STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676023	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keller Oaks Healthcare Center	8703 Davis Blvd Keller, TX 76248

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 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** 45054 Based on interview and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices for 1 resident (Resident #1) of 6 residents reviewed for clinical records. -The facility failed to completely and accurately document Resident #1's weekly skin assessments and any follow-up assessments relating to new bruises documented on the shower sheets, which would indicate details of the bruises and care as necessary. This failure could place all residents at risk of having skin conditions that are untreated and having incomplete and inaccurate records, which could lead to harm. Findings include: Record review of Resident #1's face sheet, dated 09/23/24, revealed she was an [AGE] year-old female who admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: metabolic encephalopathy (change in brain function), dementia (loss of memory and thinking abilities), muscle weakness, lack of coordination, and abnormalities of gait and mobility. Record review of Resident #1's Admission MDS Assessment, dated 08/09/24, revealed the resident had BIMS score of 3 which indicated her cognition was severely impacted. Resident #1 required partial/moderate assistance with most ADLs. Record review of Resident #1's care plan, revised on 08/15/24, revealed the resident was at risk for falls r/t poor balance with interventions that included therapy evaluation, keeping call light within reach, determining causation of falls, monitoring/documenting/reporting to MD s/x of pain, bruises, change in mental status, and providing activities that promote exercise and strength building where possible. Record review of Resident #1's weekly skin assessments, from 08/15/24-09/12/24, revealed the following: -08/08/24 (admission) - Bruising to BUE (Bilateral (both sides) upper extremities) -08/15/24 - No open skin areas (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-08/22/24 - No skin issues -08/29/24 - No skin issues -09/05/24 - No skin issues -09/12/24 - Scattered bruises to upper and lower extremities, no open areas; [Resident #1] was doing group activity when this nurse [LVN B] notice a bruise to right arm. Question [Resident #1] and she stated that she didn't know, or she may have bump it somewhere. This nurse [LVN B] notified [family] and the [family] stated that she seen that, and it was ok but [Resident #1] c/o shoulder pain. This nurse [LVN B] examine arm but [Resident #1] refused and got agitated and stated she is fine (leave me alone). Notified [NP] and she told me to monitor it. Record review of Resident #1's incident report for injury of unknown origin, dated 09/12/24, completed by LVN B revealed the following: Resident: [Resident #1] Incident location: Unknown Person preparing report: [LVN B] Nursing description: [Resident #1] has a bruise to right upper arm, no pain voiced when examine. Resident description: [Resident #1] stated she do not know how it got their [sic]. [Resident #1 stated she may have hit her arm somewhere. Was this incident witnessed: No Description: head to toe assessment, pain, loc, skin . Predisposing physiological factors: none Predisposing situation factors: none Persons notified: 1) [NP]- stated to monitor it. 2) [Family]-stated she knew and was concern about pain to right shoulder. 3) [LVN E]-monitor the area Record review of Resident #1's shower sheets, from 09/2024, reflected the following: -09/02/24 - no skin issues documented -09/06/24 - bruise to back of upper right arm documented -09/11/24 - bruises to front of both thighs (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-09/13/24 - shower refused; skin observation not completed Record review of Resident #1's nurses progress notes reflected there was no documentation on 09/11/24 about an assessment or notification to appropriate parties regarding the bruises found on the Resident #1's thighs by CNA C during the resident's shower on this date. Record review of Resident #1's nurses progress notes, dated 09/12/24 at 1:18 PM by LVN B, reflected: [Resident #1] has a bruise to right upper arm, no pain or distress noted, [Resident #1] stated she don't know how this happen and she may have it [sic] it on something. Notified doctor, rp, [LVN D] Record review of Resident #1's nurses progress notes reflected there was no documentation on 09/12/24 by LVN B about an assessment or notification to appropriate parties regarding bruises found on the Resident #1's thighs. Record review of Resident #1's physician orders reflected the following: -Aspirin 81mg oral tablet chewable-give 1 tablet by mouth one time a day for analgesic (for pain). Start date: 08/0924; End date: 09/15/24. -Clopidogrel Bisulfate Oral tablet 75mg-give 1 tablet by mouth one time a day for hematologic disorder (blood disorder). Start date: 08/0924; End date: 09/15/24. Record review of in-service titled Skin, dated 09/15/24, reflected all staff were educated on notifying the MD and family of anu skin issues and change of condition, monitoring orders, and documentation. Record review of in-service titled Shower sheets, dated 09/17/24, reflected all staff were educated on how to properly complete shower sheets regarding legibility and appropriate documentation, including identifying any bruises or other skin issues. In an interview on 09/20/24 at 12:38 PM, CNA C stated she worked at the facility for 1.5 years. CNA C stated she worked with Resident #1 on 09/11/24. She stated she gave the resident a shower on that day and completed a shower sheet. CNA C stated Resident #1 always had scattered bruises on her body because she was always moving around and was sometimes combative towards other residents. CNA C stated she cold vaguely recall Resident #1 having a more significant bruise on her upper right arm and a yellow bruise on one of her thighs. CNA C could not recall if she reported the bruises to the nurse. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/20/24 at 01:03 PM, LVN A stated she worked at the facility since 03/2024. LVN A stated she worked with Resident #1 on 09/14/24, the day she discharged from the facility. LVN A stated she completed a head-to-toe assessment of Resident #1 before she left the facility and found a large bruise on the middle part of the resident's rights arm, a lot of age spots, scattered small red dots, a yellowish bruise on abdomen, and large bruises on the front of both thighs. LVN A stated when the aides give the residents showers, they are supposed to document any new skin issues and immediately report it to the nurse. LVN A stated she did not know where the bruises came from and denied receiving reports of Resident #1 having any incidents or new skin issues. LVN A stated the large bruises on Resident #1 caught her by surprise as she was unaware of them. In an interview on 09/23/24 at 09:18 AM, LVN B stated she worked at facility since 06/2024. LVN B stated she worked with Resident #1 on 09/12/24 and completed a head-to-toe assessment on the resident after a therapist reported seeing a bruise on her right arm. LVN B stated during the assessment she found a large bruise on Resident #1's upper right arm, scattered bruising, and brown spots on Resident #1's skin. LVN B stated she completed an incident report for the bruise on Resident #1's arm because it was significant, and no one knew how it happened. LVN B denied seeing significant or large bruises on Resident #1's thighs, only small, scattered ones, which was normal for the resident because she wandered a lot, bumping and hitting walls. In an interview on 09/23/24 at 11:30 AM, the NP stated she was not aware of any concerns for abuse of Resident #1. The NP stated she was aware that Resident #1 admitted to the facility with multiple bruises on her body and the resident had a history of bruising easily due to the use of blood thinners. The NP stated she was notified on 09/12/24 by LVN B that Resident #1 had a large bruise on her right arm, and she ordered an X-ray that was negative for injury. The NP stated on 09/14/24, LVN A completed a discharge skin assessment on Resident #1 and found scattered bruises to abdomen, back, arm, and thighs. The NP stated LVN A notified her and sent pictures. The NP stated Resident #1 discharged on the same day and she did not get a chance to assess her; however, if the resident remained at the facility, she would have ordered labs and an ultrasound to check for hematomas due to the resident's use of blood thinners. The NP stated it was possible for the blood thinners to cause smaller bruises to spread and become larger. The NP could not recall being made aware of any bruises on other dates. In an interview on 09/23/24 at 02:44 PM, the DON stated all residents received skin assessments each week and as needed. The DON stated the importance of head-to toe skin assessments was for the nurses to identify any wounds, rashes, discoloration, bruises, or anything potentially going on with the residents. The DON stated it was also important for the aides and nurses to accurately document the skin assessments, shower sheet, incident reports, and progress notes to reflect exactly when and what was found on the residents so that appropriate treatment can be provided. In an interview on 09/23/24 at 03:33 PM, the Administrator stated it was the expectation for complete and accurate documentation to be done for all residents, and for it to be objective and timely. The Administrator stated the risk of not having complete and accurate clinical records could be the residents not receiving appropriate continuum of care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/07/24 at 12:45 PM with the DON and the Administrator, the Administrator stated the expectation was for the CNAs to document on the shower sheet and report and changes/skin issues to the charge nurse, then for the charge nurse to assess and see if further investigation or care was needed. The Administrator stated if the nurse did not see anything suspicious in nature after the assessment, they would sign-off on the CNA's shower sheets to indicate that follow-up was completed with no concerns. The DON stated after a nurse signed off on a shower sheet, there was no need to document a separate clinical note or skin assessment unless there were concerns, then the documentation needed to be accurate and thorough. The DON stated there had been issues with the nurses' documentation and there had already been education provided to all staff. Review of the facility's policy titled Nursing Clinical: Charting and Documentation, revised 05/2024, revealed in part the following: Definition of record: The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Is also necessary to include data needed for identification and communication with family and friends. Complete history of resident and present illness is required under current law and regulations at the time of admission. . Rules for charting: 1. Notes are to be written on all long-term residents by day, evening, and night shifts; frequency is determined by the individual nursing service. 2. Daily notes are required as the necessary arises. 3. The admitting nurse to complete an admission assessment.