

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 03/28/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177</p> <p>Based on observation, interview, and record review the facility failed to provide services to residents with reasonable accommodation of resident needs and preferences by not providing a call light system within reach for 2 of 31 (Residents # 1 & #2) observed for call lights.</p> <p>The facility failed to ensure Residents #1 and #2 had a call light within reach to communicate to staff they needed assistance.</p> <p>This failure affected residents by placing them at risk for not getting their needs met and diminishing their quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #1's Face Sheet, dated 3-26-2024, revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of calculus of gallbladder and bile duct with acute cholecystitis with obstruction (gallstone blockage) and secondary diagnosis of enterocolitis (intestines inflammation) due to clostridium difficile (a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) recurrent, gait/mobility abnormality (the pattern one walks), and dementia (loss of brain function).</p> <p>Record review of Resident #1's MDS (a standardized assessment tool that measures health status in nursing home residents), dated 11-22-2023, indicated a BIMS Score of 12, indicating Resident #1 had a moderate cognitive impairment. The MDS indicated Resident #1 needed Substantial/maximal assistance - (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene, shower/bathe self, putting on/take off footwear, and personal hygiene.</p> <p>In an observation/interview, of Resident #1, on 3-26-2024, at 10:30 AM, revealed Resident #1 was in pain distress and needing assistance. Resident #1 stated she did not know where her call light was. Resident #1 stated she knows how to use the call light and does. Observation revealed Resident #1's call light was drooped down, on the right side of Resident #1's bed, touching the floor. Resident #1 stated not being able to reach her call light caused her to feel worried she could not get help.</p> <p>Record review of Resident #1's, doctor surgical note, revealed Resident #1 had surgery on her (left foot/left 2nd toe) to drain an abscess on 3-25-2024.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA-E, on 3-26-2024, at 10:35 AM, revealed the concern for Resident #1 not having her call light within reach as Resident #1 could not call the nursing staff for help as she was in pain.</p> <p>In an observation/interview with ADON-D, on 3-26-2024, at 10:40 AM, ADON-D was informed of Resident #1 being in pain and not having her call light within reach. ADON-D revealed the nurses are responsible to ensure call lights of residents are within reach. ADON-D stated this was important because it is the main way residents can let staff know they need help. ADON-D was observed giving pain medicine to Resident #1.</p> <p>Record review of Resident #1's care plan, dated 3-10-2024, indicated Resident #1 is at risk for falls and stated, be sure the call light is within reach and encourage to use it to call for assistance as needed.</p> <p>Record review of Resident #1's nursing notes, dated 3-26-2024, revealed Resident #1 fell just 10 hours prior to this observation, while getting into/out of bed.</p> <p>Record review of Resident #2's face sheet, dated 3-27-2024, indicated a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had a primary diagnosis of dementia, and secondary diagnosis of right artificial hip joint, abnormalities of gait and mobility, need of assistance with personal care, and anxiety disorder.</p> <p>Record review of Resident #2's MDS, dated [DATE], revealed a BIMS score of 03, indicating significant cognitive impairment with a functional impairment rating of 3 (Extensive assistance - resident involved in activity, staff provide weight-bearing support) for transfers, toileting, bed mobility, and dressing. Record review of Resident #2's care plan dated, 03-15-2023, indicated Resident #2 had ADL self-care deficit due to right shoulder/right hip fractures requiring extensive assistance bathing, personal hygiene, and dressing. Record review of Resident #2's care plan revealed she was at risk for falls stating, Be sure the call light is within reach and encourage to use it to call for assistance as needed.</p> <p>In an observation/interview, on 3-27-2024, at 12:15 PM, revealed Resident #2 did not know where her call light was and that she uses her call light. Observation showed Resident #2's call light was dangling, on the left side of Resident #2's bed on the floor, while Resident #2 was sitting in a wheelchair, on the right side of her bed. Resident #2 said not being able to find her call light made her feel alone.</p> <p>In an interview with RN-A, on 3-27-2024, at 12:20 PM, it was revealed the concern for Resident #2, not being able to reach her call light, was Resident #2 could have been in distress and not be able to contact the nursing staff for help.</p> <p>In an interview with the DON, on 3-27-20245, at 3:00 PM, it was disclosed that the concern for residents, not having their call lights within reach, was they will not be able to get help when needed. The DON stated every direct care staff is responsible for ensuring call lights are within reach for each resident. The DON said the facility ensures call lights are within reach of each resident by teamwork and communication between staff members. The DON stated the facility provides education to ensure staff understand the importance of call lights being within reach of residents.</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 - Few</p>	<p>In an interview with the Administrator, on 3-28-2024, at 5:40 PM, it was revealed that her expectation, concerning call lights being within reach, was to follow the facility's call light policy and for the call lights to be within reach of the resident, before the staff member leave the resident's room.</p> <p>The Administrator stated that the CNAs work under the license of the nurses, so the nurses are responsible to follow up behind the CNAs ensuring call lights are placed within reach of residents.</p> <p>Record review of the facility's call light policy, dated 8-2020, stated it is the policy of this facility to provide the resident a means of communication with nursing staff by</p> <ol style="list-style-type: none"> 1 - Answering the light/bell within a reasonable time frame 2 - Turn off the call light/bell 3 - Listen to the residents need 4 - Respond to the request . 5 - Leave the resident comfortable. Place the call device within resident's reach before leaving room .

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not 5 percent (5%) or greater for 2 of 25 opportunities resulting in an 8 percent medication error rate for 2 of 6 residents reviewed for medication administration.</p> <p>Facility failed to ensure Resident #80's and Resident #223's medications were administered as physician ordered as whole pills.</p> <p>Facility failed to ensure Resident #80's and Resident #223's medications were not crushed and mixed into a cocktail without a physician order.</p> <p>These failures could place residents at risk for significant medication errors and jeopardize the resident health and safety.</p> <p>Finding included:</p> <p>Review of Resident #80's admission record, dated 03/27/24, revealed a [AGE] year-old female admitted to the facility 03/13/24. Her diagnoses included bilirubin disorder, muscle weakness, major depressive disorder with recurrent, severe psychotic symptoms, unsteady on feet, dementia in other diseases, severe, with psychotic disturbance, schizotypal disorder (this is a mental health disorder), and fracture of unspecified part of neck of right femur (right hip fracture).</p> <p>Review of Resident #80's physician order summary dated 03/27/24, reflected Acetaminophen-Codeine Oral, Tablet 300-30 MG (Acetaminophen w/ Codeine) Give 1 tablet by mouth two times a day for pain r/t hip fracture until 03/29/2024 11:59 PM Start Date-03/24/2024 7:00 PM. Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for Depression AEB social isolation related to major depressive disorder, recurrent, severe with psychotic symptoms-start date-03/15/2024 0700 AM.</p> <p>Oxcarbazepine Oral Tablet 300 MG (Oxcarbazepine) Give 1 tablet by mouth two times a day related to major depressive disorder, recurrent, severe with psychotic symptoms -start date-03/14/2024 0700 AM.</p> <p>Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1.5 tablet by mouth two times a day for schizotypal disorder.</p> <p>AEB Physical Aggressions related to schizotypal disorder-Start Date- 03/21/2024 7:00 PM. The order summary did not reflect a physician's order to crush and mix medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #223's admission record dated 03/27/24, revealed a 75-year male admitted to the facility on [DATE]. His diagnoses included sebaceous Cell carcinoma of right lower eyelid including canthus (this is a type of cancer of the eyelid and surrounding skin), atherosclerotic heart disease of native coronary artery without angina pectoris (this a heart disease in the walls of arteries that are blocked by plaque buildup without chest pain), cerebral infarction due to unspecified occlusion or stenosis left posterior cerebral artery (this is a stroke as a result of disrupted blood flow to the left side of the brain), stroke affecting right dominant side, presence of prosthetic heart valve (artificial heart valve), adult failure to thrive, unspecified severe protein-calorie malnutrition, and hypertension (high blood pressure).</p> <p>Review of Resident #223's physician order summary dated 03/27/24, reflected Aspirin 81 Oral Tablet Chewable (Aspirin) Give 1 tablet by mouth one time a day for heart health, Ferrous Sulfate [Iron] Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for iron supplement, Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for elevated blood pressure Hold for sbp Less than 100; dbp Less Than 60 or hr Less than 60. if held for 3 consecutive doses notify MD, Nifedipine ER Oral Tablet Extended Release 24 Hour 30 MG (Nifedipine) Give 1 tablet by mouth two times a day for elevated blood pressure Hold for sbp Less than 100; dbp Less Than 60 or hr Less than 60. if held for 3 consecutive doses notify MD. The order summary did not reflect a physician order to crush and mix Medications.</p> <p>Observation and interview during medication observation with LVN A on 03/27/24 at 08:25 AM revealed LVN A has worked at the facility for three weeks. She checked Resident #223's blood pressure reading 138/72, Pulse 72. LVN A crushed all medications and mixed them with 1 spoon of vanilla pudding and administered to Resident #223. LVN A said that she crushed the medications because the resident was on a mechanical soft diet. She said that there was no order to crush medication, but she was told in report that resident's medications were to be crushed. LVN A said she knew not to crush a medication that said Extended Release (ER) if a contraindication was noted in the MAR, she would not have crushed it. She said the risk for crushing an ER medication and administering to resident was that the medication would get absorbed faster and could drop residents blood pressure or heart rate. She said that she would monitor Resident #223 and notify the physician and get an order to crush the medications.</p> <p>Observation and interview with LVN B on 03/27/24 at 09:35 AM, revealed LVN B crushed all medications for Resident #80 and mixed them in chocolate pudding and administered medications to Resident #80. LVN B said that ever since Resident #80 was readmitted (03/13/24), she started having a hard time taking her medications. LVN B said that she thought Resident #80 had orders to crush all her medications because they had been crushing them. She said that she would obtain an order. She said Resident #80 should have had an order to crush medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with DON on 03/27/24 at 02:26 pm revealed that she expected nurses to use their judgement and crush residents' medications when needed. She said that the facility policy said to use nursing judgment to crush medication. She said the only exception was if medication was marked with DO NOT Crush or if physician said not to crush. DON said, what about potassium, it comes in powder, its crushed. She said if there was a medication error nurses would notify the physician, the resident, and their family, and she would be notified as well. She said that she was aware of Resident #223's incident. DON did not say anything about Resident #80's incident. DON said that she spoke with her medical director and was told to do as their policy recommended and their policy stated, use nursing judgement. DON said only on gastral tube (g-tube) was medication orders specific on crushing and not mixing medications together.</p> <p>Interview with ADON on 3/28/24 at 09:48 AM, revealed that LVN A notified her that Resident #223 had been given an ER medication that was crushed on 03/27/24 but she was not aware about Resident #80's incident with LVN B.</p> <p>ADON said she told LVN A to monitor Resident #223's vitals and orientation. ADON said that she went in to see Resident #223 to see if he was showing any signs and symptoms of increased confusion, lethargy, or dizziness (these are adverse effects) and he did not exhibit any. She said that her expectation was the nurse would verify orders before administering and before crushing any medications. She said she expected nurses and all staff to report incidents immediately. ADON said if there was a medication error nurse would be expected to notify the physician, the resident, their family or POA, herself, the DON and Administrator. She said the risk for crushing medications that should not be crushed such as ER medication was that a resident could get a burst of the medication at once.</p> <p>Interview with administrator on 03/28/24 at 05:39 pm revealed that she did not feel it was fair for surveyor to interview her about clinical medication error and the error rate and referred surveyor to interview the DON again. She said she did not understand that it was a medication error from the clinical staff standpoint.</p> <p>Review of facility policy titled Medication Pass Policy and Procedure dated 04/2008, reflected .know diagnoses and indication for every medication. A change in form of medication (e.g., from tab to liquid) requires a change of physician's order .Remember: DO NOT CRUSH medications may be crushed only if a physician's order is obtained. Recommend the order be specific and allow for nursing judgment. Use the word may in order (e.g., may crush meds or may add to applesauce) .If the prescription label and MAR are different and the container is not flagged to indicate a change, the physician's order must be checked to confirm order prior to administration. Once verified, the nurse is responsible for applying a change label to the medication container .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observations, interview, and record review the facility failed to ensure that residents are free of any significant medication errors for one (Resident # 223) of six residents reviewed for medication administration.</p> <p>Facility failed to verify Resident #223's Nifedipine Extended Release 12-hour blood pressure medication could be crushed without a pharmacist review or a physician order.</p> <p>This failure could place residents at risk for significant medication errors and jeopardize the resident health and safety.</p> <p>Finding included:</p> <p>Review of Resident #223's admission record dated 03/27/24, revealed a 75-year male admitted to the facility on [DATE]. His diagnoses included sebaceous Cell carcinoma of right lower eyelid including canthus (this is a type of cancer of the eyelid and surrounding skin), atherosclerotic heart disease of native coronary artery without angina pectoris (this a heart disease in the walls of arteries that are blocked by plaque buildup without chest pain), cerebral infarction due to unspecified occlusion or stenosis left posterior cerebral artery (this is a stroke as a result of disrupted blood flow to the left side of the brain), stroke affecting right dominant side, presence of prosthetic heart valve (artificial heart valve), adult failure to thrive, unspecified severe protein-calorie malnutrition, and hypertension (high blood pressure).</p> <p>Review of Resident #223's physician order summary dated 03/27/24, reflected Aspirin 81 Oral Tablet Chewable (Aspirin) Give 1 tablet by mouth one time a day for heart health, Ferrous Sulfate [Iron] Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for iron supplement, Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for elevated blood pressure Hold for sbp Less than 100; dbp Less Than 60 or hr Less than 60. If held for 3 consecutive doses notify MD, Nifedipine ER Oral Tablet Extended Release 24 Hour 30 MG (Nifedipine) Give 1 tablet by mouth two times a day for elevated blood pressure Hold for sbp Less than 100; dbp Less Than 60 or hr Less than 60. if held for 3 consecutive doses notify MD. The order summary did not reflect a physician order to crush and mix Medications.</p> <p>Observation and interview during medication observation with LVN A on 03/27/24 at 08:25 AM revealed LVN A has worked at the facility for three weeks. She checked Resident #223's blood pressure reading 138/72, Pulse 72. LVN A crushed all medications and mixed them with 1 spoon of vanilla pudding and administered to Resident #223. LVN A said that she crushed the medications because the resident was on a mechanical diet. She said that there was no order to crush medication, but she was told in report that resident's medications were to be crushed. LVN A said she knew not to crush a medication that said Extended Release (ER) if it contraindicated, she would not have crushed it. She said the risk for crushing an ER medication and administering to resident was that the medication would get absorbed faster and could drop residents blood pressure or heart rate. She said that she would monitor Resident #223 and notify the physician and get an order to crush the medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LVN C on 03/28/24 at 03:56 PM revealed that he was a new LVN, and he had worked with Resident #223 on 03/26/24. He said he was told in a report that Resident #223's medications were to be crushed before administration. He said that he could not remember if he looked at the orders to verify crush medication order for Resident #223. He said that he remembered from nursing school that enteric coated and Extended-Release medications should not be crushed because it goes straight to the abdomen and amplifies the effects of the medication. He said, logically would notify the physician, and ADON. He said that he will check orders going forward before he crushes medication so that he is aware of the risk.</p> <p>Interview with the Pharmacist on 03/27/24 at 03:55 PM revealed that she had not seen Resident#223 because he was a new admission. She said that she would not have recommended the facility to crush an extended-release medication. She said that there were some components of medications [Nifedipine] that can be crushed. She said crushing a medication that should not be crushed can result in adverse effects. She said she would send to the facility a list of medications that should not be crushed. She said that the DON was very good at verifying medication, but she had been on maternity leave, and the nurse might have been a new nurse that crushed the medication. She said that she would send over to facility some new education materials on medications to crush or not. She said the medication card should say on it DO NOT CRUSH.</p> <p>Interview with DON on 03/28/24 at 06:14 PM revealed she started in service yesterday 03/27/24 and the pharmacist sent over to the facility a DO NOT CRUSH medication list. She said the physician was notified and he said, to keep an eye on him [Resident #223] and let him know of any changes.</p> <p>Interview with administrator on 03/28/24 at 05:53 PM revealed she expected nurses to follow physician order, if they needed a physician order, then they express the need to the physician and get an order. She expected nurses to monitor residents after medication. She expected staff to use the best practice. She expects staff to follow facility's policy and procedures.</p> <p>Review of facility policy titled Medication Pass Policy and Procedure dated 04/2008, reflected .know diagnoses and indication for every medication. A change in form of medication (e.g., from tab to liquid) requires a change of physician's order .Remember: DO NOT CRUSH medications may be crushed only if a physician's order is obtained. Recommend the order be specific and allow for nursing judgment. Use the word may in order (e.g., may crush meds or may add to applesauce) .If the prescription label and MAR are different and the container is not flagged to indicate a change, the physician's order must be checked to confirm order prior to administration. Once verified, the nurse is responsible for applying a change label to the medication container .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen.</p> <ol style="list-style-type: none"> The facility failed to ensure food items in the facility's only dry storage were dated and sealed appropriately. The facility failed to ensure food items in the facility's only walk in refrigerator were dated and sealed appropriately. The facility failed to ensure cleaning chemicals were not near prepared food. The facility failed to ensure drinks and food for personal use were properly stored. The facility failed to ensure the kitchen door opening to the outside was closed. <p>These failures could place residents at risk for food-borne illness, and food contamination.</p> <p>Findings include:</p> <p>Observations of the facility kitchen's only walk-in refrigerator and dry storage on at [DATE] at 9:04 AM revealed the following items were not sealed or dated:</p> <ul style="list-style-type: none"> - In the walk-in refrigerator a metal container with sliced cheese, onions, tomatoes, pickles, and lettuce covered with plastic wrap not labeled or dated. - In the walk-in refrigerator in a zip lock bag contain sliced ham not labeled or dated. - In the walk-in refrigerator in a small plastic bowl covered with plastic wrap leftover puree lemon pudding not labeled or dated. - In the walk-in refrigerator a small container of watermelon spears for personal use. - In the walk-in refrigerator a zip lock bag contained a tomato not labeled or dated. - In the walk-in refrigerator an uncovered box of dried mushroom and a whole tomato not labeled or dated. - In the walk-in refrigerator a zip lock bag contained lettuce not labeled or dated. - In the walk-in refrigerator a zip lock bag contained sliced cheese not labeled or dated. - In the walk-in refrigerator stored on the top shelf personal use lunch bag. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- In the dry goods storage, a zip lock bag contained crumbled cookies not labeled or date.</p> <p>Observation on [DATE] at 11:05 AM revealed the kitchen backdoor held open with a rock.</p> <p>Observation on [DATE] at 9:04 am revealed a container labeled spray cleaner with bleach next to a plastic bin container of individually wrapped slices of bread.</p> <p>Observation on [DATE] at 11:22 am revealed two personal use cups on the counter while food was being prepared.</p> <p>Interview on [DATE] at 1:34 PM with Cook A reflected that food stored should be labeled with the name of item and dated with day and year because it is only good for 3 days. The risk of not labeling or dating food can result in cross-contamination. She stated that the pink lunch bag belonged to her. She stated that she should have placed it in the staff refrigerator in the staff room. The risk of storing personal items in the facility refrigerator is cross contamination.</p> <p>Interview on [DATE] at 1:47 PM with Cook B reflected each food item should be placed in a separate container labeled and dated to prevent cross contamination and the residents could get sick. Food is only supposed to be used with in 2 days and then thrown away. The backdoor should not be propped open because insects can come in and get on the food.</p> <p>Interview on [DATE] at 2:00 PM with Cook C and Cook D reflected unable to interview staff, staff members was unable to remain after shift for interview.</p> <p>Interview on [DATE] at 4:14 PM with Dietary Manager reflected all items that are opened and placed in storage should be labeled and dated. The risk is infection control, giving the residents old or spoiled food, and food borne illness. All foods must be separated to prevent cross contamination. She stated that the mushroom and whole tomato in the uncovered box should have been thrown away. She stated that the chemical should have been stored in the chemical room and not next to food. The risk is that it could poison a resident. The back door should not be propped open because bugs could come into the kitchen.</p> <p>Interview on [DATE] at 5:24 PM with DON reflected the risk of kitchen items not being labeled or dated is food poisoning if things are expired.</p> <p>Interview on [DATE] at 5:38 PM with ADM reflected staff should follow policy and procedure for proper storage of food. The risk is food borne illness.</p> <p>Record review of facility policy dated revised ,d+[DATE] revealed 4a Foods should be covered, labeled, and dated. Foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. 5. Pesticides or other toxic substances and drugs are not to be stored in the kitchen area or in storerooms for food or food preparation equipment and utensils. 6. Soaps, detergents, cleaning compounds or similar substances are stored in separate storage areas.</p> <p>(continued on next page)</p>		

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 03/28/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed ,d+[DATE].17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, , d+[DATE].11, revealed: Preventing Contamination from the Premises - Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, Paragraph ,d+[DATE].11 stated . Personal belongings can contaminate food, food equipment, and food-contact surfaces. Proper storage facilities are required for articles .</p>