signed the audit record during the medication cart audit in an effort to conceal her lack of documentation, however, LVN A signed the audit record incorrectly as the nurse going off duty at 2PM and then again on duty at 10PM. Observation of treatment cart audit for North Hall with LVN C conducted on [DATE] at 10:51AM revealed no discrepancies. Observation of treatment cart audit for East Hall with LVN B conducted on [DATE] at approximately 10:53AM revealed no discrepancies. Observation of med cart audit with LVN A on [DATE] at 10:55AM revealed 2 Fentanyl Transdermal Patches contained in the prescription box belonging to Resident #14. Observation and review of Resident #14's Controlled Substance Administration Record on [DATE] at 10:55AM revealed LVN A documented the administration of 1 Fentanyl 12MCG/HR Patch on [DATE] at 12PM, leaving 1 remaining. In an interview with LVN A on [DATE] at 10:55AM, she admitted she documented the administration of a Fentanyl Patch for Resident #14 on the Medication Administration Record but did not actually administer the medication or sign out the medication. She stated documenting the administration of medications before they are actually given is a bad habit. LVN A stated Resident #14 was a hospice patient who was sleeping hard. She did not want to disturb him. LVN A said she should have documented that she was unable to administer the medication and that she would re-check the resident in 30 minutes. The negative outcome that could have resulted was inaccurate documentation and unaccounted for medications. LVN A stated that she had been in-serviced on this topic some in the past 3 months, (continued on next page)		

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 02/26/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN A on [DATE] at approximately 11AM, she admitted that she had pre-poured the 3 cups of medication found and acknowledged the cups contained narcotics. LVN A said that she has been in-serviced on this issue. She said she is never to pre-pour medications. LVN A stated she believed doing it this way saved time and was more efficient. She said she recognized now this is why the facility is in the situation it's in. LVN A also admitted that the missing signature on the med cart log was Her's. Observations and/or interviews were conducted on [DATE] from 12:52PM until 1:39PM, of Resident #5, #8, #9, #10, #11, #12, #14, and #19. Of those residents that were able to be interviewed, none expressed complaints or issues. All believed they received all medications and treatments as ordered. All expressed satisfaction with their treatment by staff at the facility and denied being subjected to any form of abuse or neglect. Observations of those residents unable to be interviewed revealed no concerns for the residents, their environment, or their state of being. No residents were observed to be in distress or unhappy. Review of Employee Disciplinary Report dated [DATE] stated LVN A was placed on investigatory suspension pending investigation into allegations of medication error. Review of 1:1 In-service Record on Medication Administration Procedure with LVN A on [DATE] stated, Under no circumstance are we to ever preset meds. When you pop a narcotic or any other medication that requires counting you must sign out for that medication right after you pop the medication. Review of statement written by LVN A on [DATE], indicated an admission by LVN A to pre-filling 3 residents' 11:00AM meds. LVN A stated she did this to save time. She stated that she had been in-serviced many times about setting up meds. LVN A also admitted that she did not sign the narcotic sheets as she was punching out each med. She stated she waits until she is done with med pass to sign the narcotic sheets. Review of LVN A's personnel file on [DATE], at 3:51PM revealed as of [DATE] LVN A holds a current LVN license with no restrictions. LVN A was also a CNA whose certification expired on [DATE] and who was not listed in the Employee Misconduct Registry. LVN A's personnel file included an In-Service Training dated [DATE] on the topic: No setting up medications prior to giving them. The in-service showed to be a 1:1 in-service in that LVN A was the only employee in attendance with DON, ADON, and ADM listed as the instructors. LVN A's personnel file showed		