STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center	2322 Morgan Ave Corpus Christi, TX 78405

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, interview, and record review the facility failed to ensure a resident receives care, consistent with professional standards of practice, to prevent deterioration of existing pressure ulcers, promote healing, and prevent development of new pressure ulcers, for one (Resident #46) of three residents reviewed for pressure ulcers, in that: -Wound care nurse did not pat dry Resident #46's pressure ulcer after cleaning the wound with wound cleanser as ordered. This failure could place residents with existing pressure ulcers receiving preventive skin care at risk for developing new pressure ulcers and/or a deterioration in existing pressure ulcers. The findings included: Record review of Resident #46's face sheet dated 6/18/24 reflected a [AGE] year-old-male originally admitted on [DATE]. Diagnoses included cerebral infarction (stroke, blood supply to part of the brain is blocked or reduced), contractures (shortening or hardening of the muscles) to the left and right hand, and muscle atrophy (wasting or thinning of muscle mass). Record review of Resident #46's physician orders stated: Dated 5/18/2024 Left posterior (closer to back of) ischium (hip bone) stage 3 (full thickness skin loss) pressure injury. Cleanse with wound cleanser and pat dry. Apply barrier cream over the site. Every day for aid in wound healing. Record review of Resident #46's care plan dated 5/7/24 stated Resident 46 had pain r/t contractures to bilateral (both) hands, pressure ulcer stage 3 to the ischium. Interventions included: Administer analgesia as per orders. Give 1/2 hour before treatments or care. (continued on next page)

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Respond timely to any complaint of pain. Observation of wound care on 06/17/24 at 02:37pm, the Wound Care nurse cleansed Resident #46's left posterior ischium with wound cleanser, removed gloves, washed hands for greater than 20 seconds, put on new gloves, and applied barrier cream. The - Wound Care nurse did not pat dry after cleansing Resident #46's left posterior ischium as ordered after cleansing wound with wound cleanser. Attempted an interview with Resident #46 however, Resident #46 was uninterviewable. In an interview on 06/17/24 at 02:56pm, the Wound Care nurse stated she did not pat dry Resident #46's wound after cleansing the wound with wound cleanser because she was nervous and missed a step. The Wound Care nurse stated after washing her hands, she felt the wound cleanser she applied to Resident #46's wound had enough time to dry. The Wound Care nurse stated it is important to follow doctor's orders because it is person centered and care that was ordered by a physician for Resident #46. The Wound Care nurse by not pat drying Resident #46's wound, the wound could become macerated (soften or become softened by soaking in liquid), and could delay healing. The Wound Care Nurse she usually pat dries the wound and could not stated when the last time she received in-service on wound care. In an interview on 06/18/24 at 11:01am, the DON stated it is important to follow all doctor orders because it is person centered. In-service was conducted yesterday on following doctors' orders and infection control. DON stated by the DON stated by not pat drying the Resident #46's wound, it could lead to infection, sepsis, hospitalization , and the wound not healing properly. The DON stated she and the ADON on the floor was in charge of overseeing the Wound Care nurse was following doctors' orders. The DON stated she had watched the Wound Care nurse perform wound care last week with no concerns noted. The DON stated the wound care doctor comes twice a week and watches the Wound Care nurse perform wound care on Resident #46 as well as other residents and stated the doctor has never had any issues with the Wound Care nurse's performance. The DON stated the Wound Care nurse was nervous and visibly upset about the mistake. Record review of Medication Administration dated 10/24/22 stated: Policy: Medications are administered by a licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46038 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and under proper temperature controls on 2 of 6 treatment/medication carts and 3 of 3 medication storage rooms reviewed for storage of drugs. 1. The 200-floor treatment/medication cart was left unlocked by the nurse's station with the drawers facing outward. 2. 300 floor treatment/medication cart was left unlocked outside room [ROOM NUMBER] with its back against the wall and drawers facing the hallway. 3. The temperature log for the medication storage refrigerator in the 400 floor medication storage room did not have a temperature recorded for 06/15/24 or 06/16/24 and the refrigerator was not clean. 4. The temperature log for the medication storage refrigerator in the 300 floor medication storage room did not have a temperature recorded for 06/09/24 AM or 06/17/24 AM. 5. The temperature log for the medication storage refrigerator in the 200 floor medication storage room did not have a temperature recorded for 06/17/24 AM. These deficient practices could affect residents who have medications in the nurse's treatment/medication cart or in refrigerated storage and could result in lost medications, drug diversion, harm due to accidental ingestion of unprescribed medications, or medications that are ineffective and/or contaminated. Findings included: 1. Observation on 6/16/24 at 11:02am revealed an unlocked medication/treatment cart located by the 200-floor nurse's station. The medication/treatment cart was against a wall and one staff member (LVN A) located at the nurse's station. There were two residents by the nurse's station near the treatment/medication cart. This surveyor opened the top drawer recognizing the treatment/medication cart being unlocked. Multiple medications in bulk bottles were easily assessable and removable. This surveyor was able to open all drawers and go through various medications and treatment supplies. In an interview on 6/16/24 at 11:05am, LVN A stated she had been on shift since 6:00am and did not see the treatment/medication cart unlocked. LVN A stated the treatment/medication cart was closer to the nurse's station, but a resident had pushed it out the way to grab snacks that were located on the nurse's station counter. LVN A stated that was not her treatment/medication cart and she was not doing any treatments on residents. LVN A stated the treatment nurse was not working at that that time and had no idea of how long it had been unlocked. LVN A stated she was not in-serviced on making sure treatment/medication carts are to be locked when not in use. LVN A stated since the treatment/medication cart was unlocked, residents could gain access to the cart easily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 06/16/24 at 11:16 AM revealed an unlocked medication cart unattended on the 3rd floor across from room [ROOM NUMBER]. All drawers on the medication cart could be opened with medication easily accessible. The surveyor was able to open all drawers and look inside the cart. The medication cart was unlocked and unattended for approximately 30 seconds before LVN D exited room [ROOM NUMBER] and locked the cart. In an interview with LVN D on 06/16/24 at 11:17 AM, LVN D stated that the unlocked cart was hers. LVN D stated that her cart had been unlocked for a few minutes while she went into room [ROOM NUMBER] to assist a resident. LVN D stated that she has received many in-services on keeping her medication cart locked when not actively in use. LVN D was unable to recall specifically when the last in-service she received on medication cart usage. LVN D stated any unauthorized person walking by could access the medications in the cart while it was unlocked. LVN D stated residents could steal medications from an unlocked cart and potentially ingest them causing harm. In an interview on 06/17/24 09:07am, the DON stated, sated the treatment/medication carts should be locked when not in use. The DON stated unauthorized people could gain access to medications and supplies within the cart. The DON stated there should not be any reason the treatment/medication cart was unlocked. The DON stated it is the charge nurses' job to ensure all carts are locked when not in use and the last in-service on locking all carts when not in use was sometime in May. In an interview on 6/16/24 at 12:02pm, the Regional Nurse Consultant stated all treatment/medication carts are supposed to be locked at all times when not in use for the safety and protection of residents, staff, and visitors. 3. Observation of 400 floor medication storage room on 06/16/24 at 11:30am revealed the temperature log for the medication refrigerator had columns for date, shift, temperature, initials, and Clean? Y/N. There were no temperatures recorded for 06/15/24 or 06/16/24, the clean column was marked with a Y for 06/01/24 - 06/14/24, and there was a brown sticky substance on the left side of the bottom shelf. Repeat observation of the 400 floor medication refrigerator and temperature log on 06/16/24 at 2:30pm revealed the temperature was recorded for 06/16/24; 1400 (2:00pm) was entered in the Shift column, 36 degrees was entered in the Temperature column, there were intials entered in the Initials column, and Y was entered in the Clean column. The brown sticky substance was still on the bottom shelf of the refrigerator. Repeat observation of the 400 floor medication storage refrigerator on 06/17/24 at 10:54am revealed the brown sticky substance on the bottom shelf of the refrigerator was still there and a Y was entered in the Clean column of the temperature log. In an interview on 06/17/24 at 10:55am, LVN E stated she did not know what the substance was on the bottom of the refrigerator, but she would clean it up. LVN E stated spills could cause contamination of resident medications that were stored in there which could cause illness. LVN E stated if the temperature was not kept track of the refrigerator may not be working properly and it could lead to medications not being stored at the proper temperatures. LVN E stated if medications were not stored at the proper temperature, it could lead to medication ineffectiveness or contamination, residents not receiving the medication benefits, such as insulin not working, and residents' blood sugar not being controlled. LVN E stated elevated blood sugar could result in illness and/ or death. LVN E stated the last in-service on medication storage was last month. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/17/24 at 11:10am, LVN F stated she had not seen the brown substance on the bottom of the refrigerator. LVN F stated it could cause contamination of medication which could lead to residents getting sick. LVN F stated the nurses were responsible for cleaning up messes and spills because they were the only ones allowed in the medication room. LVN F stated night shift was responsible for checking and logging temperature on the refrigerator and if the temperature was not checked or logged, the refrigerator could be too warm or too cold and could lead to medications not working like they were supposed to. LVN F stated residents could get sick or get hospitalized if their medications were not working properly. LVN F stated they got in-services on medication storage about once a month. In an interview on 06/17/24 at 11:22am, LVN G stated she was not aware of the substance at the bottom of the refrigerator. LVN G stated if a medication was to fall in it/on it, they would have to discard the medication and get a new one. LVN G stated if the medication was given to a resident after it touched the substance, it could cause harm to the resident if given. LVN G stated if someone contaminated a medication then put it back with all the other medications, it could contaminate all of the medications. LVN G stated whoever caused the mess was responsible for cleaning it, but if that did not happen, whoever saw it was responsible for cleaning it. LVN G stated nurses primarily on the night shift were responsible for checking the temperatures and logging them but if it was not filled out for the day, all nurses were responsible for checking and logging it. LVN G stated medications could go bad if the temperatures were out of range and no one noticed it and that could lead to residents getting sick or hospitalized . LVN G stated she thought the last in-service on medication storage was in May. 4. Observation of the 300 floor medication storage room on 06/17/24 at 12:10pm revealed the temperature log for the medication refrigerator had columns for Day, AM Temperature, Initials, PM Temperature, Initials, and Weekly Clean Initials. There was no temperature recorded for 06/09/24 AM or 06/17/24 AM. In an interview on 06/17/24 at 12:22pm, the DON stated that there should never be spilled substances of any kind in a medication refrigerator. The DON stated spilled substances could cause illness to residents if medication came into contact with them and it could contaminate the entire storage of the medication. The DON stated it is everyone's responsibility to clean up any spills or leaks in the refrigerators and the ADON and DON are responsible for making sure that they are kept clean. The DON stated the temperature logs had to be kept accurately to make sure that medications were stored at the correct temperatures to prevent issues such as medications becoming ineffective or contaminated. The DON stated nurses on both shifts were responsible for checking the temperature and recording it in the log, and it was every nurse's responsibility to make sure the refrigerators were functioning properly. The DON stated if the refrigerator was not functioning properly or there was no thermometer, the nurse should contact maintenance to get a new thermometer or refrigerator and contact the DON or ADON to remove the medications until a new refrigerator was acquired. The DON stated if there was an issue with a refrigerator, they would get a replacement as soon as they were notified. The DON stated if the refrigerators were not at the correct temperature and no one noticed, it could lead to medications becoming ineffective or contaminated and could cause resident illness or worsening of their medical condition which could lead to hospitalization or death. 5. Observation of the 200 floor medication storage room on 06/17/24 at 12:58pm revealed the temperature log had an AM block with columns for Date, Temperature, and Initials and a PM block with the same columns for the medication refrigerator. There was no temperature recorded for 06/17/24 AM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/17/24 at 1:11pm, the ADON stated it was the responsibility of the nurses on both shifts to check and log the temperature of the medication refrigerator in the storage room. The ADON stated if the temperatures did not get checked, no one would know if the refrigerator was not functioning properly and medications could go bad which could lead to them not working properly and residents getting sick. The ADON stated she was going to do an in-service specifically on temperatures in the medication refrigerators. In an interview on 06/17/24 at 1:16pm, LVN H stated nurses on both shifts were supposed to check the temperature and record it as well as make sure the refrigerator and room were clean. LVN H stated if temperatures were out of range, medications could go bad and could make residents sick which could lead to hospitalization . LVN H stated depending on the medication, it could lead to resident death if medications were ineffective. Record review of Medication Carts and Supplies for Administering Meds dated 10/01/19 stated: Policy The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents. The mobile medication cart will be used to facilitate administration of medications to residents. The purpose of the mobile medication system is to ensure appropriate control and surveillance of resident assigned medications. 2. The medication cart is locked at all times when not in use. 3. Do not leave the medication cart unlocked or unattended in the resident care areas. Supplies: The following equipment and supplies are acquired and maintained by the facility for the proper storage, preparation, and administration of medications. 2. A refrigerator and freezer with a thermometer for each section. 4. A temperature log with acceptable temperature ranges for each area should be maintained at all times. 49157 50039 FACILITY FTAGDIR

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44748 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation. 1. The facility failed to ensure juice dispenser guns were sanitary. 2. The facility failed to ensure equipment was clean and sanitized. 3. The facility failed to ensure dry goods were sealed. 4. The facility failed to ensure spices and a freezer item were not left open to air. 6. The facility failed to ensure personal items were not in the prep area or refrigerator 7. The facility failed to ensure the kitchen was following their policies These failures could place residents at risk of foodborne illnesses. Findings included: Observation and initial tour of the kitchen on 06/17/24 beginning at 11:05 am revealed 95 of 108 coffee cups, 27 of 61 juice glasses, and 28 of 84 plastic bowls were scratched and/or badly stained inside with a whitish powdery substance and/or dark brown-red stains. There were 8 drying mats of 22 needed for drying the cups, glasses, and bowls on the trays. The dishes on the trays without drying mats were wet inside. There were 2 of 2 juice guns hanging from the juice machine. There was only one holster on the juice machine table. The tip of one of the juice guns was touching the top of a cardboard box that had a thick, sticky red substance the nozzle of the juice gun was resting in. The other juice gun was hanging with the nozzle touching the outside of a cabinet and not in its holder, which was near the juice gun. There were gnats around the juice machine. Both juice guns had a similar thick, red sticky substance on the handles and in and around the dispense buttons. There was an open, partially full 16-ounce bottle of soda on the juice machine table. There was an open and partially full unlabeled 12 ounce can of soda on a tray labeled residents for Monday, June 17 in the refrigerator. There were 2 tape dispensers on a prep table. The sugar bin in the dry storage area did not have the lid sealed, leaving the sugar exposed to the air. There were 4 of 15, 16-ounce containers of spices open to the air. There was a large bag labeled breaded fish in the freezer that was open to the air. There was a large non-stick frying pan that was worn down to the metal and hanging on the pot hanger. The underside of the shelf above the steam table holding area had a brownish red substance the length of the holding table. The substance was formed in small droplets and potentially falling off into the food on the prep table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the juice guns and interview with the FSM on 06/17/24 at 11:35 am revealed the FSM removed the nozzles from the juice gun heads revealing a build-up of a red substance and a black substance. The FSM stated the black substance was the same as the red substance and neither substance should be there. The FSM stated she did not know about the underside of the holding table shelf. She stated the kitchen had a cleaning schedule that staff were responsible for and she was ultimately responsible for the kitchen. Observation of the cleaning schedule dated June 2024 revealed all spaces filled, as if the cleaning had been done regularly. An interview with COOK A on 06/17/24 at 11:08 am she stated the worn pan was in use, and they used it for making grilled cheese sandwiches. She stated they probably should not be using the pan because the non-stick surface could flake off even more and get into the food. She stated it could make residents sick. COOK A stated the spices should not have been open to air because the spices could clump, and it could affect the residents-maybe make them sick or cause some kind of reaction. She stated the stained and scratched cups, bowls, and glasses were on the clean racks, and in use. An interview with [NAME] B on 06/17/24 at 11:09 am she stated the stained and scratched cups, bowls, and glasses were on the clean rack, and about to go out on the carts for delivery to the residents. She did not know who was responsible for checking the dirty dishes. She stated she did not know the dishes looked the way they did and would not want to drink or eat from them because it would probably make her sick. She stated the dishes needed to be re-washed because whatever was in the dirty dishes on the clean rack could make the residents sick. An interview with the FSM on 06/17/24 at 11:30 am she stated the stained and scratched cups, bowls, and glasses were used every single shift. She stated there were no problems with the dishwasher and proceeded to check a chem strip, which was normal. She stated the stained and scratched cups, bowls, and glasses should not be used and the dishwasher was responsible for checking them. She stated they would not send the dishes out like that. When shown the dirty dishes, she stated, they're not washing them. She stated the dishwashers were trained to check every load. She stated she was ultimately responsible for the entire kitchen. Regarding the juice guns, the FSM stated they were not supposed to be hanging down and should be in the holsters. She stated the red sticky substance was old juice. She stated the juice guns were cleaned after each use. She stated she cleaned them herself last week. She stated they did not look like they had been cleaned after every use. The FSM stated if the nozzles got dirty, it could transfer germs into the glasses and it could make residents sick. The FSM stated cross contamination could occur with the juice guns in the condition they were in as well as the scratched and dirty dishes. The FSM stated the spices and sugar should not have been open to air because it could cause clumping. She stated the residents could get sick. The FSM stated staff should not be using the worn, non-stick pan for anything, and it should have been replaced. The FSM stated she was not sure what their policy said about cleaning, sanitation, and personal items. The FSM stated she did not know who the personal sodas belonged to, but they should not have been on the juice machine table or in the refrigerator. The FSM stated the tape dispensers on the prep table should not have been on the shelf above the prep table because kitchen staff used the prep table to place sandwiches and other snacks in bags or plastic wrap and used the tape to secure the bags and plastic wrap. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DW on 06/17/24 at 11:40 am she stated the stained and scratched cups, bowls, and glasses were typically not looked at after the wash cycle. She stated all of the stained and scratched cups, bowls, and glasses were on the clean rack and about to be used. She stated the stained and scratched cups, bowls, and glasses typically looked like that and they used them anyway. She stated she guessed the staff was moving too fast to notice. She stated cross contamination could occur, especially in the scratches and make the residents sick. She stated she tried to say something to the FSM, but nothing happened, and she was afraid she could get fired if she said anything more. She stated drying mats were needed for drying the cups, glasses, and bowls on the trays and that all of the drying trays should have had a drying mat on them so air could circulate and keep bacteria from growing, which could make the residents sick. She stated without the drying mats, the dishes did not dry properly. Record review of the facility policy, Food Storage revised 10/05/21: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes an HACCP (Hazard Analysis Critical Control Point-a management system in which food safety is addressed through the analysis and control of bilogical, chemical, and physical hazards from raw material production, procurement and handling, to manufacturing, distribution and consumption of the finished product) guidelines. Procedure: 1. Dry storage rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. 2. Refrigerators d. Date, label, and tightly seal all refrigerated foods . Facility policies for cleaning and personal items were requested from the FSM on 06/17/24 at 11:45 am but not provided. In-services for kitchen staff was requested from the FSM on 06/17/24 at 11:45 am but not provided. References: TAC 554.1111 (b) The facility must store, prepare, and serve food under sanitary conditions, as required by the Texas Department of State Health Service sanitation requirements.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49157 Based on observation, interview, and record review, the facility failed to have sufficient staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one (Resident #272) of eight residents reviewed for medication administration. The facility failed to ensure that four nurses (LVN A, LVN H, LVN I, and LVN J) admistered medication that was ordered for Resident #272 as documented. This failure could place residents at risk for not receiving their medications, not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. Findings included: Record review of Resident #272's admission record dated 06/18/24 revealed a [AGE] year old male admitted to the facility on [DATE]. Diagnoses included encounter for orthopedic aftercare following surgical amputation, iron deficiency anemia, gastrostomy (a tube inserted through the abdominal wall into the stomach that is used to give residents nutrition, medications, and/or fluids) status, congestive heart failure, type 2 diabetes, primary hypertension, history of skin cancer removal on nose, chronic kidney disease, and cerebral infarction (disrupted blood flow to the brain that causes brain cells to die). Record review of Resident #272's order summary report dated 06/18/24 revealed an order for Alkalol Saline Nasal Solution (Nasal Moisturizer Combination); 2 sprays in both nostrils one time a day for allergies. Order date: 06/11/24. Start date: 06/11/24. Observation of medication pass on 06/18/24 at 9:10am revealed that Resident #272's ordered nasal spray was not in the medication administration cart that was being used by the WCN, who was also the floor charge nurse that day, to administer medications. Record review of Resident #272's MAR on 06/18/24 revealed that Resident #272's nasal spray was administered on: 06/12/24 at 9:00am by LVN I 06/13/24 at 9:00am by LVN A 06/14/24 at 9:00am by LVN A 06/15/24 at 9:00am by LVN J 06/16/24 at 9:00am by LVN A (continued on next page)

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	455575	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center	2322 Morgan Ave Corpus Christi, TX 78405

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/17/24 at 8:00am by LVN H In an interview on 06/18/24 at 10:15am, the WCN stated the nasal spray was not in the medication cart nor in the medication storage room. The WCN stated she contacted the nurse practitioner by phone who advised the WCN to try to get the nasal spray from the pharmacy. The WCN stated she contacted the pharmacy and was told the nasal spray is an over the counter medication and should be obtained by central supply. The WCN stated if a medication is not administered as prescribed, it could cause the resident to have medical issues, depending on the medication, such as high blood pressure for a hypertension medication or decreased wound healing for vitamins/minerals. The WCN stated she was not able to tell who the other nurses were that were on the MAR because it only showed initials or abbreviations, but that she would try to run a report to show who each nurse was. (She was not able to run that report). In an interview on 06/18/24 at 12:29pm in Resident #272's room, Resident #272's family member stated that she was at the facility with the resident every day and had observed his medication administration on 4 days out of 7 that she had been at the facility. The family member stated Resident #272 had not received nasal spray on any of the days that she observed him being given medications. The family member stated that Resident #272 got the nasal spray at home due to the cancer removed from the top of his nose on the right side. The family member stated the nasal spray was used at home as needed, not necessarily every day, to help prevent infections. Resident #272 also stated that he had not gotten the nasal spray since he had been in the facility. In an interview on 06/18/24 at 12:32pm, MA K stated that you should never document that you gave a medication that you did not give. MA K stated if the medication is not on the cart or in the medication room, she would tell the nurses so that they could get it. MA K stated it would be false documentation and could have adverse effects such as high blood pressure or high blood sugar due to the resident not getting prescribed medication. MA K stated if she saw that a medication was not administered, but was documented that it was, she would let the charge nurse know. In an interview on 06/18/24 at 12:35pm, the WCN stated she would not document that a medication was given if she did not have the medication. The WCN stated she would contact the pharmacy and/or the practitioner as needed to advise them of the situation and see if the order needed to be changed or what needed to be done. The WCN stated as charge nurse, if she knew about a medication being documented but not given, she would find out who that person was, find out the reason, and tell the DON. The WCN stated that she talked to central supply and now has the nasal spray for the resident and the nurse practitioner has updated the order to as needed instead of scheduled, per Resident #272 and family request. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/18/24 at 12:46pm, the DON stated, I'm working on the in-service now. The DON stated she would expect that if a medication was ordered and had not been available for over 24 hours, the nurse would notify the ADON, DON, pharmacy, and/or central supply to get the prescribed medication or over the counter medication. The DON stated she would also expect the nurse to notify the practitioner to let them know what was going on and see if they wanted to make any changes. The DON stated she would expect the nurse to NOT document that a medication had been given if it had not. The DON stated if a medication is not really given but documented as administered, it could cause complications such as a physician ordering another blood pressure medication because documentation showed that a resident had been receiving an anti-hypertensive medication but the blood pressure was still high which could have possibly lead to a resident having a critically low blood pressure due to the extra medication. The DON stated false documentation of medication administration could lead to resident complications up to and including death, depending on the medication. The DON stated that the nurses that falsified the documentation would be disciplined and re-trained on medication administration and documentation. The DON stated she had notified the family and was waiting on a call back from the doctor. Telephone contact was attempted on 06/18/24 with LVN A, LVN I, LVN H, and LVN J, two times each between 1:00pm and 3:00pm. Messages were left each time with surveyor's name and contact number with no call backs received. In an interview on 06/18/24 at 1:32pm, the ADMIN stated she would expect the nurse to contact the pharmacist or supply to get the medication, then to contact the ADON or DON if they still were not able to get it. The ADMIN stated if the medication was still not available after all that, the nurse would have to contact the prescriber to see if the order needed to be changed. The ADMIN stated she would expect all staff to follow physician orders and not just document that it was done. The ADMIN stated that all of the nurses who falsified the documentation would be disciplined by the facility and in-serviced/ retrained on medication administration and documentation. Record review of the facility's Medication Administration Policy and Procedure dated 10/01/19 states in part: D. 10 Rights of Medication Administration- 6. Right Documentation- Nurses need to document medications as they're given. Any medication documentation needs to be initialed yourself, never let anyone document for you. Chart the time, route, and any other specific information as necessary. E. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. K. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit. 2. Administration B. Medications are administered in accordance with written orders of the prescriber. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Documentation (including electronic) A. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering medications reviews the MAR to ensure necessary doses were administered and documented. D. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are cross referenced to a full signature in the space provided. G. If an electronic MAR system is used, specific procedures required for resident identification, identifying medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameters are described in the user's manual. These procedures should be followed and may differ slightly from the procedures for using paper MARs.

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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. 44748 Based on observation and record review, the facility failed to provide the required 80 square feet per resident in 46 multiple resident rooms (201, 203, 205, 207, 209, 211, 216, 218, 220, 222, 225, 227, 229, 231, 301, 303, 305, 307, 309, 311, 312, 314, 316, 318, 320, 322, 325, 327, 329, 331, 401, 403, 405, 407, 409, 411, 412, 414, 418, 420, 422, 424, 425, 427,429, and 431) out of a total of 90 resident rooms. Rooms measured between 120 and 132.3 square feet instead of the 80 square feet per resident required. This failure could impede the ability or residents living in these rooms to attain their highest practicable well-being. Findings included: Offsite facility reviews revealed an existing room size waiver from recertification survey exit date 01/14/22. The following rooms were determined not to provide the required 80 square feet per resident rooms: 201, 203, 205, 207, 209, 211, 216, 218, 220, 222, 225, 227, 229, 231, 301, 303, 305, 307, 309, 311, 312, 314, 316, 318, 320, 322, 325, 327, 329, 331, 401, 403, 405, 407, 409, 411, 412, 414, 418, 420, 422, 424, 425, 427,429, and 431 based on the facility's Bed Classification Form 3740 dated 06/18/24. Each of the above rooms were identified as accommodating two resident per room, according to the facility's Bed Classification Form 3740 dated 06/18/24.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 20 residents r(Resident #273), staff, and the public. -A facility staff member left an empty covered needle syringe on top of Resident #273's drawer in his room. This failure could place 20 residents who reside on the 200 floor at risk for injury or illness due to an unsafe environment. The Findings: Record review of Resident #273's face sheet dated 6/17/24 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included type 2 diabetes (insufficient insulin production in the body), surgical aftercare following surgery, and end stage renal failure (kidney failure). Record review of Resident #273's MDS reflected a BIMS score of 15 (cognition intact). Record review of Resident #273's care plan reflected Resident #273 has the need for enhanced barrier precautions due to: (open wound, wound vacuum). Interventions included: -Gown and gloves only for high- contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shield as indicated. -Assess the resident for risk factors or current injuries or treatments that could put the patient at risk for infection (wounds, central lines, drains, catheters, tracheostomy). -Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures. During an observation/interview on 6/16/24 at 03:19pm, this surveyor noticed a covered empty needle syringe on Resident #273's dresser approximately 5 to 6 feet away from Resident #273's bed. Resident #273 stated he did not know how long that needle had been there and could not say who could have left it there. Resident #273 denied getting an injection and did not know why the needle syringe would be in his room. Resident #273 denied touching it, stating he did not notice the needle syringe was even there. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/16/24 at 03:21pm, LVN B, stated she was not aware there was a covered needle on Resident 273's dresser. LVN B stated she got to work at 2:00pm and started her rounds in resident rooms around 2:00pm and stated she peeked into Resident #273's room and did not see the needle. LVN B stated all needles are to be disposed of in the sharp's container located on the nurse's cart. LVN B stated she had no idea who could have left the needle in Resident #273's room or if it even belonged to him. LVN B stated by the needle being in Resident's 273's room could possibly cause staff, visitors, or other residents to get injured by getting poked and could cause an infection control issue. LVN B stated she could not remember the last time she was in-serviced on placing sharps in the appropriate sharps container. In an interview on 6/17/24 at 9:12am the DON stated, she did not now who was responsible for leaving the needle syringe in Resident #273's room. The DON stated it could have been the previous night nurse (LVN C) and stated possibly when LVN C went into the Resident #273's room to monitor the wound care vac, LVN C could have placed the needle syringe down on the dresser to tend to the wound vac machine and forgot to dispose the needle. The DON stated all sharps containers are located on the nurse's medication carts. The DON stated by having a needle syringe in Resident #273's room, it was putting visitors, residents, and staff at risk for injury or harm. The DON stated rounding is done by staff at a minimum of every 2 hours and staff are supposed to look into the rooms, assess residents, and make sure everything is in order. The DON stated staff should be going into resident rooms and not just peeking in. The DON stated Crown Rounds are conducted every morning and throughout the day by administration to ensure residents do not have any concerns and to identify anything out of the ordinary. The DON stated on the weekends, the weekend supervisor should be conducting those rounds to ensure residents are checked but was unsure if rounds were conducted on 6/16/24. The DON stated she was unsure when the last in-service on rounding was. This surveyor called LVN C on 6/18/24 at 2:30pm, 6/18/24 at 2:40pm, and on 6/18/24 at 2:49pm with no answer, message left. Record review of Medication Administration- Injectable Administration Policy dated 10/01/19 stated: Policy To administer medications via subcutaneous, intradermal, and intramuscular routes in a safe, accurate and effective matter. Procedure Dispose of syringe in a sharps container and supplies in a appropriate waste container.