STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455549	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/Jourdanton	1504 Highway 97e Jourdanton, TX 78026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611 Based on interview and record review, the facility failed to ensure residents had the right to be free from accidents for 1 of 5 residents (Resident # 196) reviewed for accidents and hazards. On 9/19/2024, Resident # 196 was not properly secured in the facility transport van and sustained a head laceration and a fractur to her right clavicle. The non-compliance was identified as past noncompliance. The IJ began on 9/19/2024 and ended on 9/19/2024. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of harm, serious injury, or death. Findings include: Record review of Resident # 196's face sheet revealed she was admitted [DATE] with an initial admission on 9/19/2023 with diagnoses of traumatic brain injury, transient ischemic attack (mini stroke), depression and alcohol abuse. Record review of Resident # 196's MDS indicated a BIMS score of 15 indicating no cognitive impairment. Record review of the Facility Incident Report, dated 9/23/2024, reflected the transport driver failed to buckle Resident # 196 prior to transportation to an appointment via the facility van. Record review of Resident #196's hospital record dated 9/19/2024 revealed: Acute oblique fracture of the right distal clavicle and right frontoparietal scalp contusion and laceration. Record review of a written statement from the van driver dated 9/19/2024 revealed: He admitted resident slid out of the wheelchair when he had to stop abruptly. Resident's head slid under the backseat causing a laceration. Van driver immediately transported the resident to the local hospital emergency room . Attempted to call van driver on 10/1/2024 at 9:30 am, no answer, unable to leave a message. Attempted to call van driver again on 10/2/24 at 1:00 pm, again no answer and unable to leave a message. No return call as of exit date. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 10/1/2024 at 1:44 pm with CNA K, she stated that she, the resident's family member, and the van driver were all in the van when transporting Resident #196 to her appointment. The van driver made a sudden, abrupt stop due to a car stopping in front of him. This caused Resident #196 to slide out of her wheelchair and under the seat in front of her because she was not secured with lap belt or cross body strap. She stated the van driver pulled over to check on the resident and that the resident was bleeding from her head. The van driver immediately transported the resident to the local hospital emergency room . During an interview on 10/1/2024 at 1:25 pm with Resident # 196's family member, she stated that she was sitting in the seat in front of the resident during transport and that when the van came to a sudden, abrupt stop, she turned around and saw Resident #196 had slid out of the wheelchair and under her seat because the resident was not secured with a lap belt or cross body strap. She stated the resident's head was bleeding and that the van driver transported them to the local hospital emergency room immediately. Observation on 10/4/2024 at 9:20 am, of resident transportation on facility van by maintenance director- revealed maintenance director properly secured resident on the van lift, anchored the wheelchair in the van, and checked the seat belt and shoulder strap; no deficiencies or violations were noted. Record review of in-service training for Abuse and Neglect was provided to all staff on 9/19/2024. Record review of the Transportation Safety Checklist for 4 van drivers was completed by the administrator. Record review of in-service certification conducted on 9/19/2024 on transportation safety for 8 employees was conducted by the administrator. Record review of in-service certification conducted on 9/19/2024 on transportation safety for employees responsible for transportation was conducted by the administrator to include: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, Secure wheelchair using wheelchair tiedown, Place safety belt on resident, Double check wheelchair restraints and safety belt are secure, Re-eval of all transport drivers, Transportation safety checklist to include: Equipment is visually checked for proper working conditions prior to loading residents, Safety straps are not frayed, torn or broken, Vehicle is not started until all passengers are properly seated and secured. How and who to report neglect to. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of safety binder titled, Transportation Safety Checklist, revealed staff are using the safety checklist when transporting residents. Staff interview with DON on 10/4/2024 at 9:25 am, she stated she was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. Staff interview with HR personnel on 10/4/2024 at 9:40 am, she stated she was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. Staff interview with OT staff on 10/4/2024 at 9:55 am, she stated she was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. Staff interview with housekeeping staff on 10/4/2024 at 10:10: am, she stated she was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. Staff interview with activities staff on 10/4/2024 at 10:25 am, she stated she was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. Staff interview with business office staff on 10/4/2024 at 10:25 am, she stated she was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. Staff interview with medical records staff on 10/4/2024 at 10:35 am, she stated she was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interview with maintenance personnel on 10/4/2024 at 10:45 am, he stated he was in-serviced on key elements of transporting residents and the van safety checklist which included: Checking seat belts and wheelchair tiedowns to make sure they are operational and safe for use, secure wheelchair using wheelchair tiedown, place safety belt on resident, double check wheelchair restraints and safety belt are secure. The non-compliance was identified as a past non-compliance IJ. The non-compliance began 9/19/2024 and ended 9/19/2024. The facility had corrected the non-compliance before the investigation began on 10/1/2024.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46677 Based on observations, interviews and record reviews the facility failed to offer a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet for 1 (Resident #6) of 1 residents reviewed for diets. The facility failed to provide Resident #6 with large protein portions as ordered by his physician. This failure could affect all residents on therapeutic diets by placing them at increased risk for significant weight loss and malnutrition. Findings include: Record review of Resident #6's face sheet, dated 10/03/2024, revealed resident was a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #6's order summary dated 10/03/2024 revealed Resident #6 was ordered large protein portions at all meals starting 09/06/2024. Record review of Resident #6's Nutritional Assessment, dated 09/04/2024, revealed Resident #6 was under his IBW (ideal body weight). Section 8 Summary stated, Change diet to Regular with large protein portions at meals. Observation of Resident #6 on 10/01/2024 at 12:14 PM revealed resident was eating his lunch. Resident #6 received a slice of meatloaf, potatoes and peas. Resident #6 did not have a large portion of protein. Observation of lunch service in the kitchen on 10/03/2024 at 12:03 PM revealed Dietary Manager making Resident #6 a sandwich for lunch. Dietary Manager made a turkey sandwich using two slices of turkey, lettuce and tomato. Observation of Resident #6 on 10/03/2024 at 12:38 PM revealed resident was eating his sandwich. Resident #6 did not have large portion of protein on his sandwich. Interview with Dietary Manager on 10/03/2024 at 12:14 pm revealed she was unaware that Resident #6's diet changed. Dietary Manager stated the nurses are responsible to inform the kitchen staff when a resident's diet changes and then she updated the resident's dietary card. Dietary Manager stated if residents did not receive the therapeutic diets as ordered it could put them at risk for losing weight. Interview with Resident #6 on 10/03/2024 at 12:38 PM revealed resident had not received large protein portions at meals since being in the facility. Resident #6 stated he likes the food and tends to eat as much as he could at mealtimes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 10/04/2024 at 2:05 PM revealed nursing staff update diet orders in the residents' medical records and communicate changes to the kitchen staff. DON was unable to say why Resident #6 had not received large protein portions. DON stated if a resident does not get the prescribed therapeutic diet they would be at risk for further weight loss or malnutrition. Record review of facility policy titled Interdepartmental Notification of Diet (Including Changes and Reports) dated October 2017, revealed 1. When a new resident is admitted , or a diet has been changed, the nurse supervisor shall ensure that the food and nutrition services department receives a written notice of the diet order. 2. The food and nutrition services department will be notified verbally if the diet change or report occurs one hour or less before a scheduled meal, or if circumstances indicate that the written procedures will not be adequate to ensure service at the next meal.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 3 medication carts (the Treatment Cart) reviewed for medication storage, in that; The facility failed to ensure the Treatment Cart was locked when it was left unattended in the common area in front of the nurses' station, and then again left unlocked and unattended in the 200-hallway opposite of room [ROOM NUMBER]. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings were: In an observation on 10/03/2024 at 10:46 AM, the Treatment Cart was left unlocked and unattended in the common area in front of the nurse's station. The cart contained scissors, prescription and over the counter medications related to skin and wound care. There were staff, residents, and visitors in the immediate vicinity. In an interview on 10/03/2024 at 10:47 AM, RN A stated the Treatment Cart was her responsibility. RN A stated the Treatment Cart should not be left unlocked when not in use. RN A stated she had been trained not to leave it unlocked when not attended. RN A stated that the Treatment Cart had been unlocked and unattended just while I stepped into the DON's office to pick up some print outs. RN A stated she was unsure off the top of her head if any of the items in the Treatment Cart could cause harm if used inappropriately. RN A stated that she believed some risk of harm was always possible. In an observation on 10/03/2024 at 10:52 AM, the Treatment Cart was left unlocked and unattended in the 200-hallway opposite of room [ROOM NUMBER]. The cart contained scissors, prescription and over the counter medications related to skin and wound care. There were staff, residents, and visitors in the immediate vicinity. Specifically, an unidentified resident could be seen pacing in the hallway near where the Treatment cart was parked during the provision of resident care. The drawers were facing out in to the 200-hallway. In an interview on 10/03/2024 at 11:22 AM, RN A stated that she could not believe she had left the Treatment Cart unlocked again. RN A stated that she had only been working at the facility for about a week and had not ever been through a SA survey and was very nervous. RN A stated she had mistakenly left the Treatment Cart unlocked when she stepped into room [ROOM NUMBER] to begin a procedure that was being observed by a SA surveyor. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/03/2024 at 1:50 PM, the DON stated that she had her eyes on the cart through the window when it was at the nurses' station, when RN A was in her office at the printer. The DON stated she did not believe the Treatment Cart should be considered unattended when it was left unlocked at the nurses' station because she could see it from where she sat in the DON office. The DON conceded that she did not intervene before the drawers on the Medication Cart were opened and assessed by this SA surveyor. The DON inquired if the cart drawers opened into the room when the Medication Cart was observed for a second time unlocked and unattended in the 200-hallway opposite of room [ROOM NUMBER]. The DON stated that if the drawers were facing into a resident's room while the nurse was working in that room, that would be acceptable. [This SA surveyor explained that the drawers were accessible and facing out in the 200-hallway in the above observation.] Record review of the facility policy entitled Medication Labeling and Storage, revised February 2023, reflected under the heading Medication Storage 4.) Compartments .including carts . are locked when not in use .are not left unattended if open or otherwise potentially available to others. Record review of the undated facility policy entitled Administering Medications, reflected in step 17.) .During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. Review of Lippincott procedures entitled Medication Delivery Acceptance: Long Term Care, reviewed 5/19/2024, accessed from https://procedures.lww.com/lnp/view.do?pId=4420028&hits=care,long, term&a=false&ad=false&q=long%20term%20care, accessed on 10/04/2024, reflected under the heading Implementation, subheading Ordering and Receiving Regular Medications, Place the delivered medication in a locked cart, cabinet, or room as designated by your facility. Review of Lippincott procedures entitled Oral drug Administration, reviewed 5/19/2024, accessed from https://procedures.lww.com/lnp/view.do?pId=4420477, accessed on 10/04/2024, reflected, under the heading Reducing Medication Risk in an Older Adult, Store medications in a secure, dry location, away from sunlight.

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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** 44906 Based on observations, interviews and record reviews, the facility failed to establish and 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 1 of 2 residents (Resident #12) with wounds observed for infection control, in that: The facility failed to ensure hand hygiene was initiated between glove changes during wound care for Resident #12 on 10/03/2024. This deficient practice could affect residents who required wound care by contributing to the bacteria load and/or cross contamination in the wound resulting in delayed healing. Findings included: Record review of Admission Record printed 10/03/2024, reflected Resident #12 was a [AGE] year-old female originally admitted on [DATE]. Record review of Diagnosis Report, printed 10/03/2024, reflected Gastrostomy Status was the admitting diagnosis for Resident #12. Other active diagnoses included Stage 4 pressure injury [full thickness tissue loss with exposed underlying tissue (such as bone, tendon, or muscle], slough or eschar [collection of dry, dead tissue within a wound] may be present, and often includes undermining and tunneling] of right buttock with an onset of 11/20/2023. Record review of Progress Note dated 11/28/2023 at 5:00 AM, reflected that Resident #12 had returned from hospitalization with new, stage 4 pressure injury to right buttock and had a wound vacuum in place upon arrival to the facility. Record review of the quarterly MDS assessment, dated 9/26/2024, reflected Resident #12 had a BIMS summary score of 11, indicative of moderate cognitive impairment. Under section M - Skin Conditions, Resident #12 was coded as having a pressure injury, considered unhealed, and at stage 4. Record review of the Care Plan reflected Resident #12 had a focus area of pressure injury with a revision date of 08/07/2024; with the following associated interventions: follow facility policies/protocols for the prevention/treatment of skin breakdown, initiated 12/13/2020. Record review of Order Details, printed 10/03/2024 at 12:19 PM, reflected Resident #12 had physician orders to perform wound care 4 times per day and as needed to stage 4 pressure injury to right buttock with an order date of 9/27/2024. Record review of Weekly Wound Review dated 9/27/2024 reflected Resident #12 had a pressure injury on the right buttock measuring 0.5 centimeters length by 0.4 centimeters width and a depth of 0.3 centimeters, considered a stage 4, with undermining 0.5 centimeters on the 12 to 6 o'clock directional. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 10/03/24 at 10:47 AM, RN A performed wound care on Resident # 12 with CNA B present to assist in positioning. RN A failed to sanitize hands after removing gloves prior to donning clean gloves. RN A stated she did not realize she did not use an alcohol-based hand sanitizer prior to donning clean gloves for the next step in the wound care procedure. RN A stated that she should have used an alcohol-based hand sanitizer after discarding her gloves. RN A stopped the process to go wash her hands at the sink in the resident's restroom and obtain additional supplies needed for the continuation of the wound care procedure. RN A stated she was nervous due to being a new employee at the facility, and her experience was in the acute care setting not in long term care. RN A stated that she had been trained both in nursing school, and at this facility that hands must be either washed or use hand sanitizer after removing gloves. RN A then used an alcohol-based hand sanitizer before donning clean gloves to resume the wound care procedure. Record review of undated Handwashing/Hand Hygiene Policy, reflected under the implementation section in step 7.) Use an alcohol-based hand rub .After removing gloves. Under the applying and removing gloves section, the final step included: Perform hand hygiene. Review of CDC Clean Hands web page, dated 02/27/2024, entitled Clinical Safety: Hand Hygiene for Healthcare Workers, accessed from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, accessed on 10/07/2024, reflected, under the subheading Know when to clean your hands, immediately after glove removal.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 47611 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms or at least 100 square feet in single resident rooms in all of the resident rooms reviewed for room size, in that: The facility failed to ensure all resident rooms had the required minimum of 80 square feet per resident in rooms occupied by multiple residents. This failure could place residents who reside in these rooms at-risk for a limitation their ability to move around the room and a decreased quality of life. The findings were: Observations on 10/02/2024 of all the resident rooms revealed the rooms were all two-person rooms and each room measured 11 feet by 14 feet which equaled 154 square feet total per room. For all rooms, 154 square feet divided by two beds per room equaled 77 square feet per bed. During an interview on 10/2/2024 at 12:30 pm with the maintenance director, he stated he measured the rooms, and they were under the required size and measured 154 square feet. During an interview on 10/2/2024 at 12:15 pm the Administrator revealed all resident rooms did not measure the minimum 80 square feet per resident. The Administrator stated that there had been no changes to the rooms. The Administrator stated that she wished to continue the current room size waiver. Record review of the CMS-3740 Bed Classification form, dated 07/28/2022, provided by the Administrator, revealed all resident rooms were all certified rooms for two beds each.