

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/31/2026
NAME OF PROVIDER OR SUPPLIER  Keller Oaks Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 3 Residents (Resident #1, Resident #2, Resident #3) observed for infection control. 1.The facility failed to ensure PTA B, CNA C and RN A utilized enhanced barrier precautions during incontinent care and gait belt transfer on Resident #1 on 03/31/26. 2. The facility failed to ensure CNA C performed hand hygiene during incontinent care on Resident #2 on 03/31/26. 3. The facility failed to ensure CNA D performed glove changes and hand hygiene during incontinent care on Resident #3 and Staffing Coordinator failed to prevent cross contamination of Resident #3 oxygen cannula, and CNA D and Staffing Coordinator to perform hand hygiene after incontinent care before leaving Resident #3's room on 03/31/26. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record Review of Resident #1's Face Sheet dated 03/31/26 reflected a [AGE] year-old female with an admission date of 01/22/25. Her diagnoses included pressure ulcer of sacral (buttocks) region, cerebral infarction (stroke), dysphagia (difficulty swallowing) and gastrostomy status (artificial opening into the abdomen for a feeding tube). During an observation on 03/31/26 at 10:35 a.m. with Resident #1 in her room, the resident was observed on a low air loss mattress. Resident #1 was observed to have a G-tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) and a PICC (a line inserted into an arm vein threaded to a large vein near the heart) line in her upper left arm. The resident was non-verbal but smiled in response to questions. There was an enhanced barrier precautions sign posted outside of Resident #1's room which indicated she was in enhanced barrier precautions for high contact care. During an observation on 02/21/2026 at 1:25 p.m. revealed PTA B and CNA C completing incontinent care on Resident #1 and preparing the resident to get up for physical therapy. PTA B and CNA C had on gloves but no gown. RN A entered the room, performed hand hygiene and put on gloves but no gown and disconnected the feeding tube from the resident so PTA B could transfer Resident #1 to her wheelchair. PTA B, with assistance of CNA C, sat the resident on the side of the bed and PTA B placed a gait belt around the resident and performed a one-person gait belt transfer from her bed to the wheelchair. During an interview on 03/31/26 at 1:40 p.m. with RN A, PTA B and CNA C, they all stated they had received training on enhanced barrier precautions and stated any resident who had a wound, g-tube or any other medically inserted device required enhanced barrier precautions. They all stated the risk was the spread of drug-resistant organisms and acknowledged they should have had a gown on during Resident #1's care since it was considered high contact care. 2. Record review of Resident #2's face sheet, dated 03/31/26, reflected a [AGE] year-old female admitted [DATE], diagnosis included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production), chronic obstructive pulmonary disease (lung disease causing obstructive air flow) and overactive bladder (causes a sudden, uncontrollable urge to urinate). During an interview and observation with Resident #2 on 03/31/26 at 1:50 p.m. Resident #2 was observed in her room lying in bed. CNA C entered the room and told Resident #2 she was there to provide her (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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>expected to follow those protocols. She stated they trained and did in-services constantly on infection control. She stated she had tried to teach enhanced barrier precautions in the simplest to understand way, and stated the sign clearly tells the staff what is considered high-contact care if they don't remember. She stated anytime oxygen cannula was found on the floor the staff was to discard it and replace it with a new cannula. She stated she would be doing skills checks and re-education with the staff on overall infection control. Record review of the facility's policy titled, IPCP Standard and Transmission-Based Precautions, revised October 2022, reflected, .It is the policy of this facility to implement infection control measure to prevent the spread of communicable disease and conditions. Enhanced Barrier Precautions (EBP) expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDRO's to staff hands and clothing then indirectly transferred to residents or from resident-to- resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs) .Examples of high-contact resident care activities requiring gown and glove use.transferring.changing briefs.Device care or use.feeding tubes. Record review of the facility's policy titled, Hand Washing reflected, It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for resident's and staff. Hand washing/hand hygiene is generally considered the most important single procedure for preventing nosocomial infections.Some situations require hand washing in areas where sinks are not readily available. In these circumstance, waterless hand-washing products may be used.</p>		