

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2024
NAME OF PROVIDER OR SUPPLIER  Retama Manor Nursing Center/San Antonio West		STREET ADDRESS, CITY, STATE, ZIP CODE  636 Cupples Rd San Antonio, TX 78237	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38511</p> <p>Based on interview and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents for 1 of 4 residents (Resident #1) reviewed for medication administration, in that:</p> <p>The facility failed to administer Keppra (a medication used to treat seizures) to Resident #1 on 5/10/2024 in a timely manner and within the facility's medication window for administration.</p> <p>This deficient practice could result in a risk to the residents' health and complications which can lead to seizures.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 5/15/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: epilepsy, not intractable, without status epilepticus (a type of epilepsy that can be managed with medication), seizures and muscle spasms.</p> <p>Record review of Resident #1's quarterly MDS assessment revealed a BIMS score of 15 which indicated the resident was cognitively intact.</p> <p>Record review of Resident #1's care plan last revised on 10/09/2023 revealed Resident #1 had a behavioral concern of insisting medications be given at a certain time and becoming angry when medications are not being given exactly when requested with interventions which included: educate Resident #1 on policies and procedures of medication administration [Resident #1] has been made aware of and educated on medication administration window.</p> <p>Record review of Resident #1's care plan last revised on 04/04/2024 revealed Resident #1 had a seizure disorder with interventions which included: give medications as ordered.</p> <p>Record review of Resident #1's physician orders revealed an order dated 12/22/2023 for Keppra oral solution 100 mg/ml, give 7.5 mg by mouth in the morning and 10 mg by mouth in the evening for seizures.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Medication Administration Audit Report dated 5/15/2024 revealed on 5/10/2024 Keppra oral solution 10 mg by mouth was scheduled to be given at 7:00 p.m., LVN A documented she administered Keppra on 5/10/2024 at 9:31 p.m. (which exceeded the medication window of 1 hour before or 1 hour after the scheduled time frame by 1 hour and 31 minutes).</p> <p>During an interview on 5/15/2024 at 10:12 a.m., Resident #1 stated two days last week, specifically on 5/10/2024 he did not get his Keppra on time. He stated his 7:00 p.m. medication was given at 9:30 p.m. He stated he told his nurse, but he does not remember who he told or what they looked like. Resident #1 stated the nurse responded by saying they would make sure he gets his medication on time, but he does not believe them.</p> <p>During an interview on 5/15/2024 at 1:24 p.m., LVN B stated Resident #1 had a history of grand mal seizures. LVN B stated Resident #1 received Keppra for the seizures. She stated Resident #1 wants his Keppra at very specific times, right at 7:00. She stated there was a two-hour window surrounding the 7:00 administration time. She stated the window was 6:00-8:00 a.m./p.m. LVN B stated because she knows how very concerned Resident #1 was about the timing of his medication, she prioritized giving him his Keppra in the morning as soon as she arrived for work. She stated Resident #1 had complained that other staff did not ensure he was getting him medication timely, but he was unable to say who they were. LVN B stated he complains a lot that if he does not get his seizure medication when he wants it, then he can feel an aura that he is going to have a seizure. She stated Resident #1 had never informed her he had a seizure.</p> <p>During an interview on 5/15/2024 at 2:21 p.m., the DON reviewed Resident #1's Keppra time medication audit and confirmed that Resident #1's Keppra was administered late on 5/10/2024. The DON stated she expected staff to administer medication within a window of one hour before to 1 hour after the medication was due. The DON stated she knew how important Resident #1's Keppra administrator was to him. She stated approximately one year ago, he complained about his Keppra getting to him on time. She stated he was only concerned about that one particular seizure medication and not his other seizure medications or other medications in general. She stated to rectify the situation she moved Resident #1's Keppra from the medication aides' cart to the nurses' cart. She stated since that time, to her knowledge, there had been no other issues. The DON stated on 5/10/2024 Resident #1's Keppra was administered late by an agency nurse (a nurse who does not employed by the facility) and not one of their regular staff nurses. She stated agency staff were given the tools to do their job prior to working on the unit. She stated her expectations for the agency staff were the same as her regular staff. She expected them to administer medications on time or attempt to rectify any situation that was preventing the medications from being administered on time. The DON stated the risk for not receiving Keppra as prescribed by the physician was seizures.</p> <p>During an interview on 5/15/2024 at 5:03 p.m., the DON stated the ADON and herself were responsible for monitoring the timeliness of the medication but prior to surveyor intervention it had not been something either she or the ADON were monitoring. She stated the first time she had ever viewed or knew about the medication time audit report was after surveyor intervention. She stated since they had not had any complaints of late medication, it was not something that they were currently addressing. The DON stated Resident #1 had not had any seizures in 2024 .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a facility policy, titled Administering Medications last revised April 2019 revealed: Medications are administered in a safe and timely manner, and as prescribed. 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. 7. Medications are administered within one (1) hour of their prescribed time .</p> <p>An attempt to o reach agency LVN A on 5/15/2024 at 5:34 p.m. before exit were unsuccessful.</p>		