STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455817	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR NURSING CENTER/SAN ANTONIO NORTH	**501 OGDEN SAN ANTONIO, TX 78212**

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 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 provide personal privacy and confidentiality of his or her personal and medical records for 1 of 8 residents (Resident #8) reviewed for privacy in that: LVN A did not log out of the medication cart computer and left Resident #8's personal information up on the screen while the cart was unattended. This deficient practice could place residents who receive medications at risk of having their medical information being unnecessarily exposed and their personal privacy violated. The findings were: Record review of Resident #8's face sheet, dated 09/24/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 6, which indicated severe cognitive impairment for daily decision-making skills. Observation on 09/24/2020 at 8:40 a.m. of the medication care located on the D Hall revealed an unsecured and open computer screen with Resident #8's picture, name, and medications. During an interview with LVN A on 09/24/2020 at 8:43 a.m., LVN A stated she had just walked away for a minute. LVN A confirmed she left the computer screen open and did not lock it. During an interview with the DON on 09/24/2020 at 11:58 a.m., the DON confirmed the computer should have been locked when an employee walked away from it. Record review of the facility's poster, Resident Rights, undated, revealed, Privacy and confidentiality: you have the right to have facility information about you maintained as confidential.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of 1 of 1 resident (Resident #1) in that: Resident #1 had a [MEDICATION NAME] (a medication used to treat constipation) pill left on her bedside table. This deficient practice could place residents at risk of not receiving the prescribed medications and could place them at risk for not receiving the intended therapeutic benefit of their medication and treatment. The findings were: Record review of Resident #1's face sheet, dated 09/23/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Annual MDS, dated [DATE], revealed the resident had a BIMS score of 12, which indicated moderate cognitive impairment for daily decision-making skills. Record review of Resident #1's September 2020 Physician order [REDACTED].#1's bedside table. During an interview with Resident #1 on 09/23/2020 at 11:15 a.m., the resident stated the pill was a [MEDICATION NAME] pill and she told MA B she did not want to take it. During an interview with MA B on 09/23/2020 at 11:30 a.m., MA B confirmed the pill on Resident #1's bedside table was a [MEDICATION NAME] pill. MA B stated she had not realized Resident #1 had not taken the medication when she administered the resident's medications. During an interview with the DON on 09/23/2020 at 11:58 a.m., the DON stated medication aides and nurses should stay in the room until a resident took all of their medications. The DON further stated Resident #1 had a history of [REDACTED]. Record review of the facility's policy titled, Medication Administration, dated 06/2008, revealed, 7. Observe the residents swallows oral drugs. Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records that were complete and accurate, in accordance with accepted professional standards and practices, for 4 of 4 residents (Residents #2, #3, #5, and #6) whose records were reviewed, in that: Residents #2, #3, #5, and #6 were positive for COVID-19 and did not have orders for isolation. This deficient practice could place residents who reside in the facility at risk of errors in care and treatment. The findings were: 1. Record review of Resident #2's face sheet, dated 09/23/2020, revealed the resident was admitted on [DATE] to the facility, and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed the resident had short term and long-term memory loss with severe cognitive impairment of daily decision-making skills. Record review of Resident #2's COVID-19 test, dated 09/13/2020, revealed the resident was positive. Record review of Resident #2's September 2020 Physician order [REDACTED]. Record review of the facility roster revealed Resident #2 was residing on F hall. 2. Record review of Resident #3's face sheet, dated 9/23/2020, revealed the resident was admitted on [DATE] to the facility, and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 6, which indicated severe cognitive impairment of daily decision-making skills. Record review of Resident #3's COVID-19 test, dated 09/14/2020, revealed the resident was positive. Record review of Resident #3's September 2020 Physician order [REDACTED]. Record review of the facility roster revealed Resident #3 was residing on F hall. 3. Record review of Resident #5's face sheet, dated 09/24/2020, revealed the resident was admitted on [DATE] to the facility, and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #5's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 12, which indicated moderate cognitive impairment of daily decision-making skills. Record review of Resident #5's COVID-19 test, dated 09/02/2020, revealed the resident was positive. Record review of Resident #5's September 2020 Physician order [REDACTED]. Record review of the facility roster revealed Resident #5 was residing on F hall. 4. Record review of Resident #6's face sheet, dated 09/24/2020, revealed the resident was admitted on [DATE] to the facility with [DIAGNOSES REDACTED]. Record review of Resident #6's Quarterly MDS, dated [DATE], revealed the resident had short term and long-term memory loss with severe cognitive impairment of daily decision-making skills. Record review of Resident #6's COVID-19 test, dated 09/02/2020, revealed the resident was positive. Record review of Resident #6's September 2020 Physician order [REDACTED]. Record review of the facility roster revealed Resident #6 was residing on F hall. During an interview with the Administrator on 09/23/2020 at 10:17 a.m., the Administrator stated the residents (including Resident #2, #3, #5, and #6) on the F Hall behind the double doors were in isolation for COVID-19. During an interview with the DON on 09/23/2020 at 10:53 a.m., the DON confirmed Residents #2, #3, #5, and #6 were positive for COVID-19 and were still in isolation. During an interview with the DON on 09/24/2020 at 11:58 a.m., the DON confirmed Residents #2, #3, #5, and #6 should have orders for isolation. The DON stated, We probably overlooked it, to be honest. Record review of the CDC website (www.cdc.gov) titled, Responding to Coronavirus (COVID-19) in Nursing Homes, dated 04/30/2020, revealed: residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.
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 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 8 residents (Residents #2 #3, #5, #6, and #7) reviewed for infection control, in that: 1. There was no signage indicating the F Hall was an isolation unit for COVID-19. 2. MA C and NA D took lunch trays to Residents #2, #5, #6, and #7 in the COVID-19 unit without wearing gloves. 3. MA C did not sanitize or wash her hands during perineal care for Resident #3. These deficient practices could place residents at risk of transmission of communicable diseases, illness, infections, and COVID-19. The findings were: Record review of Resident #2's face sheet, dated 09/23/2020, revealed the resident was admitted on [DATE] to the facility, and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #2's COVID-19 test, dated 09/13/2020, revealed the resident was positive. Record review of Resident #3's face sheet, dated 09/23/2020, revealed the resident was admitted on [DATE] to the facility, and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #3's COVID-19 test, dated 09/14/2020, revealed the resident was positive. Record review of Resident #5's face sheet, dated 09/24/2020, revealed the resident was admitted on [DATE] to the facility, and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #5's COVID-19 test, dated 09/02/2020, revealed the resident was positive. Record review of Resident #6's face sheet, dated 9/24/2020, revealed the resident was admitted on [DATE] to the facility with [DIAGNOSES REDACTED]. Record review of Resident #6's COVID-19 test, dated 09/02/2020, revealed the resident was positive. Record review of Resident #7's face sheet, dated 09/24/2020, revealed the resident was admitted on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #7's COVID-19 test, dated 08/08/2020, revealed the resident was positive. 1. During an interview with the Administrator on 09/23/2020 at 10:17 a.m., the Administrator stated the residents on the F Hall were in isolation for COVID-19. Observation on 09/23/2020 at 10:20 a.m. revealed there was no signage on the doors to the F Hall where residents who were positive for COVID-19 resided. Further observation on the F Hall revealed there was no signage outside resident rooms which indicated they were in isolation. During an interview with the DON on 09/23/2020 at 10:53 a.m., the DON confirmed two residents were positive on the COVID-19 unit. The DON further confirmed the other residents on the F Hall were still in isolation and the physician had not released them from isolation yet. 2. Observation on 09/23/2020 at 11:55 a.m. revealed MA C entered Resident #6's room, who was in isolation, with no gloves and placed the lunch tray on the bedside table and raised the resident's bed. Further observation revealed MA C then took Resident #5's lunch tray, who was in the same room and in isolation, moved the bedside table, and placed the lunch tray on the table with no gloves. Observation on 09/23/2020 at 11:57 a.m. revealed MA C entered Resident #7's room, who was in isolation, with no gloves and placed the resident's lunch tray on the bedside table. During an interview with MA C on 09/23/2020 at 11:59 a.m., MA C confirmed she did not wear gloves when she passed out lunch trays to Residents #5, #6, or #7. MA C stated if a resident was in isolation staff were to treat the resident as though they were positive for COVID-19. Observation on 09/23/2020 at 12:01 p.m. revealed NA D took Resident #2's, lunch tray, who was in isolation, into the resident's room, moved the bedside table, and place the lunch tray down with no gloves. During an interview with NA D on 09/23/2020 at 12:04 p.m., NA D confirmed if a resident was in isolation then gloves needed to be worn when passing their food trays. NA D stated she did not know the F Hall was a COVID-19 unit. During an interview with the DON on 09/24/2020 at 11:58 a.m., the DON confirmed staff should wear gloves when passing trays on the COVID-19 unit. 3. Observation on 09/24/2020 at 9:16 a.m. revealed MA C removed Resident #3's brief and wiped down her perineal area. Further observation revealed MA C then changed her gloves and did not wash or sanitize her hands. During an interview with MA C on 09/24/2020 at 9:20 a.m., MA C confirmed she did not wash or sanitize her hands between glove changes during perineal care for Resident #3. MA C stated, in my head I did it. During an interview with the DON on 09/24/2020 at 11:58 a.m., the DON confirmed staff should change gloves when they provided care and between patients. The DON confirmed MA C should have washed or sanitized her hands after she wiped down Resident #3's perineal area and before putting on a new pair of gloves. Record review of the facility's policy titled, Managing COVID-19 in your Center, dated 09/03/2020, revealed: Caring for a resident with suspected/confirmed COVID-19: initiate droplet and contact transmission-based precautions and post appropriate signage. . full PPE is recommended in the following areas: admission units, observation units, dedicated areas where residents with suspected or confirmed COVID-19 are located, and, other units as directed by local/state health departments. . Enhanced Droplet-Contact Precautions included perform hand hygiene, N95 or surgical mask when entering room, eye protection when entering room, gown when entering room, gloves when entering room, private room and keep door closed. Record review of the facility's policy titled, Hand Hygiene, dated 06/14/2019, revealed, . Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct resident contact; before putting on gloves; before inserting an invasive device; after contact with a resident; when moving from a contaminated body site to a clean body site during resident care . after removing gloves.