STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR NURSING CENTER/SAN ANTONIO WEST	636 CUPPLES RD SAN ANTONIO, TX 78237

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** - Few	**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 designed to provide a safe, sanitary and comfortable environment or appropriate handwashing and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Residents #1 and #2) reviewed for infection control, in that: 1a. RA A did not change soiled gloves and wash hands before putting a new brief for Resident #1 after incontinent care. 1b. Resident #1's oxygen concentrator filter was filled with gray layer of substance. 2. Resident #2's vent next to the filter door in the back of the oxygen concentrator was filled with gray substance. These deficient practices could place residents in the facility who received incontinent care and residents on oxygen therapy at risk for infection. The findings were: 1. Record review of Resident #1's admission record, dated 05/14/2020, revealed an admission date of [DATE], and readmission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #1's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 8, which indicated the resident had moderated cognitive impairment for daily decision making. Further review revealed Resident #1 had always had urinary incontinent and frequent bowel incontinence. Record review of Resident #1's care plan, with initiation date on 02/14/2020, revealed, Resident #1 had mixed bladder incontinent related to weakness . Intervention: Clean peri-area with incontinence episode . Hand washing before and after delivery of care. Further review revealed, Resident #1 has altered respiratory status/difficulty breathing related to sleep apnea and SOB (Shortness of breath) . intervention: check and clean concentrator filter every month an as needed. Oxygen settings: oxygen via nasal cannula at 2 L per minute as needed to maintain oxygen level at or above 92% as needed. Record review of Resident #1's Order Summary Report, dated 05/14/2020, revealed orders of, Check and clean concentrator filter every month and PRN one time a day for SOB. Start date: 3/16/2020, and, Oxygen 2 L/min via as needed to maintain oxygen level at or above 92% as needed for SOB. Start date: 3/16/2020. 1a. Observation of peri care for Resident #1 on 05/14/2020 at 12:04 PM revealed RA A wore gloves and wiped Resident #1's perineal area, anal area, and buttocks with disposable cloths. Further observation revealed after RA A cleaned Resident #1's buttocks, RA A removed Resident #1's soiled brief and put the soiled brief in a trash can. Without removing soiled gloves and wash hand, RA A got a new brief and put the brief on for Resident #1. During an interview with RA A on 05/14/2020 at 12:13 PM, RA A confirmed she did not change her soiled gloves and wash her hand after she wiped Resident #1's private areas and removed Resident #1's soiled brief. RA further confirmed she used the same soiled gloves to put a new brief on Resident #1. During an interview with the DON on 05/14/2020 at 4:23 PM, the DON confirmed RA A should have removed her soiled gloves and washed her hands after providing peri care and after removing Resident #1's soiled brief. Record review of the facility's policy and procedure Perineal Care of the Female Patient, dated 11/15/2019, revealed, Completing the procedure: after cleaning the perineum, apply a moisture-barrier skin protectant . dispose of soiled article in the appropriate receptacle. removed and discard your gloves. Perform hand hygiene. 1b. Observation on 05/14/2020 at 12:04 PM revealed Resident #1 was lying in bed receiving oxygen via nasal cannula at flow rate 2 Liter per minute. Further observation revealed the filter in the back of the oxygen concentrator filled with thick layer of gray substance. During an interview with LVN B on 05/14/2020 at 12:58 PM, LVN B confirmed the filter in the back of oxygen concentrator was covered with dust. LVN B further confirmed the filter of oxygen concentrator should be cleaned daily. 2. Record review of Resident #2's admission record, dated 05/14/2020, revealed an admitted on 10/06/2017 with [DIAGNOSES REDACTED]. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 14, which indicated the resident was cognitively intact for daily decision making and received oxygen therapy. Record review of Resident #2's care plan, with revision date on 04/14/2020, revealed, (Resident #2) use oxygen for respiratory illness related to [MEDICAL CONDITION] . Interventions: 2-3 liters oxygen via nasal cannula to maintain oxygen level at or above 90% as needed, change oxygen tubing when visibly soiled, check and clean concentrator filter every month and PRN. Record review of Resident #2's Order Summary Report, dated 05/14/2020, revealed orders for, Oxygen continuous at 2 Liters via nasal cannula for oxygen saturation above 90% every shift related to [MEDICAL CONDITION]. Start date 10/25/2018. Change oxygen tubing when visibly soiled. Start date: 11/18/2019. Check and clean concentrator filter every month and prn. Start date: 11/24/2019 Observation on 05/14/2020 at 10:26 AM revealed Resident #2 was lying in bed and receiving oxygen via nasal cannula at 2 liters per minute flow rate. Further observation revealed the vent next to the filter door in the back of the oxygen concentrator was filled with gray substance in between the space of the vent. During an interview with LVN C on 05/14/2020 at 1:52 PM, LVN C confirmed the vent in the back of Resident #2's oxygen concentrator was dirty and had dirt in between the space of the vent. LVN C further confirmed he did not know who was responsible for cleaning the oxygen concentrator or when the oxygen concentrator should be cleaned. During an interview with the DON on 05/14/2020 at 1:56 PM, the DON confirmed the oxygen concentrator filter should be cleaned or changed every Sunday. Record review of the facility's policy Oxygen Administration, dated 12/2010 revealed there was no oxygen concentration filter or cleaning oxygen concentrator was addressed in the policy. During an interview with the Administrator on 05/14/2020 at 5:12 PM, the Administrator confirmed there was no policy on oxygen concentrator or oxygen concentrator filter.

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