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	06/18/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of four residents (Resident #1) reviewed for catheter and incontinence care. The facility failed to ensure staff provided Resident #1 timely perineal care after an incontinent episode when they failed to check and change the resident from 06:00 a.m. to 9:35 a.m. on 06/18/26. This failure could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections.Findings included: Record Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female with an admission date of 11/05/25. She had a BIMS score of 7 which indicated she was severely cognitively impaired. She was always incontinent of bowel and bladder and was dependent for toileting assistance. Her diagnoses included chronic obstructive pulmonary disease (lung disease causing obstructive air flow) and diabetes. Record review of Resident #1's care plan with a revision date of 12/05/25 reflected, Has bowel/bladder incontinence related to overactive bladder.Goal-Will remain free from skin breakdown due to incontinence.Interventions-Incontinent: Check as required for incontinence. Wash, rinse and dry perineum. During an interview and observation with Resident #1 on 06/18/2026 at 09:35 a.m. Resident #1, was observed in her room lying in bed. CNA B entered the room and told Resident #1 she was here to provide her with incontinent care. Resident #1 was asked if she consented to the surveyor observing the care and she stated, yes, CNA B then performed hand hygiene and put on gloves and assisted Resident #1 onto her back. CNA B uncovered the resident revealing she had soaked through her brief onto the bed pad. The edges of the urine stain were light brown and had begun to dry. CNA B unfastened the resident's brief revealing her brief was saturated with urine. CNA B wiped from front to back down each groin and then down the middle and assisted the resident onto her side, removed the soiled brief and wiped the resident's buttocks area from front to back. There was no skin breakdown or redness noted. CNA B then placed the clean brief and a clean bed pad under the resident. CNA B then fastened the brief and repositioned the resident. During an interview with CNA B on 06/18/26 at 9:45 p.m. she stated this was the first time she had changed Resident #1 since coming on duty at 06:00 a.m. today (06/18/26). She stated she thought the night shift aide had changed her close to 06:00 a.m. but stated she was not sure since she was so wet. She stated they were expected to check and change any incontinent resident every 2 hours and change them as needed. She stated the risk of not changing them timely was a risk of urinary tract infections and skin problems. During an interview with the DON on 06/18/26 at 11:30 a.m. she stated any resident who was incontinent of bowel and bladder needed to be checked for incontinence every 2 hours and changed as needed. She stated by not providing timely incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. She stated they were going to have to increase their monitoring to ensure residents were getting changed timely. During an interview with Resident #1 on 06/18/26 at 3:08 p.m. she stated she could not remember what time she was changed on the night shift. She stated she rarely soaks through her brief. She stated the staff were usually (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	good about changing her timely. During an Interview with Administrator on 06/18/26 at 3:10 p.m. she stated they had recently increased their staffing and had been doing additional training on activities of daily living care and infection control. She stated they had added additional observations and tasks to be done during their Angel rounds with an emphasis on resident hygiene and quality of life. She stated they were going to start doing more one on one observations with the staff, instead of just classroom education. She stated the expectation was all the residents' hygiene needs were provided timely to prompt dignity and comfort. Record review of the facility's policy titled, Perineal Care, revised May 2025, reflected, It is the policy of this facility to: Cleanse the perineum, Eliminate odor, Prevent irritation or infection, Enhance resident's self-esteem.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 4 Residents (Resident #1 and Resident #2) observed for infection control. 1. The facility failed to ensure CNA B performed hand hygiene during incontinent care on Resident #1 on 06/18/26. 2.The facility failed to ensure CNA B utilized Enhanced Barrier Precautions and performed hand hygiene during incontinent care Resident #2 on 06/18/26. These failures could place the residents at risk of cross-contamination and development of infection.Findings included: 1. Record Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female with an admission date of 11/05/25. She had a BIMS score of 7 which indicated she was severely cognitively impaired. She was always incontinent of bowel and bladder and was dependent for toileting assistance. Her diagnoses included chronic obstructive pulmonary disease (lung disease causing obstructive air flow) and diabetes. During an interview and observation with Resident #1 on 06/18/2026 at 09:35 a.m. Resident #1, was observed in her room lying in bed. CNA B entered the room and told Resident #1 she was there to provide her with incontinent care. Resident #1 was asked if she consented to the surveyor observing the care and she stated, yes, CNA B then performed hand hygiene and put on gloves and assisted Resident #1 onto her back. CNA B unfastened the resident's brief revealing her brief was saturated with urine with had soaked through to the bed pad. CNA B wiped from front to back down each groin and then down the middle and assisted the resident onto her side, removed the soiled brief and wiped the resident's buttocks area from front to back. CNA B then changed her gloves but did not perform hand hygiene and placed the clean brief under the resident. CNA B then fastened the brief, repositioned the resident and removed her gloves and then performed hand hygiene. During an interview with CNA B on 06/18/26 at 9:45 p.m. she stated she was supposed to do hand hygiene before and after incontinent care but then stated she should have done it after she finished cleaning the resident and changed her gloves. She stated the risk of not doing hand hygiene was the spread of germs and infection. 2. Record Review of Resident #2's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male with an admission date of 11/29/25. He had a BIMS score of 12 which indicated he was moderately cognitively impaired. He was occasionally incontinent of bowel and bladder and was dependent for toileting assistance. His diagnoses included chronic obstructive pulmonary disease (lung disease causing obstructive air flow) cerebral vascular accident (stroke), dementia and venous ulcers (slow healing open wounds caused by damaged vein valves). During an observation and interview on 06/18/26 at 09:50 a.m. with Resident #2 revealed an Enhanced Barrier sign posted outside of Resident #2's room which indicated he was on Enhanced Barrier precautions for high contact care. Resident #2 was observed lying in bed. He had a gauze wrap around the lower portion of his right leg and a large fluid filled blister on his left leg. Resident stated he had dealt with the wounds on his legs for long time. He stated the blisters would pop up and once they popped they would drain until they closed up. He stated this was a chronic condition. He stated he also had areas on the back of both of thighs the facility had been treating and they were improving. He stated he took fluid pills and was a heavy wetter right after breakfast and after he took his medications. During an observation on 06/18/26 at 9:55 a.m. revealed CNA B entered Resident #2's room to perform incontinence care and get him up for the day. CNA B performed hand hygiene and put on gloves but no gown. CNA B unfastened the resident's brief and provided peri care, changing the wipes with each wipe. Resident rolled onto his side and CNA B wiped from the front to back, cleaning the resident's buttocks and upper thighs. There was a dressing in place on both the resident's upper thighs. CNA B then changed her gloves without performing hand hygiene and picked up the clean brief. She then stated, I forgot to wash my hands, and removed her gloves and performed hand hygiene. CNA B then (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed the brief on the resident and fastened the brief. CNA B then pumped lotion onto her gloved hands and rubbed lotion on the resident's lower legs, around the dressing on his right leg and around the blister on his left lower leg. CNA B then removed her gloves and put on clean gloves without performing hand hygiene and dressed the resident and assisted him into his wheelchair. CNA B then removed her gloves and performed hand hygiene. During an interview on 06/18/26 at 10:00 a.m. with CNA B she stated she remembered she was supposed to perform hand hygiene after she had cleaned the resident but stated she did not realize she had not performed hand hygiene after she put on the lotion and changed her gloves. She then realized she had forgotten to wear a gown during Resident #2's care. She stated she had received training on enhanced barrier precautions and stated any resident who had a wound required enhanced barrier precautions. She stated the risk was the spread of infection and acknowledged she should have had a gown on during Resident #2's care since it was considered high contact care. During an interview with the DON on 06/18/26 at 11:25 a.m. she stated staff were to change their gloves and perform hand hygiene before going from dirty to clean, before entering a resident's room and before leaving a resident's room. She stated all residents who were on Enhanced Barrier Precautions had signs posted on their doors and the staff were expected to follow those protocols. She stated they train and do in-services constantly on infection control. She stated the sign clearly tells the staff what is considered high contact care if they don't remember. She stated she was really disappointed since they had done so much training. 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. Record review of the facility's policy titled, Hand Washing , revised July 2025, 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.