

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 04/10/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065</p> <p>Based on observations, interviews, and record review the facility failed to protect and promote an environment that ensured the resident's right to a dignified existence for 2 of 2 residents (Resident #24 and #3) reviewed for resident rights.</p> <p>The facility failed to to address Resident #3's eating restrictions in a dignified manner and protect confidentiality related to incontinence care needs on Resident #24.</p> <p>This failure could place residents at risk for shame and loss of dignity that could negatively impact their quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #3's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of pneumonitis, epilepsy (seizures), stroke, malnutrition, right side muscle weakness related to stroke, dementia, and anxiety.</p> <p>Record review of Resident #3 's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 99, which indicated the resident's cognitive ability could not be determined due to other medical conditions.</p> <p>Record review of Resident #3's Care Plan, reflected a focus area was initiated for depression on 5/16/23 (ongoing) with a goal for the resident to decrease signs and symptoms of depression.</p> <p>Record review of Resident #24's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of diabetes type 2, depression, anxiety, stroke, falls, and muscle weakness.</p> <p>Record review of Resident #24 's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 02, which indicated the resident's cognitive ability was severely impaired.</p> <p>Record review of Resident #24's Care Plan, reflected a focus area was initiated for depression with a goal for the resident to be free from discomfort or adverse reactions from antidepressants.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/08/25 at 10:46 AM revealed Resident #24, had a note on her door that opened into the public hallway saying, Please Check Resident 24's (Sign had residents name on it.) Pull-ups are on both legs Thanks.</p> <p>In an interview on 04/09/2025 at 11:50 AM with the ADON when asked by the state surveyor where Resident #3 could be located, she stated he was at the feeder table. There was 1 resident in the presence of the state surveyor and the ADON when this was said.</p> <p>In a follow up interview on 04/09/2025 at 11:58 AM with the ADON when asked why she referred to the table in the dining room as the feeder table she stated she was not supposed to say feeder table; she did not know the correct term for it, and she realized as soon as she said it, she should not have said it. She stated she was aware that was a dignity issue, and she would ask her DON what the correct term was.</p> <p>In a phone interview on 04/10/2025 at 11:15 AM, the Responsible Party for Resident #24 stated she posted the sign.</p> <p>In an interview on 4/10/2025 at 1:32 PM, CNA G stated the policy on maintaining confidentiality regarding resident's incontinence/wearing briefs was to keep all information private and it was important to maintain privacy because it was not anyone else's business. She stated the negative outcome to residents if not done could be embarrassment and it could cause them depression. She stated a sign stating a resident wears a brief might indicate the resident was incontinent and that a sign visible in the hallway was not private.</p> <p>In an interview on 4/10/2025 at 1:43 PM LVN H stated, the policy on maintaining confidentiality regarding resident's incontinence/wearing briefs was they were not supposed to tell anybody. She stated it was important to maintain privacy on incontinence for resident's dignity and privacy and the negative outcome to residents if not maintained could be humiliation and loss of dignity. She stated a sign stating a resident wore a brief would indicate the resident was incontinent and a sign visible in the hallway was not private.</p> <p>In an interview on 4/10/2025 at 1:50 PM the ADM stated, the policy on maintaining confidentiality regarding incontinence/wearing briefs was that the facility was confidential about that information, and it was important to maintain privacy on incontinence because it was a dignity issue for the resident. He stated the negative outcome to residents if not done could be aggressiveness and embarrassment. He stated a sign stating a resident wore a brief would of course indicate the resident was incontinent and a sign visible in the hallway was not private.</p> <p>A record review of the facility undated policy titled, Resident Rights, reflected the following:</p> <p>The resident has a right to a dignified existence.</p> <p>A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes quality of life.</p> <p>The facility must protect and promote the rights of the resident.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097</p> <p>Based on observations, interviews, and record review the facility failed to ensure each resident's bedside, toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 3 of 10 residents (Resident #20, Resident #28, and Resident #31) reviewed for the resident call system .</p> <p>The facility failed to provide a working communication system, which was easily at reach, which would allow Resident #20, Resident #28, and Resident #31 the ability to safely call for staff for assistance.</p> <p>This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living.</p> <p>Findings included:</p> <p>Record review of Resident #20's face sheet dated 04/09/2025 reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #20 had diagnoses which included metabolic encephalopathy (brain disease), cellulitis (bacterial infection involving inner layers of the skin), vitamin D deficiency, dry eye, constipation, muscle wasting, abnormalities of gait and mobility, unsteadiness on feet, lack of coordination, reduced mobility, insomnia (difficulty sleeping), glaucoma (eye disease), hypertension (high blood pressure), adult failure to thrive, and history of falling.</p> <p>Record review of Resident #20's Quarterly MDS dated [DATE] reflected Resident #20 had a BIMS score of 03, which indicated severe cognitive impairment. The MDS further reflected Resident #20 needed assistance of two or more helpers for his activities of daily living. Resident #20 required moderate assistance for bed mobility, and transfers, and he used a wheelchair for mobility.</p> <p>Record review of Resident #20's Care Plan, dated 03/07/25, ensure Resident #20's call light was within reach and encourage the resident to use it for assistance as needed.</p> <p>Review of Resident #28's Face Sheet dated 04/09/2025 reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #28's diagnoses included dementia (memory, thinking, difficulty), toxic encephalopathy (neurological disorder dur to being exposed to toxic substances), pain due to trauma, muscle wasting, abnormalities of gait and mobility, sexual disorder, delusional disorder (serious mental illness that causes unshakeable false beliefs for at least a month), muscle weakness, unsteadiness on feet, reduced mobility, muscle wasting, lack of coordination, depression, hyperthyroidism (excessive production of thyroid hormones), anxiety (feeling of uneasiness or worry), hyperlipidemia (high cholesterol), seizures, and hypertension (high blood pressure).</p> <p>Record review of Resident #28's Quarterly MDS dated [DATE] reflected Resident #28 had a BIMS score of 06, which indicated severe cognitive impairment. The MDS further reflected Resident #28 required supervision and touching assistance from staff for her activities of daily living, and transfers, and she walked independently.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #28's Care Plan, dated 01/27/25, Ensure/provide a safe environment: Call light in reach, Adequate low glare light, bed in lowest position and wheels locked, Avoid isolation.</p> <p>Review of Resident #31's Face Sheet dated 04/09/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #31's diagnoses included encephalitis and encephalomyelitis (inflammation of the brain and the spinal cord), dysphagia (difficulty swallowing), insomnia (difficulty sleeping), calculus of gallbladder (stones in the gallbladder), muscle wasting, unsteadiness on feet, abnormalities of gait and mobility, collapsed vertebra (compression fracture of the spine), nicotine dependency, muscle weakness, nystagmus (involuntary eye movement), hypertension (high blood pressure), and ataxia (impaired balance or coordination due to damage to the brain, nerves or muscles).</p> <p>Record review of Resident #31's Quarterly MDS dated [DATE] reflected Resident #31 had a BIMS score of 07, which indicated severe cognitive impairment. The MDS further reflected Resident #21 required supervision and touching assistance from staff for his activities of daily living, and transfers, and he walked independently.</p> <p>Record review of Resident #31's Care Plan, last revised on 03/01/25, Encourage the resident to use bell to call for assistance.</p> <p>Observation of Resident #31's call light on 04/08/2025 at 11:08am revealed his call light was not within reach of the resident. Resident #31's call light was hanging straight to the floor between the bed and the wall. The resident could not reach the call light. Resident #31 was sitting on the end of his bed in the middle and could not reach the call light if he needed it.</p> <p>Observation of Resident #20's call light on 04/08/2025 at 11:08am revealed his call light was not within Resident #20's reach. Resident #20's call light was on his roommate's bedside table. The resident was laying in his bed, and he could not reach the call light if he needed it.</p> <p>Observation of Resident #28's call light on 04/08/2025 at 1:09pm revealed her call light was on the floor approximately 40 feet from the resident. Resident #28 was laying in her bed and could not reach her call light if she needed it.</p> <p>During an interview with Resident #20 on 04/08/2025 at 11:10am revealed he would not answer questions about the call light.</p> <p>During an interview on 04/09/2025 09:33am with Resident #28 revealed her call light was rarely in reach. She said she would have to go underneath her bedside table to get her call light.</p> <p>During an interview on 04/09/2025 09:35am with Resident #31 revealed his call light was always hung straight to the floor. Resident #31 also said he did not use the call light anyway.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the ADON on 04/10/2025 at 09:312am revealed she had been trained on resident rights. She said the policy was the call light should always be within the resident's reach. She said the call light should be within reach any time the resident was in their room. She said if the call lights were not in the resident's reach the resident would not be able to get the help they needed, and the staff could not tend to them quickly. She also said the resident could fall or worst-case die depending on what was going on with the resident. She said everyone was responsible for ensuring the call light was within reach. She said it was monitored by doing rounds. She said the call light was not in reach because the residents were not in their room a lot and staff may have forgotten to put it back after making the bed.</p> <p>During an interview with LVN B on 04/02/2025 at 1:22pm revealed she had been trained on resident rights. She said the call light was supposed to be where the resident could reach it. She also said that if the resident was paralyzed the call light should be placed on the side that was not paralyzed. She said all staff were responsible for ensuring the call lights were within reach. She said if the call lights were not within the resident's reach the resident could fall or get hurt. She also said the nurses and CNA's were responsible for ensuring the call lights were within the resident's reach. She said the CNA's and nurses monitor the call lights by doing rounds and would put the call light in the resident's reach if it was not in their reach. She said the staff did not pay attention to the call lights and that was why the call lights were not in reach.</p> <p>During an interview with MA B on 04/10/2025 at 10:00am revealed she and staff had been trained on resident rights. She said the call light was supposed to be within the resident's reach. She also said if the resident was in the wheelchair the call light was supposed to be close to the wheelchair. She said the call light needed to be within the residents reach in case of an emergency or in case the residents needed staff. She said the call lights were monitored by the charge nurse and all staff were responsible for ensuring the call lights were within the resident's reach. She said call lights were monitored by walking the halls and checking the call lights. She said she did not know why the call light was not in reach. She said some may have fallen off the residents bed.</p> <p>During an interview with the ADM on 04/10/2025 at 10:16am revealed she and staff had been trained on resident rights. She said the call light was supposed to be within the resident's reach. She also said it was important to have the call light in the resident's reach in case of an emergency. She said if the call lights were not within the resident's reach the resident could die in worst case scenario. She also said management were responsible for ensuring the call lights were within the resident's reach. She said the call lights were monitored by doing rounds. She said she did not know why the call light was not in reach.</p> <p>Policy for dignity and call lights were requested from the ADM on 04/09/2025 at 11:11am, and at 4:17pm. The policy was not received on exit.</p>		

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<p>F 0565</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 organize and participate in resident/family groups in the facility.</p> <p>49097</p> <p>Based on interviews, and record review the facility failed to provide a private space for residents' monthly council meetings and the confidential resident group meeting during survey for five of five residents reviewed for resident council.</p> <p>The facility did not provide a private space for resident council meetings.</p> <p>This failure could place residents, who attended resident council meetings, at risk of not being able to exercise their rights of being able to voice their grievances in private without uninvited staff being present.</p> <p>Findings included:</p> <p>During an interview on 04/08/2025 at 10:20 am, with the Activity Director revealed the Resident Council meetings were held in the dining room. She stated there was not another area for the residents to meet in private. She stated she would close the doors and place signs on the doors. She stated she would notify staff before the meeting not to come in or out of the dining room until after the resident group meeting. The Activity Director offered to move the Resident Council meeting to a bedroom so it would be private since it was a few residents.</p> <p>During an interview on 04/09/2024 at 09:30am, during a confidential resident group meeting held in a bedroom with five residents revealed their meetings were normally held in the dining room. The residents in attendance of the resident group meeting stated interruptions occurs every- time they had a Resident Council meeting. The residents stated their meetings have never been private. The residents in the meeting stated they could not speak freely because staff would come in. The residents stated the AD would get the staff out during the meeting, but staff continued to interrupt their council meetings. The residents in the meeting stated they would like some place private to meet.</p> <p>During an interview with the ADON on 04/10/2025 at 9:35am revealed she had been trained on resident rights. She said the resident council must have a private place to meet. She said staff were not to be a part of the meeting unless the council invited them. She said the AD was responsible for ensuring the resident council had a private place to meet. She said she had not heard the resident council wanted a more private place to meet. She said if the resident council did not have a private meeting space the residents may not feel comfortable voicing their concerns.</p> <p>During an interview with the AD on 04/010/2025 at 9:37am revealed she had been trained on resident rights. She said the residents were to have a private meeting space for their resident council meeting. She said staff could not be in the meeting without the permission of the resident council. She said she was responsible for ensuring they had a private place to meet. She said she put signs on the dining room door to keep staff out. She said the resident council had not asked for a private place. She said the residents may not feel comfortable saying what they want or would not come to the meetings because it was not private.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the ADM on 04/10/2025 at 10:12am revealed she had been trained on resident rights. She said the resident council should have a private area to meet, and staff could not attend unless invited. She said she was responsible for ensuring the resident council had a private area to meet. She said if the resident council did not have a private area people could overhear their meeting and try to retaliate. She also said it was a dignity issue.</p> <p>Record Review of the facility's Resident Rights Policy dated 3/09/2022 revealed the residents had the right to be treated with respect and dignity. The resident had the right to privacy. The residents had the right to organize and participate in resident groups in the facility.</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>47172</p> <p>Based on interviews and observations, the facility failed to provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible for 1 of 1 memory care units (10 total residents) reviewed for homelike environment.</p> <p>The facility failed to provide a homelike environment inside the rooms (by hanging pictures, having decor present, or having color present) for the residents who lived in the memory care unit of the facility.</p> <p>This deficient practice could lead to regression and/or a feeling of institutionalization for the residents.</p> <p>Findings included:</p> <p>In an observation on 4/09/2025 at 09:33 AM in the facility's secured unit revealed a few paintings hung in the hallway as well in the dining room and dayroom. Observations of all 5 rooms (2 residents per room) revealed grey colored walls that were barren of any decorations. No personal or homelike decorations were observed in any of the 5 rooms. Each room contained 2 beds, 2 dressers, televisions, blinds on the window, over-bed lights, a privacy curtain between beds, and in some rooms, a recliner.</p> <p>In a confidential interview on 4/09/25 at 10:15 AM with a residents FM who resided in the facility's secured unit revealed the family of the resident had given the resident a few family pictures to have in the room. This FM did not regularly visit the resident. No pictures were visible in this resident's room.</p> <p>In an interview on 4/09/2025 at 11:30 AM with CNA D she stated she had been working at the facility for a year and a half. When asked about the walls in the resident rooms being bare and not personalized, she stated a lot of the residents exhibited behaviors such as tearing things off the walls. She stated it was just the rules here because some have behaviors and can take the stuff off the wall others cannot have decor in their rooms. She stated they had decor in the dining room and day room because that's where residents gathered and can be watched by the staff. She stated the memory care unit was full; having 2 residents per room for a total of 10 residents and it was hard to watch everybody if they were not in the same location.</p> <p>In a telephone interview on 04/09/25 at 2:54 PM with Resident #36's FM he stated he did not visit the resident often and another FM would be able to provide decor to the resident during that FM's next visit.</p> <p>(continued on next page)</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>In an interview on 04/10/25 at 9:16 AM the ADM stated the facility in the past had a decorative team that came and decorated the facility but the residents in the memory care unit took down the pictures that were up. She stated the facility had consistently tried to add more decorations and residents would pull them down. She stated they [facility staff] told family members to bring things to make the resident rooms their home. She stated it was a challenge to keep things in place. She stated a negative outcome to the rooms not feeling homelike could be regression, and she did not want the residents to feel institutionalized.</p> <p>Review of the facility's undated policy titled Resident Rights packet reflected,</p> <p>Safe environment - The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-</p> <ol style="list-style-type: none"> 1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. <ol style="list-style-type: none"> a. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. b. The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. 2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; 		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (Resident #36) of five residents reviewed for ADL care.</p> <p>The facility failed to shave Resident #36's facial hair all along the under side of her chin that was approximately 1 cm in length</p> <p>This deficient practice could place residents at risk of a decline in their sense of well-being and level of satisfaction with life.</p> <p>Findings included:</p> <p>Review of Resident #36's quarterly MDS assessment dated [DATE], reflected an [AGE] year-old-female that was admitted to the facility on [DATE] with diagnoses including high blood pressure, dementia, anxiety, depression, muscle wasting and atrophy, muscle weakness, and unsteadiness of feet. Her BIMS score was a 04, indicating severe cognitive impairment. She required substantial/maximal assistance to maintain personal hygiene.</p> <p>Review of Resident #36's care plan revealed she had an ADL Self Care Performance Deficit with goals to remain clean, dry, and well-groomed and to maintain or improve current level of function in personal hygiene. She had interventions including to assist with personal hygiene was required: hair, shaving, and oral care.</p> <p>Observation and interview on 4/09/25 at 09:36 AM with Resident #36 in her room revealed her sitting in her wheelchair looking at one of the bare walls. The resident had facial hair along her chin that was approximately 1 cm in length. When asked about her chin hair the resident stated it bothered her that it was there, and she wanted it trimmed if the hair was not plucked out 1 by 1. She was unable to recall the last time the facility shaved it for her.</p> <p>In a telephone interview on 04/09/25 at 2:54 PM with Resident #36's FM he stated the resident used to always take care of her shaving needs herself. He did not think there would be any issues with someone helping her out in that area now, she had not shown any combative behaviors.</p> <p>In an interview on 04/09/25 at 3:11 PM with CNA E she stated she had worked at the facility PRN for 2 years, worked 2 days a week, usually 2 or 3 days during the week. She did help with showers, and she had been waiting on razors to be brought back to the memory care unit. She stated some days she had a hard time persuading Resident #36 to get in the shower, but the resident did not regularly refuse or have a history of being combative. She could not recall the last time she shaved Resident #36 . She stated that shaving should be done during the residents' shower time if needed or when asked by the resident.</p> <p>In an interview on 04/10/25 at 9:16 AM the ADM stated typically during showers was when residents would be shaved, but it could be outside of that time as well . The CNA's were responsible for providing showers and ADL care during the residents' assigned shower days.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Shaving, Electric/Safety Razors policy undated reflected:</p> <p>It [shaving] is usually done as a part of daily personal hygiene, although every other day is sufficient for some based on the beard growth. It is done to promote cleanliness and a positive body image.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>47172</p> <p>Based on observations, interviews, and record review the facility failed to provide, based on the comprehensive assessment and care plan, both facility-sponsored group and individual activities and independent activities designed to meet the interests of and support the physical, mental, and psychosocial well-being in the 1 of 1 memory care units (10 residents) reviewed for activities.</p> <p>The facility did not provide the memory care unit residents with individual or group activities.</p> <p>Findings included:</p> <p>In an observation on 04/09/25 at 9:35 AM in the memory care unit revealed the residents all sitting in the day room with a television on and 1 staff member present with them. Some residents were looking at the television and some were looking around and mumbling to themselves. There was no activity calendar posted in the memory care unit. There was no evidence of activities (puzzles, books, baby dolls, toys, coloring books, pencils, crayons) within the memory care unit.</p> <p>In an observation and interview on 04/09/25 at 2:09 PM with CNA D she stated they did not do activities back there [in the memory care unit], and at the time they were just chilling. The residents were observed to be sitting in the day room talking to themselves and looking around. CNA E was observed to be trying different remote controls to turn on the television, but they did not work. She then got a radio and turned it on for the residents to listen to.</p> <p>In an observation on 04/09/25 at 3:00 PM in the memory care unit revealed all the residents sitting in the day room with 1 staff member present. The television was on, and some residents were watching, and some were looking around and mumbling to themselves. There was no activity schedule posted.</p> <p>In an interview on 04/09/25 at 3:11 PM CNA E stated she had worked at the facility PRN for 2 years, worked 2 days a week, usually 2 or 3 days during the week. She stated activities vary, sometimes they watched the television and/or listened to the radio. She stated the residents liked to walk up and down the hall for exercise and when it was nice outside, they would go outside in the secure courtyard .</p> <p>In an interview on 04/09/2025 at 3:25 PM CNA F stated she did not work in the memory care unit, but she usually went back there to provide breaks to the CNA's when they asked. She stated the residents could have activities back there, but it did not take long for the residents to wander back into the day room. She stated the residents were usually in the day room when she provided breaks so the 1 staff could see all the residents .</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/09/2025 at 4:40 PM the AD stated she had been working at the facility for less than 6 months. She had been using the previous AD's activity calendar's and would adjust the activities as needed, but she did not utilize the activity calendar to provide activities to the memory care unit. She stated she did not have an activity log for the memory care unit because she did not do activities with them, but that she was responsible for doing activities with them. She stated the CNA in the memory care unit had recently painted 2 residents nails. The AD inquired with the state surveyor if activities should be done daily in the memory care unit to which the state surveyor recommended, she check with the ADM .</p> <p>In an interview on 04/10/25 at 9:16 AM the ADM stated they did some activities in the memory care unit, but it was not as much as the other population of residents. She stated she did not feel the posted activity calendar in the main area of the facility should apply to the MC unit because some activities were inappropriate for the ability levels of the residents in the MC unit. She stated that due to the state surveyors concerns a group activity was prompted to be done in the memory care unit at 11:00 AM on 4/10/25 .</p> <p>Review of the facility's policy titled SecureCare Activity Program dated last revised January 2023 reflected,</p> <p>The SecureCare Program will provide a robust therapeutic activity program to meet the individual needs of each resident, provide a safe environment that maximizes independence, and provides resident centered care. Therapeutic activity programs will promote a variety of engaging activities geared towards sensory stimulation and skill retention.</p> <ol style="list-style-type: none"> 1. The Activity Director and Director of Nursing or designee will work in conjunction to develop an organized therapeutic activity program for the SecureCare Program to include community resources and involvement within, as well as outside the health care center. 2. Each resident will have a therapeutic plan of care to meet individual needs and interests, maintain functional ADL skills, and provide social interaction, while protecting the resident from environmental over-stimulation. 3. The Activity Program will include small group activities and individual activities. 4. Programs should take place in mornings, afternoons and evenings that span throughout the entire week. 		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065</p> <p>Based on observations, interviews, 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 transmission of communicable diseases and infections for 4 of 4 resident (Resident #13, #14, #24, and #39) and 1 of 1 laundry carts reviewed for infection control.</p> <p>The facility failed to ensure MA B performed proper hand hygiene and sanitize contaminated medication cart and blood pressure equipment when passing medications on Resident #13, #14, #24, and #39.</p> <p>The facility failed to ensure laundry staff handled and stored linens in a manner to ensure cleanliness and protect from dust and soil to prevent cross-contamination and the spread of infections for 1 of 1 laundry carts.</p> <p>This failure could place residents at risk for development of communicable diseases and infections.</p> <p>Findings included:</p> <p>Record review of Resident 13's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (lung disease makes breathing hard), malnutrition, depression, anxiety, and heart disease.</p> <p>Record review of Resident #13's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 07, which indicated the resident's cognitive ability was severely impaired.</p> <p>Record review of Resident 13's Care Plan, reflected a focus area was initiated for Impaired cognitive function/dementia 7/25/2024 with a goal for the resident to be able to communicate basic needs and an intervention to administer medications as ordered.</p> <p>Record review of Resident #14's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of dementia, kidney disease, anemia, abnormal gait, depression, and heart failure.</p> <p>Record review of Resident 14's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 06, which indicated the resident's cognitive ability was severely impaired.</p> <p>Record review of Resident 14's Care Plan, reflected a focus area was initiated for Respiratory Infection on 1/31/25 with a goal for the resident to be free from signs and symptoms of infection.</p> <p>Record review of Resident 's 24 undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of diabetes type 2, depression, anxiety, stroke, falls, and muscle weakness.</p> <p>Record review of Resident 24 's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 02, which indicated the resident's cognitive ability was severely impaired.</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 - Some</p>	<p>Record review of Resident #24's Care Plan, reflected a focus area was initiated for a skin cellulitis infection on 4/1/25 with a goal for the resident to be free from complications related to infection.</p> <p>Record review of Resident 39's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of vascular dementia, stroke, anxiety, hypertension (high blood pressure), and cellulitis of lower limb.</p> <p>Record review of Resident 39's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 03, which indicated the resident's cognitive ability was severely impaired.</p> <p>Record review of Resident 39's Care Plan, reflected a focus area was initiated for impaired cognitive function/dementia with a goal for the resident to maintain current level of cognitive function.</p> <p>Observation on 04/08/25 at 01:14 PM to 1:25 PM revealed LS-1 pushing the uncovered laundry cart up and down the North Hall delivering linens to residents' rooms. LS-1 then took the cart into the secure unit with the cover still up.</p> <p>Observation on 04/09/25 at 08:45 AM revealed MA B removed a blood pressure cuff from the top of the medication cart and preceded into Resident #24's room to take her blood pressure. MA B touched the resident's arm then returned to work on the medication cart to prepare the medications. She placed the uncleaned blood pressure cuff on top of the cart. After preparing the medications, she returned to the resident, and gave the medications. She then returned to the medication cart to move to the next resident without performing hand hygiene.</p> <p>Observation on 04/09/25 at 08:53 AM revealed MA B removed an uncleaned blood pressure cuff from the top of the medication cart and preceded into Resident #14's room to take her blood pressure. MA B touched the resident's arm then returned to work on the medication cart to prepare the medications. She placed the uncleaned blood pressure cuff on top of the cart. After preparing the medications, she returned to the resident, and gave the medications. She then returned to the medication cart to move to the next resident. She performed hand hygiene here but did not clean the blood pressure cuff or the medication cart top.</p> <p>Observation on 04/09/25 at 09:10 AM revealed MA B removed an uncleaned blood pressure cuff from the top of the medication cart and preceded into Resident #13's room to take his blood pressure. MA B touched the resident's arm then returned to work on the medication cart to prepare the medications. She placed the uncleaned blood pressure cuff on top of the cart. After preparing the medications, she returned to the resident, and gave the medications. She then returned to the medication cart to move to the next resident without performing hand hygiene.</p> <p>Observation on 04/09/25 at 09:23 AM revealed MA B removed a blood pressure cuff from the top of the medication cart and preceded into Resident #39's room to take his blood pressure. MA B touched the resident's arm then returned to work on the medication cart to prepare the medications. She placed the uncleaned blood pressure cuff on top of the cart. After preparing the medications, she returned to the resident, and gave the medications. She then returned to the medication cart to move to the next resident without performing hand hygiene.</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 - Some</p>	<p>Observation on 04/09/25 at 10:16 AM to 10:24 AM revealed LS-J pushing the partially uncovered laundry cart up and down the North Hall delivering linens to resident rooms. LS-J then took the cart into the Secure unit and the cover was then lifted completely, leaving the clothes open while she delivered clothes to the rooms. The residents had full access to the clothes and linens on the cart.</p> <p>In an interview on 4/8/25 at 01:50 PM LS-I stated, she worked the laundry area 2 days a week and she stated she kept the cart covered when travelling to the halls, but when she started delivering laundry to the rooms down the hall, she left the cart uncovered because the rooms were close together. She stated, laundry should be covered to protect it from germs and that was done because the residents could get sick if you did not.</p> <p>In an interview on 4/9/25 at 09:23 AM MA B stated, the policy on cleaning equipment between residents was to clean after every 2-3 residents and that was important to prevent the spread of infection and illnesses. She stated the policy on hand hygiene was to clean between each resident to stop the spread of infections. She stated if this was not done residents could get infections and get sick.</p> <p>In an interview on 4/9/25 at 01:50 PM LS-J stated, she normally delivered the laundry with the top down, and she slid it over so she can see what room to go to. She stated the policy was to keep linen carts always covered to prevent cross-contamination that could make residents sick.</p> <p>In an interview on 4/10/25 at 01:32 PM CNA G stated, the policy on hand hygiene between residents was to perform hand hygiene between residents and the policy on cleaning equipment between residents was to clean between residents. She stated it was important to clean hands and equipment for infection control and the negative outcome if that were not done was residents could get an infection or illness. She stated the policy for delivering linens was to keep the cart covered and that was important to keep them clean so residents would not get illnesses.</p> <p>In an interview on 4/10/25 at 01:43 PM LVN H stated, the policy on hand hygiene between residents was to hand sanitize between each resident for 2 times then hand wash the next time and the policy on cleaning equipment between residents was you need to use purple wipes between residents to clean and allow it to sit the appropriate time to dry. She stated it was important to clean hands and equipment because of infection control and the negative outcome if that were not done could be infections or sepsis that could lead to death. She stated the policy for delivering linens was linens were supposed to be always covered and that it was important to keep linens covered during transport because of infection control. She stated, and the negative outcome if that were not done could be infections or sepsis that could lead to death.</p> <p>In an interview on 4/10/2025 at 1:50 PM the ADM stated, the policy on hand hygiene between residents was that staff were required to do hand hygiene always between residents-100% of the time. He stated the policy on cleaning equipment between residents was that it was required 100% of the time. He stated it was important to clean hands and equipment between residents because it could cause infection to spread if not done and could cause death. He stated the policy for delivering linens was to keep them covered during transport for infection control and the negative outcome to residents if linens were not covered could be infections.</p> <p>A record review of the facility policy titled, Fundamentals of Infection control Precautions-Hand Hygiene: Dated 2019 with a last revision date of 3/2024 reflected the following:</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 - Some</p>	<p>Hand hygiene continues to be the primary means to prevent the spread infections.</p> <p>Hand Hygiene is required upon and after meeting a resident's intact skin (when taking a blood pressure).</p> <p>Hand Hygiene is required after handling soiled equipment.</p> <p>A record review of the facility policy titled, Linens with a date of 2018 reflected the following:</p> <p>Transport bulk clean linen to resident's rooms in a clean, covered cart.</p> <p>All clean linen will be stored in a secured area. The linen cart will be covered.</p> <p>Per facility, there was no policy specific to sanitizing equipment between residents.</p>