STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675475	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR NURSING CENTER/RAYMONDVILLE	**1700 S EXPRESSWAY 77 RAYMONDVILLE, TX 78580**

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 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility nursing staff failed to demonstrate competencies and skills sets necessary to care for residents' needs, as identified through resident assessments and described in the plan of care, for one Resident (R#1) of two residents reviewed for nursing competency, in that: LVN A did not document R#1's vital signs when R#1 experienced a change in condition and was sent to the hospital. LVN A documented vital sign readings taken nine to 14 days prior to R#1's change in condition. This failure could affect all residents who experienced a change in condition and put them at risk for inadequate care. Findings included: Record review of R#1's electronic medical record revealed R#1 was a [AGE] year-old male who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R#1 was discharged to the hospital on [DATE]. Record review of R#1's undated comprehensive care plan revealed R#1 had a self-care deficit for Activities of daily living due to dementia. Record review of R#1's comprehensive care plan, dated 04/26/20 revealed R#1 was observed to be lethargic and to have diminished lung sounds to bilateral lower lobes, with O2 sats at 85%. Record review of R#1's nurses notes, dated 04/26/20 at 3:37 p.m., completed by LVN A, revealed: Resident presented with diminished lung sounds to bilateral lower lobes, crackle audible upon (auscultation), physician made aware, as per physician send resident out to hospital, EMS activated at 1500 (3:00 p.m.), EMS arrival at 1505 (3:05 p.m.), resident taken from building at 1510 (3:10 p.m.). resident a/o appears lethargic, unable to self-transfer, patient transferred to stretcher via EMS x 2. attempted to notify spouse, no answer, voicemail not set up for service. Record review of R#1's SBAR, dated 04/26/20 at 3:00 p.m., completed by LVN A, revealed: -SBAR summary vital signs: BP 128/78 - 04/15/20 17:46 (5:46 p.m.) Position seating l/arm, P 78 - 4/15/20 17:46 Pulse type regular, R 18.0 - 04/15/20 14:46 (2:46 p.m.), T 94.6 - 04/17/20 12:36 Route: axilla, W 121 lb 0 04/12/20 10:11 scale: standing, O2 98.0% - 04/15/20 10:47 method; room air. -RN Assessment/LPN appearance of resident - what I think is going on with resident is: resident appears short of breath upon assessment O2 of 85% prn oxygen administered as per physician standing orders patient currently satting at 90% at 3L as per physician to be sent to hospital for evaluation and treatment. additional nursing notes as applicable. resident send to hospital for evaluation and treatment. Record review of R#1 medical chart revealed no documentation of LVN A taking R#1's vital signs other than O2 sat rate on 04/26/20. There was no documentation that LVN A checked R#1's blood glucose on 04/26/20. In an interview on 04/29/20 at 2:10 p.m., LVN A said R#1 had been in the Memory Unit and needed to be reminded to eat and drink fluids. LVN A said R#1 had been ambulatory. LVN A said 04/26/20 had been his first day back at work after being gone for a month. LVN A said he was the one who sent R#1 to the hospital on [DATE] due to R#1 having a change in condition. LVN A said he had checked R#1's glucose on 04/26/20 and it was high. In an interview on 04/30/20 at 10:11 a.m., the DON said R#1 was still in the hospital, with a [DIAGNOSES REDACTED].#1's SBAR were from past readings, not from 04/26/20. The DON said maybe the nurse documented old vital signs because he was concerned about R#1's O2 readings, not the other vital signs. The DON said R#1 had a [DIAGNOSES REDACTED].#1's vital signs on 04/24/20 and wrote them on a piece of paper, but did not document the vital signs readings in R#1's chart. LVN A said he had those readings in a file that was at his home with him. LVN A said when there was a change in condition vital signs should be taken. LVN A said he did that, but did not document it. In an interview on 04/30/20 at 11:18 a.m., the DON said nurses were supposed to take vital signs and document them when there was a change in condition. Review of the facility's policy on, Change in Condition, revised 02/2017, revealed: Guidelines: 4: The SBAR communication form and the nurses notes are used to: a: access and document changes in condition in an efficient and effective manner. b: provide assessment information to the physician, and c: provide clear comprehensive documentation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.