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 _____	**04/14/2020**

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 -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility did not maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 7 of 7 residents reviewed for infection control. The facility dietary staff A, B, C, and D were not wearing face masks while inside the facility as required. This failure could place residents at risk of contracting COVID-19 and/or other communicable diseases. Findings included: Observation on 04/14/2020 at 10:20 AM revealed dietary staff A, B, C, and D were completing kitchen duties including washing trays, dishes, eating utensils, stove and counters without wearing face masks. Interview on 04/14/2020 at 10:25 AM dietary manager A stated staff were not required to wear masks while in the kitchen, only when they exit the kitchen or were taking trays to residents. Interview on 04/14/2020 at 10:25 AM dietary manager A stated three other staff members B, C, and D were currently working in the kitchen and are not wearing masks. Review of COVID-19 Long-Term Care Facility Guidance dated April 2, 2020 revealed all long-term care facility personnel should wear a facemask while they are in the facility Review of of facility staff discussion log dated 03/26/2020 revealed all facility staff requiring all personnel to wear mask to protect residents.

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.