| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675867 | A. Building<br>B. Wing | 11/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kerens Care Center | 809 NE 4th St<br>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 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.<br><br>(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 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure personnel provided basic life support, which included CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to relative physician orders and the Resident's advanced directives for 1 (Resident #1) of 6 residents reviewed for cardio-pulmonary resuscitation. RN A failed to initiate life-saving measures (CPR) when Resident #1, who had a code status of full code was found unresponsive and expired. This failure could place residents at risk of death from not receiving life-saving measures if required. The immediacy began on [DATE] and ended on [DATE]: The noncompliance was identified as PNC. The JT began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. Findings included: Record review of the face sheet, dated [DATE], reflected Resident #1 was admitted on [DATE] with diagnoses of cerebral palsy (disorder that affects a person's movement, posture, and balance), lack of coordination, muscle wasting and atrophy to lower extremity (decreased in muscle tissue size). Record review of admissions progress note, dated [DATE] at 5:20 p.m., reflected Resident # 1 was admitted from the hospital, full Code, with a terminal diagnosis of cerebral palsy and was on hospice. Record review of Resident #1's care plan, dated [DATE], reflected Resident #1 was a full code CPR status, interventions included initial BLS CPR if the resident was without a heartbeat or not breathing. Notify EMS. Record review of Resident #1 Physicians orders, dated [DATE], reflected resident #1 was a full code CPR status. Record review of RN A's written statement (not dated) reflected Resident #1 was found unresponsive with no vital signs and no respiratory effort. This written statement reflected that she contacted hospice and notified the resident's representative of the residents passing. RN A's written statement reflected that she realized she made a serious error in not transporting Resident #1to the hospital for emergency services or initiating CPR. RN A's written statement reflected that she thought it was a condition of hospice admission that residents on hospice were a DNR and she should have double checked to be sure the Resident #1 had a DNR in place. In an interview with RN A on [DATE] at 11:49 am revealed she went into Resident #1's room and found Resident #1 to be unresponsive and her eyes dilated (the body's immediate response to involuntary to the cessation of blood circulation and muscle relaxation, indicating brain stem death). RN A stated she took Resident #1's vital signs with no pulse, no blood pressure and no respiration. RN A revealed she did not provide CPR or transport Resident #1 to the hospital because she thought Resident # 1 was a DNR. She stated she did not check the code status for Resident #1 because she assumed Resident #1 was a DNR because she was on hospice. She stated she notified hospice and Resident #1's representative. Interview with the administrator on [DATE] at 10:15 a.m. revealed Resident #1 was her aunt, and she was the resident's representative listed. She confirmed Resident #1 did not have a DNR on file for and RN A should have performed CPR. She stated she felt it would not have done any good because when RN A found Resident #1, she had already passed. She stated RN A should have attempted e life saving measures because Resident #1 was a full code CPR and RN A did not follow policy. Record review of the facility's CPR policy, undated, reflected CPR was a method of providing systemic circulation by manual chest compression and oxygen by mouth-to mouth breathing or providing air to the lungs via Ambu bag (a devise used in emergencies to help a person breath) to prevent death following cardiac or pulmonary arrest.Record review of the hospice death visit summary, dated [DATE] (no time), reflected the medical director was contacted on [DATE] at 1:25 a.m. by hospice RN and advised Resident #1 was absent of vital signs with dilated and fixed pupils (the body's immediate response to involuntary to the cessation of blood circulation and muscle relaxation, indicating brain stem death). The patient's death was expected. The doctor gave time of death as 1:25 a.m. The facility completed the following interventions prior to surveyor entry on [DATE]: Record review of facility in-service, dated [DATE] (no time), reflected all staff received in-service training on abuse, neglect, resident change of status, pronouncement of death, residents' rights, CPR, self-determination end of life measures, DNR, hospice, and oxygen administration. Interview with DON on [DATE] at 2:19 p.m. revealed that she worked at the facility for six months. She received in-service training at the time of hire and on [DATE] on abuse, neglect, resident change of status, pronouncement of death, residents' rights, CPR, self-determination end of life measures, DNR, hospice, and oxygen administration. She stated she would report abuse or neglect to the administrator. The DON reflected an example of abuse was physical harm of a resident and neglect was not performing proper care for a resident. She stated a resident's code status was |