STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on interviews and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 4 residents reviewed for resident rights. The facility failed to notify Resident #1's physician of her change of condition on 8/08/2024 when an injury of unknown origin developed into a hematoma [collection of blood outside of a blood vessel where it does not belong, may result in swelling, discoloration and warmth] at the back of her head. Resident #1 was subsequently sent out to the hospital on 8/09/2024 . This failure could affect residents by placing them at risk for a delay in medical treatment, decline in health, and death. The findings included: Record review of the Admission Record, printed 8/10/2023, reflected Resident #1 was a [AGE] year-old female originally admitted on [DATE]. Record review of the quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS summary score of four, indicative of severe cognitive impairment. Under section GG - Functional Abilities and Goals, Resident #1 was coded as having used a walker and a wheelchair for mobility; partial/moderate assistance for ambulation of 10 feet, 50 feet with two turns, ambulation of 150 feet, and transfers of all types. Resident #1's primary medical condition category that best described reason for admission was coded as medically complex conditions related to type 2 diabetes mellitus [chronic condition where the body either doesn't make enough insulin or doesn't respond to it effectively; leading to high blood sugar levels which can cause symptoms like tiredness, hunger, thirst and increased urination]. Other active diagnoses included non-Alzheimer's dementia [group of symptoms affecting memory, thinking and social abilities, marked by a severe decline in cognitive functions to the extent that it interferes with the person's daily life], fracture, [broken bone] history of falling, generalized muscle weakness, difficulty in walking, other lack of coordination. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Care Plan reflected Resident #1 had a focus area of: at risk for falls related to gait/balance problems, osteopenia, and chondrocalcinosis[also known as pseudogout, buildup of inflammatory particulates in the joint], history of falls, initiated on 9/14/2024 with an actual fall on 7/09/2024; with the following associated interventions: encourage Resident #1 to ask for assistance initiated 7/06/2024; pad on bedside table and bedframe with pool noodle, initiated 6/28/2024; resident to use PVC [a strong, synthetic plastic] low bed initiated on 4/08/2024. Other focus area included: visually impaired, initiated on 9/25/2023 with the revision on 2/22/2024. Additional focus area included: Complex Behavioral Care Plan - sits self on floor and scooting on floor, initiated 12/01/2023, with a revision on 8/09/2024. Focus area: at risk for complications related to anticoagulant or antiplatelet medication, initiated on 8/06/2024; with the following associated interventions: observed for signs and symptoms of bleeding i.e., bruising with a date initiated of 8/06/2024. Focus areas of complications related to recent [September 2023] brain bleed, history of fall prior to admission initiated on 9/14/2023; with the following associated interventions: monitor for signs and symptoms of brain bleed e.g., irritability, restlessness, initiated 9/28/2023. Focus area: complications related to .fractures 9/28/2023, initiated on 9/21/2024, with a revision on 6/15/2024. Focus area: risk for spontaneous fractures as resident has osteopenia/chondrocalcinosis initiated on 10/09/2023, with a revision on 10/10/2023. Record review of Order Summary Report, printed 8/10/2024, reflected Resident #1 had physician's orders for aspirin 81 mg by mouth in the morning, with a start date of 8/06/2024. Record review of Progress Note dated 8/08/2024 at 8:27 AM, authored by LVN C reflected Resident #1 had a laceration to left eyebrow and its course of treatment. Record review of Progress Note dated 8/08/2024 at 1:49 PM, authored by Treatment Nurse, reflected Resident #1 had laceration above left eye and its course of treatment. Record review of Progress Note dated 8/08/2023 at 3:51 PM, authored by DOR, reflected assessment of furniture in Resident #1's room. Record review of Progress Note dated 8/08/2024 at 7:29 PM, authored by LVN A reflected Resident #1 was non-compliant with any medication or interventions. Record review of Progress Note dated 8/09/2024 at 1:44 PM, authored by LVN C, reflected Resident #1 sent out to local emergency room for reddish purple hematoma to left side of back of head. In an interview on 8/10/2024 at 12:35 PM, the ADM stated, she had first heard of Resident #1's injury was during morning meeting on Friday 8/09/2024 around 9:00 AM, although the injury was discovered sometime during the afternoon of Thursday 8/08/2024 by the DOR who reported it to LVN A. ADM stated LVN A told her that he did not report the change in condition, which was the development of a bump to the back of Resident #1's head, because it was associated with a previous injury, which was a laceration to her left eyebrow. The ADM stated, in consultation with the DON, she requested the Treatment Nurse immediately assess Resident #1 on Friday 8/09/2024. The ADM stated, upon confirmation of the bump to the back of Resident #1's head, by the Treatment Nurse, that the decision was made to send Resident #1 out via EMS for further evaluation and treatment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/10/2024 at 2:00 PM, the DON stated she first learned of Resident #1's injury during morning meeting on Friday 8/09/2024 at around 9:00 AM. The DON stated that the development of the bump on the back of the head was first noted by the DOR on the afternoon of Thursday 8/08/2024. The DON stated she was told the DOR reported it to the nurse assigned that area [subsequently identified as LVN A]. In an interview on 8/10/2024 at 2:40 PM, the DOR stated on Thursday 8/09/2024 she had gone to Hall A, a secured unit within the facility, to work with another resident and noted that Resident #1 was agitated and not her normal self. The DOR stated that in an effort to calm Resident #1 she was speaking to her softly and stroking her hair. The DOR stated that was when she noted a bump on the left back side of Resident #1s head. The DOR stated she was not sure what time it was, only that it was in the afternoon, after shift change at 2:00 PM on Thursday 8/09/2024. The DOR stated she informed the nurse assigned to Hall A of the bump to the back of Resident #1's head. [Who was subsequently identified as LVN A.] In an interview on 8/10/2024 at 3:40 PM, LVN A stated that the off going nurse told him at shift change report on Thursday 8/08/2024 [approximately 2:00 PM] that Resident #1 had a laceration to left eyebrow due to an unwitnessed incident. LVN A stated shortly thereafter he assessed Resident #1 and did not note any other injury. LVN A stated that later that afternoon [8/08/2024] a female member of the rehabilitation staff alerted him to the development of the bump to the back of Resident #1's head [subsequently identified as the DOR]. LVN A stated he the re-assessed and confirmed the bump to the back of Resident #1's head and reported it to the DON, and the ADM on Thursday 8/08/2024. LVN A stated he placed a call to the on-call physician services but did not receive a call back before to the end of his shift. LVN A stated he documented the information on the 24-Hour Report/Change of Condition Report. LVN A stated that he notified Resident #1's family member of the change of condition. LVN A stated that the family member was Spanish only speaking but had someone on their end that translated during the call. Record review of the 24-Hour Report/Change of Condition Report, dated 8/08/2024, reflected Resident #1's laceration to left eyebrow but did not include documentation of the bump to the back of the head. [Attempted interview with family member and physician but did not receive a call back prior to exit on 8/10/2024.] In an interview on 8/10/2024 at 4:08 PM, the Treatment Nurse stated she assessed Resident #1 on Thursday 8/08/2024 due to the injury of unknown origin resulting in a laceration to the left eyebrow. The Treatment Nurse stated she did a complete head-to-toe assessment and did not find any additional injuries or areas of redness on Resident #1. The Treatment Nurse stated she believed the bump to the back of Resident #1's head developed over time and after her assessment. The Treatment Nurse stated she was not sure of the exact time of the assessment, but it would have been some time on the 6am-2pm shift, and she believed it was around midday. In an interview on 8/10/2024 at 4:29 PM, The Maintenance Director stated he had a text message exchange with the DON dated 8/08/2024 at 6:12 PM, in which he was directed to swap Resident #1's current regular bed, to a PVC, stationary low bed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/10/2024 at 4:51 PM, with on-call physician group RN B, stated that there were no documented notes related to Resident #1 on Thursday 8/08/2024. RN B stated their expectation was those calls be documented at every point of contact for clarity and continuity of care. RN B stated the first documented notes indicating a call was made to the on-call physician group was on Friday 8/09/2024 at 11:51 AM, when the facility staff [subsequently identified as LVN C] informed the on-call physician group that Resident #1 needed to be sent out for further evaluation and treatment related to a hematoma to the back of her head. In an interview on 8/10/2024 at 5:02 PM, LVN A reiterated that he was told by someone in the Rehabilitation department, that Resident #1 had a bump to the back of her head on 8/08/2024, but he was not sure of her name or title. LVN A stated he did call the number for the on-call physician group but did not get a call back before the end of his shift. LVN A stated when he informed the DON of the bump to the back of Resident #1's head, she gave him instructions to get a low bed with out wheels for Resident #1 as a safety precaution. In an interview on 8/10/2024 at 5:10 PM, the DON stated that she was not informed Thursday 8/08/2024 that Resident #1 had additional injuries beyond the laceration to the eyebrow. The DON stated that it was not until she was reviewing the 24-Hour Report/Change of Condition Report, dated 8/08/2024, in preparation for the morning meeting on Friday 8/09/2024 that she read the information regarding the bump to Resident #1's head. It was at this point on Friday 8/09/2024 approximate 9:00 AM, that she and the ADM requested the Treatment Nurse assess Resident #1. In an interview on 8/10/2024 at 5:25 PM, the DON stated her expectation was that staff document assessment findings in the EHR timely and notify the physician or the on-call physician regarding change of conditions. The DON stated that the development of a bump to the back of the head was a significant change of condition and should have been reported immediately to the physician. The DON stated that if the physician did not call back promptly, a follow up call should be placed. The DON stated it was important to report change of condition in order not to delay care and provide treatments in a timely manner. Record review of Change in a Resident's Condition or Status policy, revised February 2021, reflected: 1. The nurse will notify the residents attending physician or physician on call when there has been a(an): a. accident or incident . b. discovery of injuries of an unknown source .d. significant change in the resident's physical/emotional/mental condition .2. Significant change of condition is a major decline or improvement .a. will not normally resolve itself with out intervention by staff. Record review of In-Service, dated 8/09/2024, included topics of New Hire/Agency Check Off List that included phone number contacts of key personnel; Reporting and Notification; Abuse and Neglect - Clinical Protocol policy revised March 2018. In-Service signed by 31 interdisciplinary staff members ranging from nursing (RNs, LVNs and CNA) staff; habilitation therapy (DOR, physical and occupational assistants) staff, dietary staff, laundry and housekeeping service staff.