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 _____	04/07/2020

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 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a written notice of room change was received, including the reason the resident's room was changed, for one Resident (R#1) of two residents reviewed for room changes, in that: The facility did not provide evidence that R#1's RP was given a written notice of a room change before the resident was moved. This failure practice could place residents at risk for being displaced without notice and/or reason, to accommodate other individuals. The findings were: Record review of R#1's Admission Record, dated 04/07/20, revealed R#1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of R#1's Quarterly MDS assessment, dated 03/04/20, revealed R#1 had moderately impaired cognitive skills for daily decision-making. Observation on 04/06/20 at 1:58 p.m. revealed R#1 was in a different room, in bed. R#1 had his eyes closed and did not respond to surveyor's greeting. In an interview on 04/07/20 at 9:44 a.m., the Administrator said the DON had advised him that LVN A addressed an incident in which R#2 had placed a pillow on R#1's face while R#1 was asleep in his bed. The Administrator said R#1 and R#2 were roommates and staff decided to move R#1 to a room closer to the nurse's station. The Administrator said R#2 would be monitored for behaviors. The Administrator said he did not know if R#1's RP was notified of the incident or the room change. In an interview via telephone on 04/07/20 at 1:15 p.m., R#1's RP said the last time she was allowed to visit with R#1 at the facility was on 03/23/20, due to the coronavirus situation. R#1's RP said she had not been informed about the room change for R#1 or informed of any incident involving R#1. In an interview via telephone on 04/07/20 at 2:33 p.m., LVN A said, on 04/02/20 shortly after midnight, she had seen R#1 in bed with a pillow over his face. LVN A said she asked R#1's roommate (R#2) about the pillow on R#1's face and R#2 said he placed the pillow on R#1's face because R#1 had been snoring. LVN A said she notified the DON and was informed to change R#1 to another room. LVN A said she understood the DON would notify the Administrator and that someone would notify R#1's RP. Record review of the facility policy titled, Room & Roommate Assignment, revised on August 2017 revealed: The facility will work with residents, residents' families, and/or the resident's representative when a resident is admitted , or a room move is requested by one of the parties. The facility will promptly notify the resident and the resident's representative or interested family members (if known) when there is a change in room or roommate assignment.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their written policies and procedures to investigate and report allegations of possible abuse/neglect, for two Residents (R#1 and R#2) of two residents reviewed for abuse/neglect. The facility did not investigate or report to HHSC an incident of possible abuse of R#1. The facility did not document an incident in which R#2 placed a pillow on R#1's face while R#1 was asleep. This failure could place residents at risk for abuse or neglect. The findings were: Record review of the facility policy titled, Abuse & Neglect Prohibition, revised July 2018, revealed: -Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident and exploitation . -Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the Administrator. - Purpose: To help ensure a resident's right to a safe and healthy environment. -The facility will timely conduct an investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property in accordance with state law. -Physical abuse includes, but is not limited to, hitting, slapping, pinching, and kicking. -The facility will report all allegation and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency, and law enforcement officials and adult protective services. -If events that cause the allegation do not involve abuse and do not result in serious bodily injury, a report is made not later than 24 hours after the facility is notified of the allegation. -The facility will complete an Incident/Accident Report in accordance with OPO2 0401.02 Incident Reporting for Residents and report events to management and Legal Departments in according with reporting procedures. Record review of R#1's Admission Record, dated 04/07/20, revealed R#1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of R#1's Quarterly MDS assessment, dated 03/04/20, revealed R#1 had moderately impaired cognitive skills for daily decision-making and a [DIAGNOSES REDACTED].#2's Admission Record, dated 04/08/20, revealed R#2 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's annual MDS assessment, dated 03/22/20, revealed R#2: -had severely impaired cognitive status, -exhibited verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others) and, -required supervision for bed mobility, dressing, and toilet use. Record review of R#2's care plan, initiated 04/07/20 revealed: When I get frustrated, I sometimes curse at others, and I had an incident on 4/2 where I was very frustrated because my roommate was snoring loud and I placed a pillow on his face because he would not stay quiet. Interventions included -notify family and MD as needed. -remove his roommate from (R#2's) room for his safety. Observation on 04/06/20 at 1:54 p.m. revealed R#2 in bed in his room. R#2 said he .tried to kill him (former roommate - R#1) because he was snoring. R#2 said he did not remember how he tried to kill his roommate. R#2 said he did not know where R#1 had gone to. Observation on 04/06/20 at 1:58 p.m. revealed R#1 was in a different room, in bed. R#1 had his eyes closed and did not respond to surveyor's greeting. In an interview on 04/07/20 at 8:52 a.m., CNA B said she had been working during the night shift when she and another CNA saw that R#1 was asleep in bed, with a pillow on his face. CNA B said she could not remember the exact date of the incident. CNA B said R#1 and R#2 were roommates at that time. CNA B said R#1 was unable to place or remove a pillow from his face. CNA B said R#2 told her he placed the pillow on R#1's face because R#1 would not stop snoring or making noise. CNA B said she went and informed the night nurse, LVN A, about her findings. CNA B said LVN A came and assessed both residents, and R#1 was moved to another room that evening. In an interview via telephone on 04/07/20 at 2:33 p.m., LVN A said, on 04/02/20 shortly after midnight, she had seen R#1 in bed with a pillow over his face. LVN A said she asked R#1's roommate (R#2) about the pillow on R#1's face and R#2 said he placed the pillow on R#1's face because R#1 had been snoring. LVN A said she notified the DON and was informed to change R#1 to another room. LVN A said she understood the DON would notify the Administrator and that someone would notify R#1's RP. LVN A said the DON instructed her to call R#2's doctor and ask for orders to do a CBC and UA test due to R#2's behaviors. Record review of R#2's nurses notes, dated 04/02/20 at 3:28 a.m. and signed by LVN A, revealed: Resident in bed, stating 'I put a pillow on his face, so he could shut the hell up and not snore.' Educated resident on importance of not putting objects on top of resident's face. Resident stated, 'I don't care I will do whatever I want.' Resident kept shouting vulgar language at staff. Will continue to monitor. In an interview on 04/07/20 at 9:44 a.m., the Administrator said the DON had advised him that LVN A found a pillow on R#1's face. The Administrator said R#2 stated he placed the

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.

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) pillow on R#1's face because R#1 was snoring. The Administrator said R#1 and R#2 were roommates and staff decided to move R#1 to a room closer to the nurse's station. The Administrator said R#2 would be monitored for behaviors. Surveyor notified the Administrator of R#2's statement about trying to kill his roommate. The Administrator said R#2 had not told staff he wanted to kill R#1, and the incident had not been reported as such. The Administrator said R#1 was questioned at the time of the incident and had not reported any concerns. The Administrator said the first action taken was to remove R#1 to another room. The Administrator said he did not know if an incident report was completed or if R#1's RP had been notified of the incident and the room change. Record review of the facility's Incident logs, dated 01/2/20 to 04/06/20, revealed no incident reports involving R#1 and R#2.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving neglect or mistreatment, including injuries of unknown source, were reported immediately to the State Survey Agency, for two Residents (R#1 and R#2) of two residents reviewed for abuse/neglect, in that: The facility did not report to HHSC an incident of possible abuse of R#1. The facility did not report an incident in which R#2 placed a pillow on R#1's face while R#1 was asleep. This failure could place residents at risk for abuse or neglect. The findings were: Record review of R#1's Admission Record, dated 04/07/20, revealed R#1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of R#1's Quarterly MDS assessment, dated 03/04/20, revealed R#1 had moderately impaired cognitive skills for daily decision-making and a [DIAGNOSES REDACTED].#2's Admission Record, dated 04/08/20, revealed R#2 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's annual MDS assessment, dated 03/22/20, revealed R#2: -had severely impaired cognitive status, -exhibited verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others) and, -required supervision for bed mobility, dressing, and toilet use. Record review of R#2's care plan, initiated 04/07/20 revealed: When I get frustrated, I sometimes curse at others, and I had an incident on 4/2 where I was very frustrated because my roommate was snoring loud and I placed a pillow on his face because he would not stay quiet. Interventions included -notify family and MD as needed. -remove his roommate from (R#2's) room for his safety. Observation on 04/06/20 at 1:54 p.m. revealed R#2 in bed in his room. R#2 said he .tried to kill him (former roommate - R#1) because he was snoring. R#2 said he did not remember how he tried to kill his roommate. R#2 said he did not know where R#1 had gone to. Observation on 04/06/20 at 1:58 p.m. revealed R#1 was in a different room, in bed. R#1 had his eyes closed and did not respond to surveyor's greeting. In an interview on 04/07/20 at 8:52 a.m., CNA B said she had been working during the night shift when she and another CNA saw that R#1 was asleep in bed, with a pillow on his face. CNA B said she could not remember the exact date of the incident. CNA B said R#1 and R#2 were roommates at that time. CNA B said R#1 was unable to place or remove a pillow from his face. CNA B said R#2 told her he placed the pillow on R#1's face because R#1 would not stop snoring or making noise. CNA B said she went and informed the night nurse, LVN A, about her findings. CNA B said LVN A came and assessed both residents, and R#1 was moved to another room that evening. In an interview via telephone on 04/07/20 at 2:33 p.m., LVN A said, on 04/02/20 shortly after midnight, she had seen R#1 in bed with a pillow over his face. LVN A said she asked R#1's roommate (R#2) about the pillow on R#1's face and R#2 said he placed the pillow on R#1's face because R#1 had been snoring. LVN A said she notified the DON and was informed to change R#1 to another room. LVN A said she understood the DON would notify the Administrator and that someone would notify R#1's RP. LVN A said the DON instructed her to call R#2's doctor and ask for orders to do a CBC and UA test due to R#2's behaviors. Record review of R#2's nurses notes, dated 04/02/20 at 3:28 a.m. and signed by LVN A, revealed: Resident in bed, stating 'I put a pillow on his face, so he could shut the hell up and not snore.' Educated resident on importance of not putting objects on top of resident's face. Resident stated, 'I don't care I will do whatever I want.' Resident kept shouting vulgar language at staff. Will continue to monitor. In an interview on 04/07/20 at 9:44 a.m., the Administrator said the DON had advised him that LVN A found a pillow on R#1's face. The Administrator said R#2 stated he placed the pillow on R#1's face because R#1 was snoring. The Administrator said R#1 and R#2 were roommates and staff decided to move R#1 to a room closer to the nurse's station. The Administrator said R#2 would be monitored for behaviors. Surveyor notified the Administrator of R#2's statement about trying to kill his roommate. The Administrator said R#2 had not told staff he wanted to kill R#1, and the incident had not been reported as such. The Administrator said R#1 was questioned at the time of the incident and had not reported any concerns. The Administrator said the first action taken was to remove R#1 to another room. The Administrator said he did not know if an incident report was completed or if R#1's RP had been notified of the incident and the room change. Record review of the facility's Incident logs, dated 01/2/20 to 04/06/20, revealed no incident reports involving R#1 and R#2. Record review of the facility policy titled, Abuse & Neglect Prohibition, revised July 2018, revealed: -Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident and exploitation . -Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the Administrator. - Purpose: To help ensure a resident's right to a safe and healthy environment. -The facility will timely conduct an investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property in accordance with state law. -Physical abuse includes, but is not limited to, hitting, slapping, pinching, and kicking. -The facility will report all allegation and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency, and law enforcement officials and adult protective services. -If events that cause the allegation do not involve abuse and do not result in serious bodily injury, a report is made not later than 24 hours after the facility is notified of the allegation. -The facility will complete an Incident/Accident Report in accordance with OPO2 0401.02 Incident Reporting for Residents and report events to management and Legal Departments in according with reporting procedures.