STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675309	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR NURSING CENTER/ALICE	606 COYOTE TR ALICE, TX 78332

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services in the facility with reasonable accommodation of resident needs and preferences, for two Residents (R #6 and R #10) of eight residents reviewed for accommodation of needs. The facility staff did not provide R #6 and R #10 with a call light that was within reach. This failure could place residents who utilized call lights at risk for not having their needs met. Findings included: R #6: Review of R #6's Face Sheet dated 03/11/20 documented a [AGE] year-old female admitted on [DATE] with the [DIAGNOSES REDACTED]. Review of R #6's Quarterly Minimum (MDS) data set [DATE] revealed R #6: -had unclear speech -rarely/never made self understood or understood others -had short and long term memory problems with severely impaired cognition -required extensive assistance with two-person physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene -had impairment on both sides of upper and lower extremities Review of R #6's comprehensive care plan dated 03/23/20 documented: I, am a LOW RISK for falls related to (r/t) incontinence, [MEDICAL CONDITION], vision/hearing problems, bedbound, and limited mobility. Interventions: Anticipate and meet the resident's needs Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Observation and interview on 03/09/20 at 10:24 AM revealed R #6 was lying in bed, on her back. R #6 said she could not use her left arm as it rested on her stomach. R #6's call light button was clipped to the top left edge of her bed sheet. After R #6 attempted to grab the call light, R #6 said she could not reach her call light and said she was hungry and asked for food. R #10: Review of R #10's Face Sheet dated 03/11/10 revealed a [AGE] year-old female admitted on [DATE] with the [DIAGNOSES REDACTED]. R #10 shared a room with R #6. Review of R #10's Quarterly Minimum (MDS) data set [DATE] revealed R #10: -had unclear speech -had a brief interview of mental status score of 02- severely cognitively impaired -required extensive assistance with two person physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene -had impairment on both sides of upper and lower extremities Review of R #10's comprehensive care plan dated 03/23/20 documented: I, am a LOW RISK for falls r/t incontinence, [MEDICAL CONDITION], vision/hearing problems, bedbound, and limited mobility. Interventions: Anticipate and meet the resident's needs Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Observation of R #10 on 03/09/20 at 11:30 AM revealed she was lying in bed, on her back holding her personal cell phone with her right hand. R #10's left arm rested on her stomach and she used her right hand to lift her left hand. R #10 did not respond verbally but used her right hand to point or she responded moving her head up and down or side to side to answer questions. R #10 moved her head side to side (meaning no) when asked if she could speak. When R #10 was asked where her call light was, she looked around her bed and with her right hand felt around in her bed looking for the call light then picked up her right hand to gesture, I don't know. Inspection around R #10's bed revealed her call light was on the floor at the right side of the head of the bed, not within her reach. In an interview on 03/09/20 at 10:41 AM, Licensed Vocational Nurse (LVN) B verified R #6 and R #10 could activate the call light independently and after inspecting the position of the call lights, LVN B confirmed neither R #6 or R #10 could reach their call lights. LVN B said both residents were unable to use their left arm/hand due to past [MEDICAL CONDITION]. LVN B stated R #6 and R #10's call lights should be positioned within reach on their right side, since they could not use their left arm/hand. LVN B said it was the responsibility of all staff to ensure call lights were positioned within each resident's reach to use in case they were to need staff assistance. In an interview on 0[DATE] at 02:17 PM, the Director of Nurses (DON) stated staff (assigned room ambassadors, nursing staff, and housekeeping) conducted rounds frequently throughout the day. The DON stated, it was everyone's responsibility to ensure call lights are within reach because that was the main communication and assistance line.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respect the resident's right to privacy during personal care, for one Resident (R #30) of three residents reviewed for personal privacy, in that: CNA C and RA D did not provide R #30 with personal privacy while assisting R #30 during personal care. These failures could place dependent residents at risk for embarrassment and low self-esteem. The findings included: Review of R #30's Face sheet dated 03/12/20 documented a 75 -year-old female admitted on [DATE] with the [DIAGNOSES REDACTED]. Review of R #30's Significant Change Minimum (MDS) data set [DATE] revealed R #30: -scored a 03- severe cognitive impairment on her brief interview of mental status score -required extensive assistance with two -person physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene -had impairment on one side of her upper extremities and impairment on both sides of her lower extremities -was occasionally incontinent of bladder and always incontinent of bowel Review of R #30's comprehensive care plan dated [DATE] documented I have bowel incontinence related to immobility, (am) forgetful and depend on staff for my toileting & incontinence care. -I have generalized weakness and limited mobility related to my disease process (and have) an activities of daily living (ADL) self-care performance deficit related to Activity Intolerance, Confusion, Dementia. I have an old healed fracture of my (Right)&(Left) femur that limits my mobility.Interventions: BED MOBILITY: Extensive Assistance (2) staff member TRANSFER: Extensive Assistance (2) staff members LOCOMOTION: Extensive/Total Assistance (1) staff member DRESSING: Extensive Assistance (2) staff members EATING: Set-up to limited Assistance from (1) staff member with meals. TOILET: Extensive Assistance (2) staff members PERSONAL HYGIENE: Extensive Assistance (2) staff members BATHING/SHOWER: Total Assistance (2) staff. At times resident is able to participate in task. Observation of R #30 on 03/11/20 at 01:48 PM revealed she was lying in bed on her right side. Certified Nurse Aides (CNA) C and Restorative Aide (RA) D entered R #30's room and informed R #30 of incontinent care to be provided. RA D used her right hand to pull the privacy curtain forward between resident beds however, neither staff closed the curtain to R #30's window nor did they ask R #30's permission to leave the curtain open while care was provided. Staff removed R #30's pants and unfastened her brief and continued with personal care, with the window curtain open, allowing R #30 to be easily visible, while partly naked, from the other side of the window. In an interview on 03/11/20 at 02:36 PM, CNA C stated she should have closed R #30's window curtains before providing care and exposing her while she was undressed but she Forgot. In an interview on 03/12/20 at 09:30 AM RA D acknowledged she did not close R #30's window curtains before providing personal care, to provide R #30 with privacy, respect, and dignity. In an interview on 03/12/20 at 11:19 AM the Director of Nurses (DON) revealed she was informed of the above observations. The DON confirmed staff should ensure full privacy by closing the window curtains. Review of the facility's undated Resident's Rights Under State Law documented g. An elderly individual is entitled to privacy while attending to personal needs.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675309	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR NURSING CENTER/ALICE	606 COYOTE TR ALICE, TX 78332

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered plan of care for 1 of 3 residents (Resident #75) reviewed for accurate comprehensive care plans in that; Resident #75's Care plan did not address the need for suctioning due to fluid build-up in his throat. This deficient practice could affect residents whose care plans were reviewed and place them at risk of not receiving needed care. The findings were: Record review of face sheet for R #75 dated 03/12/20 documented an [AGE] year old male admitted to facility on 10/09/19. His [DIAGNOSES REDACTED]. Review of R #75's Active Physician order [REDACTED]. Notify md (medical doctor) if S/S (Signs/Symptoms) present Review of R #75's Care Plan dated 02/04/20 did not reveal a care plan for suctioning resident as needed. During an interview with R #75 and his wife on 03/09/20 at 4:12 PM, R #75's wife stated that her husband had to be suctioned periodically due to inability to swallow and the build-up of fluids in his throat. R #75's wife further stated that he had to have a gastrostomy tube ([DEVICE]) inserted following his stroke due to his inability to swallow. The suction machine was observed on the night stand during the interview with R #75 and his wife on 03/09/20 at 4:12 PM. During an interview on 03/12/20 at 11:30 AM, MDS E stated the care plan was updated whenever orders were placed in the medical record. MDS E acknowledged that suctioning should have been placed in the care plan and It was not, even though there was a physician's orders [REDACTED].
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 3 residents (Resident #75) whose care plans were reviewed, in that: Resident #75's care plan was not revised when a [MEDICAL CONDITION] medication was discontinued. This deficient practice could affect residents that receive psychotrophic medications and could place them at risk of lack of appropriate behavior monitoring and interventions which could potentially arise following the discontinuation of the medication. The findings were: Record review of R #75's face sheet dated 03/12/20 documented an [AGE] year old male admitted to facility on 10/09/19. Further review revealed his [DIAGNOSES REDACTED]. Review of R #75's Care Plan dated 02/04/20 revealed a Revision on: 03/07/20 and a focus area that read R #75 has a behavior problem r/t (related to) major [MEDICAL CONDITION] and is on antipsychotic medications [MEDICATION NAME] and [MEDICATION NAME] for management. Review of R #75's Active Physician order [REDACTED]. Review of Nurses Progress Notes dated [DATE]20 at 17:30 revealed: As per MD, d/c (discontinue) [MED]. Stated he would see tomorrow when rounding. During an interview with R #75 and his wife on 03/09/20 at 4:12 PM, R #75's, wife stated that she stayed with him day and night so she could help staff figure out what he needed since he was unable to speak clearly to express his needs. She did not indicate that he expressed any type of behaviors that would require [MEDICAL CONDITION] medications. During an interview with MDS E on 03/12/20 at 11:30 AM, MDS E stated the care plan was updated whenever orders were changed in the medical record. MDS E acknowledged the Care Plan for R #75 had not been appropriately revised when it was updated on 03/07/20 and the [MEDICATION NAME] had not been removed from the Care Plan.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for one resident (R #327) of eight residents reviewed for quality of care, in that: The facility failed to provide timely dressing change to R #327's central venous access device (central line). This deficient practice had the potential to result in infection or wound deterioration, and decreased quality of life. The findings included: Review of R #327's Face Sheet dated 0[DATE] documented a [AGE] year-old female admitted on [DATE] with the [DIAGNOSES REDACTED]. R #327's Minimum Data Set was not yet complete since she was recently admitted on [DATE]. Review of R #327's Care Plan dated [DATE] documented Right neck central triple lumen due to infection. IV (intravenous) DRESSING: Right Neck triple lumen central line. Observe dressing every shift. Change dressing and record observations of site (right neck). Observe/document/report as needed (PRN) signs and symptoms (s/sx) of infection at the site: Drainage, Inflammation, Swelling, Redness, Warmth. Observe/document/report PRN s/sx of leaking at the IV site: [MEDICAL CONDITION] at the insertion site, taut, shiny or stretched skin, whitening/blanching or coolness of the skin, slowing or stopping of the infusion, leaking of I.V. fluid out of the insertion site. Review of R #327's physician's orders [REDACTED]. Document in PN (progress note). Flush IV site with 10 ml (milliliters) Normal Saline after IV Medication administration. Flush IV site with 10 milliliters normal saline before IV medication administration. There were no orders for cleaning the IV site or dressing changes. Observation on 03/09/20 at 10:12 AM of R #327 revealed she was receiving her morning medications from the nurse. R #327 was laying in bed, on her back. R #327 was alert and oriented to person but confused to place and time. R #327 looked up at the ceiling when spoken to and when she verbally responded. R #327 had a right IJ (internal jugular) intravenous three port central line with a transparent dressing dated [DATE]. The lower right aspect of the central line dressing was loose and no longer intact, with the insertion site visible and surrounded by dry blood. In an interview on 0[DATE] at 4:20 PM, Licensed Vocational Nurse (LVN) H stated he reviewed R #327's Medication and Treatment Administration Record via his computer and verified R #327 did not have orders to clean the central line site or change the dressing. LVN H said It doesn't matter, I can call and get orders, we change the dressings every seven days. I don't know when her dressing was last changed. LVN H verified the date on R #327's central line dressing was [DATE] and said the dressing should have been changed on 03/07/20. LVN H said the admitting nurse should have obtained orders from the physician for the care and dressing changes of the central line. LVN H confirmed if the dressing was loose and unsecure, the dressing would have to be changed immediately to prevent any risk of infection. Review of R #327's physician's orders [REDACTED]. Notify Medical Doctor of any changes/abnormalities, every 48 hours for IV care and as needed for loosened and soiled dressing. In an interview on 0[DATE] at 2:21 PM, the Director of Nurses (DON) verified that R #327's central venous access should have been cleaned and the dressing changed at least every seven days from the date on the dressing. The DON explained it was the responsibility of the admitting nurse and each nurse caring for R #327 to obtain orders from the physician for the care and dressing changes of the central line. The DON said she thought the nursing staff were going by R #327's admission date of [DATE] instead of the date on the dressing of [DATE]. The DON said the care of the device was important to decrease the risk of infection. Review of the facility's Central Venous Access Device Dressing Change Procedure dated 06/1[DATE]9 documented Central venous access devices are inserted centrally or peripherally and may enter the vein directly or be tunneled to the vein site. Transparent semipermeable dressings should be changed every 5 to 7 days, and gauze dressings should be changed every 2 days. If signs and symptoms of infection are present or if a dressing becomes visibly soiled, loosened or dislodged, an immediate dressing change is necessary to closely assess, clean, and disinfect the site. Review of the facility's November 2017 Physician order [REDACTED].no one other than a licensed nurse is permitted to transcribe physician orders.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that its medication error rate was below 5%. The facility had a medication error rate of 6%, based on two medication errors out of 31 opportunities for error. The errors were: 1. Administration of the incorrect multivitamin formulation to Resident (R) #45; and 2. Administration of a gastric acid inhibitor at the wrong time to R #45. This failure could result in inadequate therapeutic outcomes and increased risk for adverse effects. The findings were: 1. Surveyor observed Medication Aide (MA) A administer a multivitamin tablet (without minerals) to R #45 at 10:09 a.m. on 03-10-20. Review of R #45's current March electronic physician orders [REDACTED].#45 was to receive a multivitamin with minerals tablet. MA A acknowledged the discrepancy during an interview at 11:45 a.m. on 03-10-20. 2. Surveyor observed Licensed Vocational Nurse (LVN) B administer a 20 mg oral dose of [MEDICATION NAME], a gastric acid inhibitor, to R #45 at 9:41 a.m. on 03-11-20. Review of R #45's current

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675309	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR NURSING CENTER/ALICE	**606 COYOTE TR ALICE, TX 78332**

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 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) March electronic physician orders [REDACTED]. R #45 had finished his breakfast meal at the time of the [MEDICATION NAME] administration. LVN B acknowledged the discrepancy and stated she would check into possibly having the administration time changed during an interview at 10:45 a.m. on 03-11-20.
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** Based on interview and record review, the facility failed to currently employ a certified dietary manager. The facility has been without a certified dietary manager for approximately one year. This failure could result in inadequate delivery of food and nutrition services for all residents in the facility. The findings were: Personnel file review on 03-09-20 revealed that the facility's current dietary manager, a contracted employee hired on 09-09-19, did not have certification as a dietary manager. In an interview on 03-09-20 at 3:00 p.m., the dietary manager revealed that she had completed the online course for dietary manager certification, but was not scheduled to take the examination until 04-09-20. Interview also revealed that the last certified dietary manager in the facility left approximately one year ago.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for two Residents (R #30 and R #327) of four residents observed for infection control practices during personal care, in that: 1.) Certified Nurse Aide (CNA B) and/or Restorative Aide (RA) D did not: -perform hand hygiene before and/or after assisting R #30 with personal care -RA D did not scrub her hands with soap for at least 20 seconds -perform hand hygiene between glove changes or prior to exiting R #30's room [ROOM NUMBER].) The facility failed to change R #327's central venous access device dressing when there was evidence of dry blood adjacent to the insertion site and transparent dressing was visibly loose, risking risk of infection. These failures could place residents at risk for health-care associated cross-contamination and infections. The findings included: 1.) R #30: Review of R #30's Face sheet dated 03/12/20 documented a [AGE] year-old female admitted on [DATE] with the [DIAGNOSES REDACTED]. Review of R #30's Significant Change Minimum (MDS) data set [DATE] revealed R #30: -scored a 03- severe cognitive impairment on her brief interview of mental status score -required extensive assistance with two person physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene -had impairment on one side of her upper extremities and impairment on both sides of her lower extremities -was occasionally incontinent of bladder and always incontinent of bowel Review of R #30's comprehensive care plan dated [DATE] documented I have bowel incontinence related to immobility, forgetful and depend on staff for my toileting & incontinence care. -I have generalized weakness and limited mobility related to my disease process has an ADL (activities of daily living) self-care performance deficit r/t (related to) activity intolerance, confusion, dementia. I have an old healed fracture of my (right) & (left) femur that limits my mobility.Interventions: BED MOBILITY: Extensive Assistance (2) staff member TRANSFER: Extensive Assistance (2) staff member LOCOMOTION: Extensive/Total Assistance (1) staff member DRESSING: Extensive Assistance (2) staff member EATING: Set-up to limited Assistance from (1) staff member with meals. TOILET: Extensive Assistance (2) staff member PERSONAL HYGIENE: Extensive Assistance (2) staff member BATHING/SHOWER: Total Assistance (2) staff. At times resident is able to participate in task. Surveyor observation of R #30 on 03/11/20 at 01:48 PM revealed she was laying in bed on her right side. CNA C and RA D entered R #30's room and informed R #30 of incontinent care to be provided. RA D washed her hands scrubbing with soap for a total of 10 seconds before pulling napkins to dry her hands. RA D then used her right hand to pull the privacy curtain forward between resident beds. RA D removed her gloves and scrubbed her hands with soap for a total of 8 seconds prior to drying her hands then exited the room. Approximately two minutes later, RA D re-entered R #30's room holding clean linen, closed the door behind her, pulled the curtain closed with her right hand and immediately applied clean gloves, without performing any hand hygiene. After turning R #30 to her right side and cleaning R #30's buttocks, RA D removed her gloves and immediately applied clean gloves, without performing any hand hygiene. At 2:16 PM, RA D removed her gloves again and exited the room, without performing any hand hygiene. At 2:32 PM, CNA C gathered dirty linen and placed the linen in a clear garbage bag. CNA C then removed her gloves and carried two bags of dirty linen, opened the door and closed the door with her right hand, exiting the room, without performing any hand hygiene after removing her gloves, prior to exiting the room. Immediately outside of R #30's room, in the hallway, CNA C lifted the lid of the linen barrel with her unclean right hand and threw the bags of dirty linen in the barrel. In an interview on 03/11/20 at 02:36 PM, CNA C stated she should have washed her hands after removing her gloves and before leaving the room however, she said she did sanitize her hands after she put the dirty laundry in the barrel. CNA C confirmed she touched the door knob and the linen barrel with her unclean hands, risking cross-contamination. In an interview on 03/12/20 at 09:30 AM, RA D said she usually sang the happy birthday song a couple of times, in her head, while washing her hands to ensure she washed her hands for at least 30 seconds. RA D also confirmed she should have performed hand hygiene after removing her gloves, prior to exiting the room, and before applying clean gloves and providing personal care. RA D said the importance of hand hygiene was to protect the resident and staff from infection and cross-contamination. RA D acknowledged she failed to follow her usual practice on 03/11/20 while providing care to R #30 because she was nervous. In an interview on 03/12/20 11:19 AM, the Director of Nurses (DON) revealed she was informed of the above observations. The DON confirmed staff should perform hand hygiene via hand washing, scrubbing with soap for 20 seconds or using hand sanitizer before and after resident care, between glove changes, and before applying and after removing gloves to prevent the spread of infection. Review of the facility's Hand Hygiene Policy and Procedure dated 02/2018 documented To decrease the risk of transmission of infection by appropriate hand hygiene. Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections.Washing with soap and water is appropriate when the hands are visibly soiled or contaminated with blood or other bodily fluids, when exposure to potential spore-forming pathogens, and after using the restroom. Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact, before putting on gloves, after contact with a patient, when moving from a contaminated body site to a clean body site during patient care; after contact with body fluids, excretions, mucous membranes, non-intact skin or wound dressings, after removing gloves, and after contact with inanimate objects in the patient's room. 2.) R #327 Review of R #327's Face Sheet dated 0[DATE] documented a [AGE] year-old female admitted on [DATE] with the [DIAGNOSES REDACTED]. R #327's Minimum Data Set was not yet complete since she was recently admitted on [DATE]. Review of R #327's Care Plan dated [DATE] documented Right neck central triple lumen due to infection. IV (intravenous) DRESSING: Right Neck triple lumen central line. Observe dressing every shift. Change dressing and record observations of site (right neck). Observe/document/report as needed (PRN) signs and symptoms (s/sx) of infection at the site: drainage, inflammation, swelling, redness, warmth. Observe/document/report PRN s/sx of leaking at the IV site: [MEDICAL CONDITION] at the insertion site, taut, shiny or stretched skin, whitening/blanching or coolness of the skin, slowing or stopping of the infusion, leaking of I.V. fluid out of the insertion site. Review of R #327's physician's orders [REDACTED]. Document in PN (progress notes). Flush IV site with 10 ml (milliliters) Normal Saline after IV Medication administration. Flush IV site with 10 milliliters normal saline before IV medication administration. There were no orders for cleaning the IV site or dressing changes. Observation on 03/09/20 at 10:12 AM of R #327 receiving her morning medications from the nurse. R #327 was laying in bed, on her back. R #327 was alert and oriented to person but confused to place and time. R #327 looked up at the ceiling when spoken to and when she verbally responded. R #327 had a right IJ (internal jugular) intravenous three port central line with a transparent dressing dated [DATE]. The lower right aspect of the central line dressing was loose, no longer intact, with the insertion site visible with some dry blood adjacent to the insertion site. In an interview on 0[DATE] at 4:20 PM, Licensed Vocational Nurse (LVN) H revealed he reviewed R #327's Medication and Treatment Administration Record via his computer and verified R #327 did not have orders to clean the central line site or change the dressing. LVN H said It doesn't matter, I can call and get orders, we change the dressings every seven days. I don't know when her dressing was last changed. LVN H verified the date on R #327's central line dressing was [DATE] and said the dressing should have been changed on 03/07/20. LVN H said the admitting nurse should have obtained orders from the physician for the care and dressing changes of the central line. LVN H confirmed if the dressing was loose and not secured, the dressing would have to be changed immediately to prevent any risk of infection. Review of R #327's physician's orders [REDACTED]. Notify Medical Doctor of any changes/abnormalities, every 48 hours for IV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675309	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR NURSING CENTER/ALICE	**606 COYOTE TR ALICE, TX 78332**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) care and as needed for loosened and soiled dressing. In an interview on 0[DATE] at 02:21 PM, the Director of Nurses (DON) verified R #327's central venous access should have been cleaned and the dressing changed at least every seven days from the date on the dressing. The DON explained it was the responsibility of the admitting nurse and each nurse caring for R #327 to obtain orders from the physician for the care and dressing changes of the central line. The DON said she thought the nursing staff were going by R #327's admission date of [DATE] instead of the date on the dressing of [DATE]. The DON said the care of the device was important to decrease the risk of infection. Review of the facility's Central Venous Access Device Dressing Change Procedure dated 06/1[DATE]9 documented Central venous access devices are inserted centrally or peripherally and may enter the vein directly or be tunneled to the vein site.Transparent semipermeable dressings should be changed every 5 to 7 days, and gauze dressings should be changed every 2 days. If signs and symptoms of infection are present or if a dressing becomes visibly soiled, loosened or dislodged, an immediate dressing change is necessary to closely assess, clean, and disinfect the site.