STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. BUILDING _____ B. WING _____	**11/10/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	**1100 GALVESTON LAREDO, TX 78040**

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement its policies and procedures that prohibit neglect of residents for 13 Residents (R #1, R #3, R #4, R #5, R #6, R #7, R #8, R #9, R #10, R #11, R #12 and R #13, R #14) of 14 Residents reviewed for neglect related to Infection Control. The facility failed to provide services to prevent harm when it: 1.) failed to follow the physician's orders [REDACTED].#4 and R #7. R #4 had bleeding areas to both arms. 2.) failed to implement and follow appropriate measures and the facility's policy and procedures to prevent the re-infection and isolation of scabies for R #1, R #3, R #5, R #6, R #7, R #8, R #9, R #12, R #13, and R #14. 3) failed to clarify R #10 and R #11's orders for [MEDICATION NAME] Cream 1% as an effective treatment for [REDACTED]. These failures resulted in an Immediate Jeopardy (IJ) situation identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. These failures could affect 80 residents residing in the facility for serious infection control and risk of contracting scabies. According to the facility's list of residents treated for [REDACTED]. Based on observation, interview, and record review the facility failed to implement its policies and procedures that prohibit neglect for two Residents (R #2 and R #4) of 14 Residents reviewed for neglect. R#2 did not have a bed or chair tab alarm and a Landing Mat in place as per the Interdisciplinary Team (IDT) intervention recommendations. Fall Risk assessments were not completed after each fall as per the facility's policy and procedure to determine his current level of fall risk. R #4 did not have a low bed as per the Interdisciplinary intervention recommendations. R #4 did not have any Fall Risk Assessments throughout his residence in the facility. These failures could affect 18 residents with history of falls placing them at risk for serious injury or death. The findings included: R #4 R #4's Admission Record dated [DATE] revealed R #4 was a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses; Scabies, Allergic contact [MEDICAL CONDITIONS] with behavioral disturbance, Muscle Weakness, Atrioventricular Block (conduction between the atria and ventricles of the heart is impaired) and Cardiac Pacemaker. R #4's admission MDS dated [DATE] revealed R #4 had severe cognitive impairment, required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene, and locomotion on and off the unit. R #4 had a wheel chair for mobility. R #4 was not assessed as having a rash. R #4's Care Plan completed [DATE] did not address scabies or chronic [MEDICAL CONDITION]. R #4's Head to Toe Skin Checks dated [DATE] R #4 had an existing rash. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's In-House Communicator dated [DATE] (provided by) House Keeping Supervisor (HKS) revealed Place in contact isolation DX: (Scabies) R #4's physician's orders [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% Apply to affected areas topically one time only for scabies until [DATE] apply from neck to toes and remove by bathing 12 hours later may repeat in one week if necessary. (TAR was left blank on [DATE]/ no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. ([MEDICATION NAME] was not given as ordered [DATE]). Written correspondence from DON dated [DATE] revealed (R #4) was admitted on [DATE] with RX of Scabies. Order for [MEDICATION NAME] obtained on [DATE]. Treatment not given due to the fact that this med did not arrive from our Pharmacy. On [DATE] same order for [MEDICATION NAME] was resubmitted and med arrived and administered on [DATE]. On [DATE] [MEDICATION NAME] was reordered and reapplied due to a resurgent of Scabies again. Then as per MD order [MEDICATION NAME] was reapplied on [DATE]. As per MD Scabies subsided. On [DATE] (Dr. XX) ordered [MEDICATION NAME] 1% Cream and [MEDICATION NAME] Cream for [MEDICAL CONDITION] and on [DATE] MD ordered [MEDICATION NAME] 10 mg. R #4's physician's orders [REDACTED]. R #4's physician progress notes [REDACTED]. R #4's physician's orders [REDACTED]. R #4's Care Plan completed [DATE] did not address scabies or chronic [MEDICAL CONDITION]. R # 4's hospital admission History and Physical dated [DATE] revealed Impression: Scabies. R #4's hospital Discharge Summary dated [DATE] revealed Final Diagnoses: [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% ([MEDICATION NAME]) Apply to body as directed topically at bedtime every Thu for Scabies for 2 Administrations repeat in 1 week. (TAR was left blank on [DATE] and [DATE] no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. XX. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED].) Apply to body topically two times a day for [MEDICAL CONDITION] apply to body after applying the [MEDICATION NAME] cream. R #4's Doctor's Progress Notes dated [DATE] revealed .Has been treated x2 at least for scabies last TX. ,[DATE] when patient was hospitalized , patient now on [MEDICATION NAME] cream with partial relief but rash persists, no clear documentation of proper decontamination after TX for scabies given .Skin Presence of indurated papules with excoriations and areas of Linchenification on both arms, shoulders, lower back, and lower abdomen, both thighs .Scabies by history scabies TX X 2 at least .Plan will proceed to provide treatment for [REDACTED]. Review of facility infection control tracking and trending log dated: -,[DATE] revealed one case of Scabies. -,[DATE] revealed two cases of Scabies.

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

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 1)
-,[DATE] revealed three cases of Scabies.
-,[DATE] revealed five cases of Scabies.
-,[DATE] revealed seven cases of Scabies.
On [DATE] at 2:45 p.m., during initial rounds Surveyor observed a tracking raised red rash on R #4's arms and legs. There were areas on R #4's anterior lower forearms with scratch marks and bleeding and scattered bruise marks across both arms. R #4 lifted up his shirt and exposed his abdominal area which was also covered in a tracking raised red rash. R #4's legs were covered with a scabbed over rash from the knees down to his ankle areas. R #4 said he has had the rash off and on for months. R #4 said he wanted the rash treated because it itched him all the time. During interview with R #4 there was a female whom identified herself as a friend in R #4's room. The friend PP said she had been asking for treatment for [REDACTED].#4's insurance would not pay for a dermatologist visit. Surveyor observation and interview revealed R #4 shared closet space with a room-mate. (R #4's clothing was co-mingled with room-mates clothing)
On [DATE] at 5:45 p.m., observation revealed R #4 sitting in the dining room at a table with two other residents. R #4 was scratching at his back and arms, R #4 placed his right arm on the table cloth several times during the meal service.
On [DATE] at 6:30 p.m., interview with the DON revealed the Treatment Nurse was responsible for treating all the residents for scabies while she was in the building.
On [DATE] at 9:00 a.m., interview with the DON revealed the first case of Scabies in the facility was identified (R#8) and treated in [DATE]. The DON said the Physician was notified and the room-mate was removed from the room and R #8 was placed in Contact Isolation. All nursing staff was notified of R #8's Infection Control status by shift report, Cardex and verbal instruction to staff that was currently working with resident.
Surveyor asked the DON what the facility protocol was for scabies and the DON said, for scabies the isolation period was for five days. The DON said that the Scabies medication was applied for 24 hours then was rinsed off the resident. The DON said skin checks were conducted post treatment for [REDACTED]. The DON said while the resident was being treated with the Scabicide, House Keeping cleans the resident's room from top to bottom including the resident's clothing. The DON said if the resident had un-washable items such as stuffed animals or pillows, those items were thrown away. The DON said Rehab., Activity Director, and House Keeping Supervisor were notified, two isolation bins were placed in the resident room, one for linens and the other for trash. They placed an isolation cart outside the resident's room for PPE then posted a sign outside resident's door advising people to report to nurse's station prior to entering the room. The DON said for meal service, the staff double bag the meal tray before delivering the tray back to the kitchen. The resident was scheduled for the last shower of the day and Activities are provided in room. The DON said the Nurse that obtained R #4's orders for [MEDICATION NAME] on [DATE] and should have followed up with the Pharmacy to ensure the medication was delivered.
On [DATE] at 9:20 a.m., interview with RN A revealed the facility's process for Scabies was starting with the assessment, then notifies the CNAs to back off for a while and take Contact Isolation precautions. RN A said he would then call the Physician and obtain an order for [REDACTED]. RN A said prior to placing resident back into the room all the curtains and all linens were washed. RN A said HSK was responsible for washing the resident's clothing. RN A said that House Keeping would take down the privacy curtains and replace with new curtains. RN A said for all un-washable items such as personal pillows, are to be bagged and then ask resident's family permission to get rid of the items. RN A said HSK emptied out resident clothing from drawers and closets for washing. RN A said he thought R #4 had an active case of Scabies. RN A said he thought Scabies in the facility was spread from improper hand washing and on clothing. RN A said the facility has not had any in-services on Scabies. (RX dosage for treatment of [REDACTED].
On [DATE] at 10:05 a.m., interview with HSK revealed she was notified if a resident had Scabies either in the morning meeting or by In-House Communication Sheet. HSK said if she was in the building at the time a resident was placed in Isolation for Scabies she would set up the Cart for PPE and place it outside resident room, then place a sign on resident door, and notify her staff that the resident was on Contact Isolation. HSK said she wears PPE, wipes down resident's bed with disinfectant; nursing staff takes all the linens off the beds and places in a biohazard bag linen bin in the resident room. HSK said the nursing staff places resident clothing in biohazard linen bin. HSK said when the resident was off isolation; HSK conducts a deep clean of resident's room, takes down all curtains and wipes down blinds and chair with disinfectant. HSK said she did not remove clothing from resident's closet or drawers. HSK only washes clothing and linens that nursing staff place in biohazard bags.
On [DATE] at 10:15 a.m., interview with LVN B (treatment nurse) revealed she worked from 10:00 a.m.-6:00 p.m. Monday through Friday. LVN B said when she was in the building that she treated residents with orders for Scabicide. LVN B said the first action she takes if she identifies a resident has Scabies would be to notify the Charge Nurse and the Charge Nurse would notify the Physician and obtain orders. LVN B said all direct care nursing staff were notified and the resident would be placed on Contact Isolation, and HSK would be contacted to clean the resident's room. The Scabicide would be applied to the resident from neck down and left on for 12 hours and washed off. While the Scabicide was applied to the resident, all linens on the bed would be removed and placed in Biohazard bag by nursing staff. LVN B said she would then call HSK to clean the room and wash residents clothing. LVN B said 24 hours after the Scabicide treatment she would reassess the resident's skin. LVN B said if the resident that was infected with Scabies had a roommate; the roommate along with the roommate's belongings would be moved to another room until the infected resident was clear from scabies (without decontaminating the belongings). LVN B said if a resident with Scabies had un-washable items, the staff would place those items in the resident's closet or ask the family to take the items home. LVN B said that in her opinion R #4 no longer had Scabies and the Physician has ordered [MEDICATION NAME] 0.1% Cream for R #4's rash. Surveyor asked LVN B if she knew what
the indications for [MEDICATION NAME] Cream? LVN B said, No, Surveyor asked LVN B as a nurse was she supposed to know what
the indications were for Prescription drugs prior to application. LVN B said, yes, but I don't know.
(Nursing Staff said in interviews that HSK washed resident's clothing as part of scabies treatment, and HSK said Nursing staff was responsible for resident's clothing)
On [DATE] at 10:35 a.m., skin assessment by LVN B with R #4, LVN B said during skin assessment that #4 had raised red tracking rash to his bilateral upper extremities, left upper chest wall, behind ears and neck. LVN B said R #4 had dry scabbed areas to his lower extremities. LVN B described areas on R # 4's arms as open and bloody from scratching. LVN B said R #4 scratches until he bleeds.
On [DATE] at 12:25 p.m., interview with HSK revealed she was never notified of R #4 being in isolation the second time R #4 was treated in ,[DATE].
On [DATE] at 5:15 p.m., interview with Dr. XX revealed if the facility did not properly follow decontamination procedures during Scabicide treatment, there was a possibility that R #4 could have been re-infected with Scabies. Dr. XX said all the resident's clothing must be washed as well as the room decontaminated while resident was receiving Scabicide treatment. Surveyor showed Dr. XX R #4's clothing closet was shared with another resident and asked the Physician what would be the proper infection control procedure to isolate the Scabies. Dr. XX said the resident that shared the clothing closet with R #4 would also have to have the clothing washed because the Scabies bug lived on clothing and that the bug could be transmitted to another resident. Dr. XX said he ordered the [MEDICATION NAME] Cream for R #4 to reduce the [MEDICAL CONDITION] response and itching from the [MEDICAL CONDITION]. Dr. XX said he was going to re-treat R #4 with [MEDICATION
NAME] because there was no clear documentation that treatment orders were followed or effective decontamination was done. Dr. XX said he was going to place R #4 on Contact Isolation for one week.
Record review of the facility's Log of Residents with Scabies dated ,[DATE]-[DATE] identified 11 residents: R #1, R #3, R #4, R #6, R #7, R #8, R #9, R #10, R #11, R #12 and R #13.
R #5 and R #14 were not on the facility's log.
R #1:
R #1's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 100 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]., [MEDICAL CONDITIONS], Mood Disorder, and Unspecified Chest Pain.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's [DATE] Treatment Administration Record (TAR) indicated R #1 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #1's [DATE] Order Summary Report documented [DATE] at 11:26 a.m.- Discontinue [MEDICATION NAME] Cream 5%, Reason: Resident
expired.
R #3:

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 2)
R #3's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility in the 600 Hall on [DATE] with the [DIAGNOSES REDACTED]. This damage is often caused by an abnormally high pressure in your eye), and [MEDICAL CONDITION]
(condition in which the bones become brittle and fragile from loss of tissue).
R #3's physician's orders [REDACTED].
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #3's physician's orders [REDACTED]. Bath to remove in 12 hours and remove per schedule. Contact isolation for one week due to Scabies.
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #6:
R #6's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 500 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #6's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #6's physician's orders [REDACTED].
R #6's [DATE] TAR indicated R #6 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE].
R #6's Order Summary dated [DATE] documented Remove from isolation- Scabies resolved.
R #7:
R #7's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 600 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]. to the brain, causing limited or no blood flow to the affected areas), [MEDICAL CONDITION] (paralysis of one side of the body), and Generalized Muscle Weakness.
R #7's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to area topically one time a day every 14 days for Scabies, as
directed for two administration- Order Date: [DATE]. The TAR did not contain an entry indicating the medication was administered on any day in [DATE].
NOTE: R #7 should have been administered [MEDICATION NAME] Cream 5% on [DATE] and then a second dose should have been
administered on [DATE].
R #7's physician's orders [REDACTED].
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day starting on the 19th
and ending the 19th for Scabies for 2 administrations, as directed. Order Date: [DATE] at 10:43 a.m. The only entry that indicated the medication was administered was on [DATE].
NOTE: There was not a second administration of [MEDICATION NAME] Cream as ordered by the physician.
R #8:
R #8's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #8's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on [DATE] at 11:51 p.m.
R #8's physician's orders [REDACTED].
R #8's physician's orders [REDACTED]. [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day every Tuesday for scabies for two administrations as directed from neck to toes. May repeat in one week if necessary.
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m.
R #8's physician's orders [REDACTED].
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m.
R #8's Order Summary Report dated [DATE] at 11:17 a.m. documented Remove from isolation, scabies resolved.
R #9:
R #9's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED].
R #9's physician's orders [REDACTED]. Contact isolation for 48 hours due to Scabies.
R #9's [DATE] TAR revealed R #9 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #9's physician's orders [REDACTED].
R #12:
R #12's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 600 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #12's physician's orders [REDACTED]. Contact isolation Dx- Scabies.
R #12's physician's orders [REDACTED]. Contact isolation Dx- Scabies.
R #12's physician's orders [REDACTED].
R #12's [DATE] TAR revealed R #12 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE].
R #13:
R #13's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 200 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #13's physician's orders [REDACTED]. Contact isolation for 7 days Dx- Scabies.
R #13's physician's orders [REDACTED]. Contact isolation Dx- Scabies.
R #13's [DATE] TAR revealed R #14 no entry to indicate R #13 was administered the [MEDICATION NAME] Cream 5% as ordered on
[DATE] and [DATE].
R #13's physician's orders [REDACTED].
R #14:
R #14's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 200 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #14's physician's orders [REDACTED]. Repeat application as instructed within two weeks of initial application. Contact isolation until Scabies resolved.
R #14's Physician order [REDACTED].
R #10:
R #10's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility in the 400 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #10's physician's orders [REDACTED]. Place on contact isolation due to scabies.
R #10's [DATE] TAR revealed R #10 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #10's physician's orders [REDACTED]. Bathe in 12 hours to remove cream.
R #10's [DATE] TAR revealed there was no entry to indicate R #10 was administered [MEDICATION NAME] Cream 5% as ordered in
[DATE].
R #10's physician's orders [REDACTED].
R #10's physician's orders [REDACTED]. Repeat in one week if needed and apply entire body topically as needed for scabies until [DATE] 11:59 p.m. Contact isolation X 1 week for Scabies. This order was Confirmed by (the DON).
R #10's [DATE] TAR revealed R #10 was administered [MEDICATION NAME] Cream 1% on [DATE].
R #10's physician's orders [REDACTED].
R #11:
R #11's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #11's physician's orders [REDACTED]. Contact isolation Dx. (Diagnosis)- Scabies.
R #11's [DATE] TAR revealed R #11 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #11's physician's orders [REDACTED]. Contact isolation for Scabies.
R #11's physician's orders [REDACTED]. Contact isolation for Scabies.
R #11's [DATE] TAR revealed R #11 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE].
R #11's physician's orders [REDACTED]. Contact isolation for Scabies.
R #11's [DATE] TAR revealed R #11 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #11

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 3)
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure injuries of unknown sources were thoroughly investigated and documented to prevent potential abuse and rule out abuse and neglect for three of 14 Residents (R#1, R#2, and R#4) reviewed for neglect. The facility failed to: 1) Investigate recurrent falls for R#1, (expired on [DATE]), 2) Investigate falls for R#2, and 3) Investigate falls for R#4. This failure could place R#2 and R#4 and 18 residents with a history of falls at risk of abuse, neglect and injuries of unknown sources if incidents are not thoroughly documented and investigated. The Findings: R#1 Record review of R#1's Face Sheet dated [DATE] revealed R#1 was an [AGE] year old male who was admitted to the facility on [DATE] and expired on [DATE] at the facility of natural causes. R#1 had [DIAGNOSES REDACTED]., Unspecified Sequelae of Unspecified [MEDICAL CONDITION] Disease, [MEDICAL CONDITION] of Knee, [MEDICAL CONDITIONS], Cardiac Arrhythmia, Other nonspecific Abnormal findings of Lung Field, and Chest Pain. Record review of R#1's Situation, Background, Assessment, Recommendation (SBAR) Communication Form and Progress Note dated [DATE], revealed R#1 had a change of status of a fall with a skin tear. The Situation revealed a fall with a skin tear. The Assessment (RN-Registered Nurse) or Appearance (LPN-Licensed Professional Nurse) revealed Resident found on bedroom floor, on his left side, he has a 2 X 2 skin tear to his left elbow, he is very confused and disoriented. Wound was cleansed, R#1 was transferred to wheelchair (W/C) and staff will continue to monitor. Record review of R#1's Resident Event dated [DATE] revealed had a fall with injury in his room, 2X2 skin tear to left elbow. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-unknown, First Aid-unknown, Staff training-unknown, Therapy Screen-unknown, Resident Education-unknown. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. Description of fall found on the bedroom floor, on his left side, he had a 2x2 skin tear to his left elbow, he is very confused and disoriented. R#1's wound was cleansed, he was transferred to his wheelchair, will continue to monitor. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations revealed R#1 was currently receiving rehabilitation services at the time of the fall, to re-orient and re-direct. Monitor for safety, low bed. The Care Plan revision box was checked. Referral box to Physical Therapy (PT) and Occupational Therapy (OT) were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 was found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. The Assessment (RN) or Appearance (LPN) revealed the resident becomes more confused at night when he wakes up from sleep. Record review of R#1's Resident Event dated [DATE] revealed R #1 had a fall with injury in his room. R#1 was found to have an injury with reddish discoloration to left buttocks, Hematoma/bruise. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-no, First Aid-no, Staff training-no, Therapy Screen-no, Resident Education-no. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence for R#1 on [DATE]. The Description of the fall resident found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. Activity at time of fall listed unassisted transfer. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may contribute to the fall listed none. The IDT Intervention recommendations revealed R#1 was to be monitored for safety and re-direct as needed. Maintain bed at lowest position, and apply nonskid strips top bedside floor. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation was a fall. Nurses notes revealed Resident found on floor, near to w/c, resident transferred back to w/c, resident with skin tears X2 to R hand, both of them about 1 X 1 cm, small bleeding. Skin tears treated. Head with redness to R parietal area about 1.5 x 3 cm, no skin tear. Neurological checks started. Resident moves all extremities the same as prior fall. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. Description of the fall revealed R#1 was found lying on floor on right side near the bathroom. R#1 did not verbalize and complain of pain and no distress, deformity, or bruise was visible. Activity at time of fall listed unassisted transfer. Predisposing diseases listed none. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed Psychoactives. The IDT Intervention recommendation revealed R#1 was to be monitored for safety and re-direct. MD ordered for safety release belt and family signed consent, encourage him to ask for assistance. The Care Plan revision box and equipment box were checked. Further review revealed Intervention Recommendations, If equipment was selected, describe. Listed was a safety release belt added to Care Plan. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed Resident sitting in wheelchair with safety release belt in place, reached down to grab paper. He leaned lost his balance and fell forward hitting his right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. Resident picked up by staff and examined. No other injuries noted on c/o pain voiced. The Assessment (RN) or Appearance (LPN) revealed R#1 was confused tried to pick up imaginary paper off of floor and fell forward with wheelchair and all. Nursing notes revealed R#1's MD ordered to send R#1 to emergency room (ER) for further evaluation. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury. Injury included right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. The Action taken revealed a wheelchair and Hoyer lift used. Care Plan revised-yes, First Aid-yes, Staff Training-yes, Therapy screen-unknown, and Resident education-yes. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with possible head injury. First aid was provided and R#1 was transferred to acute care. R#1's injury was on the right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. R#1 was sent to the ER for further evaluation as ordered by R#1's MD. Activity at the time of the fall listed reaching up and down. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and vision deficits. Medications that may contribute to the fall listed Psychoactives and Diuretics. The IDT's Intervention recommendations revealed R#1's X-Ray and CT Scan Negative, no fractures. No new orders from ER, Neuro checks done, continue with safety release belt. Apply Tab alarm to wheelchair, and refer to Rehab for evaluation. The Care Plan Revision and equipment were checked. If equipment was selected, describe look at wheelchair. Refer to Physical and Occupational therapy was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 had a fall. The Assessment (RN) or Appearance (LPN) revealed resident was confused. Nursing notes revealed resident fell from wheelchair-no injuries noted. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed Fall Occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with no injury. Resident confused and disoriented while in the dining room, he proceeded to get up out of his wheelchair without locking the wheels. Wheelchair rolled back and fell down to the floor. No injuries noted no skin tears noted at this time. Predisposing diseases listed were Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may

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	675396	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) contribute to the fall are listed as Psychoactives. The IDT did not list any Intervention recommendations and Care Plan revision box was not checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall without injuries. The Situation listed a fall without injuries. Assessment (RN) or Appearance (LVN) revealed R #1 was restless with notable anxiety. Nurse's notes revealed Resident found on floor laying on right side next to WC in common lobby area. Assisted x 3 safely to WC without complications. No injuries noted upon assessment with resident verbalizing no pain when asked. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence with no injury R#1 had on [DATE] (should be [DATE]) in his bedroom. Description of fall anxious with restlessness noted. Confused calling out for wife. Resident found 0120 AM laying left sided on landing mat on floor next to bed. Bed in lowest position. No injuries or pain noted upon assessment. Resident transferred to bed safely with assist x 2. Will continue to monitor and assess. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed and wheelchair, Landing mat, bed at lowest position, continue with rehab, monitor for safety. Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] without injuries. Assessment (RN) or Appearance (LPN) revealed restless, anxious, confused as he wants to get up and walk. Nursing notes revealed resident found on floor at hallway entrance next to nurses station laying on left side beside WC. Assisted safely back to wc with assist x 3. No injuries noted at time and patent does not express pain. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of Fall revealed R#1 found on floor at hallway entrance next to nurses station laying on left side beside WC. Assisted safely back to WC with assist x3. No injuries noted at this time and patient does not express pain. Will continue to monitor and assess. Activity at time of fall listed R#1 sitting in his wheelchair. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations listed tab alarm cord must be shorten, continue with safely release belt. Monitor for safety, re-direct, continue with rehab. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with an injury at the nurse's station. Injury details revealed R#1 hit his head and had a hematoma on the right side. R #1 was sent to the local ER via ambulance. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a fall, hit his head and had a hematoma on the right side, was transferred to acute care. Resident very disoriented, tried getting up from wheelchair and fell forwards, restraint belt was in place. Resident hit his head and had decreased LOC, blood pressure ,[DATE]. Dr. was notified and orders to transfer resident to ER were given. Activity at time of fall listed as sitting in wheelchair. Predisposing diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoachives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed and wheelchair, landing mat, bed at lowest position, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. Mental status change revealed decreased consciousness (sleepy, lethargic). Assessment (RN) or Appearance (LPN) revealed R#1 with anxiety and restlessness. Nursing notes revealed resident found on floor inside his merry walker, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. R#1 was sent to the ER. Record review of R#1's Resident Event dated [DATE] revealed R#1 had an unwitnessed fall with an injury at the nurse's station. Description of fall resident found on floor inside his merry walker, on his right side, resident transferred to his bed, laceration to Right (R) forehead 4 cm, laceration x 2 to R arm, laceration x 1 Left (L) hand, cleansed with N/s pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP (Responsible Party) request resident was transferred to ER for further evaluation. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a witnessed fall, first aid was provided. The injury revealed R#1 had laceration to R forehead 4 cm, laceration x2 to R arm, laceration x1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. Resident found on floor inside her merry walker, on his right side, resident transferred to his bed, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP request, resident was transferred to ER for further evaluation. Activity at time of fall revealed R #1 was standing still in his Merry walker. Predisposing Diseases [MEDICAL CONDITION] and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, rehab to re-evaluate equipment for safety, and fall prevention, re-orient and re-direct. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a skin tear on [DATE]. The Situation revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Assessment (RN) or Appearance (LPN) revealed R#1 was restless. Record review of R#1's Resident Event dated [DATE] revealed R#1 obtained a skin tear to the right elbow and left elbow. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1' s witnessed fall occurrence on [DATE]. Description of fall revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Activity at time of fall revealed R#1 was trying to climb out of his Merry Walker. Predisposing Diseases [MEDICAL CONDITION] Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Diabetic Agents. The IDT's Intervention recommendations revealed continue with rehab, re-evaluate equipment for safety, re-direct and re-orient. The Care Plan revision box was checked. Referrals to OT and PT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change in status of a fall. The Situation revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Assessment (RN) or Appearance (LPN) revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Nurse's notes revealed the same statement as previous but indicated the family and MD aware. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in the dining room. Description of fall revealed R#1 slipped off of the dining room chair on to the floor. No visible injuries noted. Resident with increased anxiety and anxiolytic provided. Hospice nurse in to see resident, no new orders by physician. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE] with no injuries. Description of fall revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Activity at time of fall revealed R#1 was seated in a stationary chair in the dining room. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with rehab, monitor for safety while in dining room. The Care Plan box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1

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F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) had a fall during the night shift on [DATE] at 10:52 p.m. without new injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was restless, anxious and confused. Nursing notes revealed new orders for [MEDICATION NAME] and [MEDICATION NAME] with orders to give [MEDICATION NAME] providing hard copies are available by MD. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with no injury. Description of fall resident fell over on left side with Merry Walker. Assisted out of Merry Walker x 3 using gait belt safely placed into Merry Walker. No injuries noted at this time. Will continue to monitor and assess. The Action taken, R#1 was placed in front of nurse's station throughout shift to continue monitoring him. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 had a fall x 1 without injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was anxious, restless and confused. Nursing notes revealed resident found laying right side on landing mat next to bed with bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in his bedroom. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injuries. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Activity at time of fall revealed R#1 was unassisted transfer while on his bed. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, low bed, and landing mat. The Care Plan revision box was checked. Referral to PT and OT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 was found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Assessment (RN) or Appearance (LPN) revealed restlessness. Nurse's notes revealed R#1 was transferred to bed. Is now resting. Rise and fall of chest noted. No s/s of distress. Record review of R#1's Resident Event dated [DATE] revealed R#1 was found on the floor with no injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Resident transferred to bed. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's fall occurrence on [DATE] without injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Activity at the time of fall revealed R#1 was in his wheelchair and reaching up and down. Predisposing Diseases [MEDICAL CONDITION] Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed tab alarm, safety release belt, monitor for safety, encourage to ask for assistance. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident experienced fall no visible injuries noted. No c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Treatment: resident with ESHD (Early Stage Hodgkin's Disease) with episodes of [MEDICAL CONDITION], v/s monitored. Advance Care Planning revealed R#1 had a DNR (Do Not Resuscitate) status and was on Hospice services. Assessment (RN) or Appearance (LPN) revealed resident experienced fall no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode. Resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Nurse's notes revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury. Description of fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injury. Description of the fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Activity at time of fall revealed R#1 was sitting in his wheelchair in the hallway. Predisposing Disease listed [MEDICAL CONDITION] and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed tab alarm while in wheelchair, monitor for safety. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident found on the floor in his room. Bed was in lowest and fall pad in place. No visible injuries, v/s wnl (vital signs within normal limits). Assessment (RN) or Appearance (LPN) revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall in his room with no injury. Description of fall revealed R#1 was observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's fall occurrence on [DATE] without injury. The Description of fall revealed R#1 observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Activity at time of fall revealed R#1 had a fall in his room; he was sitting on his bed and had an unassisted transfer. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with low bed and landing mat, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall with injury on [DATE]. The Situation revealed fall with injury, skin tear to right elbow with no other injury noted and on pain verbalized at this time. Assessment (RN) or Appearance (LPN) revealed R#1 calmer up to WC as opposed to the restlessness of being in bed. Cleansed skin tear with normal saline, pat dry area with gauze and covered tear with dry gauze and secured with tape however patient keeps picking at dressing eventually taking it off. Will continue to monitor and assess. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury in his room. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's unwitnessed fall occurrence with injury on [DATE]. Injury included a skin tear to right elbow. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Activity at time of fall revealed R#1 was in bed and had an unassisted transfer. Predisposing Disease listed [MEDICAL CONDITIONS], and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, and history of falls. Medications that may contribute to the fall listed Psychoactives and None. The IDT's Intervention recommendations revealed low bed at lowest position, landing mat, continue with tab alarm to bed. The Care Plan revision box was checked. Referral box to Restorative Nursing was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] with injury. The Situation revealed R#1 had a fall with injury, skin tears to left arm. Assessment (RN) or Appearance (LPN) revealed R#1 took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Will continue to monitor. Record review of R#1's Resident event dated [DATE] revealed R#1 had a fall with an injury in the hall. Description of the fall revealed took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Action taken revealed monitor for

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) safety, continue w/safety release belt, and Tab alarm, re-direct and re-orient to surroundings. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence with injury on [DATE]. The injury revealed two skin tears to left arm. The Description of the fall revealed resident took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Activity at time of fall revealed R#1 was in his wheelchair in the lobby and had an unassisted ambulation. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed none.The IDT's Intervention recommendations revealed monitor for safety, continue with safety release belt, and Tab alarm, re-direct and re-orient to surroundings. The Care Plan revision box was checked. Referral box for PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status and was found on the floor on [DATE] with no injury. The Situation revealed resident found sitting on floor in hall, 2 minor skin tears from old wounds, Home treatment provided. No other apparent injuries. Resident continues with confusion. Transferred back to bed. Was up to chair prior incident with safety release belt. Assessment (RN) or Appearance (LPN) revealed R#1 had confusion. Record review of R#1's Resident Event dated [DATE] revealed R#1 was found on the floor in the hall with no injury. Description of fall revealed resident found sitting on floor in hall. 2 minor skin tears from old wounds. Home treatment provided. No other apparent injuries. Resident continues with confusion. Transferred back to bed. Record review of R#1's IDT Post Fall Review date
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement its written policies and procedures that prohibit neglect of residents for 13 Residents (R #1, R #3, R #4, R #5, R #6, R #7, R #8, R #9, R #10, R #11, R #12 and R #13, R #14) of 14 Residents reviewed for neglect related to Infection Control. The facility failed to provide services to prevent harm when it: 1.) failed to follow the physician's orders [REDACTED].#4 and R #7. R #4 had bleeding areas on both arms. 2.) failed to implement and follow appropriate measures and the facility's policy and procedures to prevent the re-infection and isolation of scabies for R #1, R #3, R #5, R #6, R #7, R #8, R #9, R #12, R #13, and R #14. 3) failed to clarify R #10 and R #11's orders for [MEDICATION NAME] Cream 1% as an effective treatment for [REDACTED]. These failures resulted in an Immediate Jeopardy (IJ) situation identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. These failures could affect 80 residents residing in the facility for serious infection control and risk of contracting scabies. According to the facility's list of residents treated for [REDACTED]. Based on observation, interview, and record review the facility failed to implement its written policies and procedures that prohibit neglect for two Residents (R #2 and R #4) of 14 Residents reviewed for neglect. R#2 did not have a bed or chair tab alarm and a Landing Mat in place as per the Interdisciplinary Team (IDT) intervention recommendations. Fall Risk assessments were not completed after each fall as per the facility's policy and procedure to determine his current level of fall risk. R #4 did not have a low bed as per the Interdisciplinary intervention recommendations. R #4 did not have any Fall Risk Assessments throughout his residence in the facility. These failures could affect 18 residents with history of falls at risk for serious injury or death. The findings included: Review of Facility Policy and Procedure titled Abuse & Neglect Prohibition (revision date:[DATE]) revealed, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, injuries of unknown origin, and misappropriation of property .Definitions .Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Injuries of unknown origin may occur as a result of neglect . The Texas Department of Aging and Disability Services Provider Letter dated [DATE] documented: Abuse, Neglect, Exploitation and Other Incidents that Must be Reported. Health and Safety Code §260A.002 and Texas Administrative Code, Title 40, Part 1, Chapter 19, §19.602(a) require any facility staff member who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person to report the abuse, neglect or exploitation. Facilities are required at 40 TAC §19.601(c)(2) to ensure that all alleged violations involving mistreatment, neglect or abuse, including suspicious injuries of unknown source and misappropriation of resident property, are reported immediately to DADS. Facilities are also required to report certain other incidents, which may or may not constitute abuse, neglect or exploitation. Certified facilities are required by 42 Code of Federal Regulations (CFR) §483.13(c)(2) and (4) (F226) to report alleged violations involving mistreatment, neglect or abuse, including suspicious injuries of unknown source and misappropriation of resident property, and the results of the investigation conducted by the facility to the state survey and certification agency 2. NEGLECT (as defined in 40 TAC §19.101(81)) The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. The facility must determine if an injury, harm to or death of a resident was due to a facility failure to provide services, treatment or care to a resident. For certified facilities, neglect is also defined at 42 CFR §488.301 and prohibited at §483.13(c) (F224) Facility staff must report abuse, neglect, exploitation and other incidents to: · DADS Consumer Rights and Services Section at (800) [PHONE NUMBER] immediately (within 24 hours) upon learning of the incident; and · send a written investigation report to the Consumer Rights and Services Section within 5 working days after the telephone report. PROCEDURES FOR The FACILITY INVESTIGATION The facility must conduct an investigation of the reported act(s) and must send a written report of the investigation to DADS no later than the fifth working day after the oral report according to 40 TAC §19.602(b)(1)(2) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse/neglect while the investigation is in progress. If the alleged violation is substantiated, appropriate corrective action must be taken .Facility Investigation: Facility actions when conducting an investigation must be documented and include: · observations, interviews and record reviews of all residents involved; · interviews of all witnesses, including residents, staff and family members; · notification of the physicians and, where appropriate, the families or responsible parties of the involved residents; and · recording of all relevant physical findings. Facility Infection Prevention Manual for Long Term Care (revised ,[DATE]) Titled Scabies Care revealed Purpose: To adequately treat cases of scabies and prevent transmission to others. Policy: Any resident with positive evidence of Scabies (Sarcoptes scabiei) must be treated upon physician's order [REDACTED].TO AVOID REINFESTATION A. Clean ALL clothing, bedclothes, etc. that have been in recent contact with the resident. Transport these items in plastic bags. Wash clothes and bedding in HOT soapy water (allow time between loads for full recovery of hot water) and dry on HOT cycle of dryer. Place unwashable clothing and articles in a plastic bag and seal for 7 days (the mites do not survive for more than ,[DATE] days without contact with the body). B. Wipe down beds, pillows, mattresses, furniture, etc. with a germicidal solution. E. Contact precautions for associates consist of wearing gloves and gown if in close contact with an infested person or things .This is necessary before treatment and for ,[DATE] hours after treatment. Hand hygiene is the best technique for protection of oneself and others .PROCEDURE .G. While treatment is being done, have bed stripped (place bedding in a plastic bag before sending to laundry); all washable clothing, etc. that has been in recent contact with the resident should be placed in a plastic bag to be washed. Unwashable items should be placed in a plastic bag and sealed for 7 days (label bag with name, date, etc.) H. Be sure the resident has CLEAN clothing and CLEAN bedding; make sure infested items have been removed from the room. I All furniture, mattresses, pillows, etc. should be wiped down with a germicidal solution. J. Have the resident bathe thoroughly after the time indicated on the product. Make sure the resident has clean clothes and that bed linens are changed again . Review of Facility Policy and Procedure titled Abuse & Neglect Prohibition (revision date: [DATE]) revealed, Each resident

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	675396	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 7) has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, injuries of unknown origin, and misappropriation of property .Definitions .Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Injuries of unknown origin may occur as a result of neglect . R #4 R #4's Admission Record dated [DATE] revealed R #4 was a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses; Scabies, Allergic contact [MEDICAL CONDITIONS] with behavioral disturbance, Muscle Weakness, Atrioventricular Block (conduction between the atria and ventricles of the heart is impaired) and Cardiac Pacemaker. R #4's admission MDS dated [DATE] revealed R #4 had severe cognitive impairment, required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene, and locomotion on and off the unit. R #4 had a wheel chair for mobility. R #4 was not assessed as having a rash. R #4's Care Plan completed [DATE] did not address scabies or chronic [MEDICAL CONDITION]. R #4's Head to Toe Skin Checks dated [DATE] R #4 had an existing rash. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's In-House Communicator dated [DATE] (provided by) House Keeping Supervisor (HKS) revealed Place in contact isolation DX: (Scabies) R #4's physician's orders [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% Apply to affected areas topically one time only for scabies until [DATE] apply from neck to toes and remove by bathing 12 hours later may repeat in one week if necessary. (TAR was left blank on [DATE]/ no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. ([MEDICATION NAME] was not given as ordered [DATE]). Written correspondence from DON dated [DATE] revealed (R #4) was admitted on [DATE] with RX of Scabies. Order for [MEDICATION NAME] obtained on [DATE]. Treatment not given due to the fact that this med did not arrive from our Pharmacy. On [DATE] same order for [MEDICATION NAME] was resubmitted and med arrived and administered on [DATE]. On [DATE] [MEDICATION NAME] was reordered and reapplied due to a resurgent of Scabies again. Then as per MD order [MEDICATION NAME] was reapplied on [DATE]. As per MD Scabies subsided. On [DATE] (Dr. XX) ordered [MEDICATION NAME] 1% Cream and [MEDICATION NAME] Cream for [MEDICAL CONDITION] and on [DATE] MD ordered [MEDICATION NAME] 10 mg. R #4's physician's orders [REDACTED]. R #4's physician progress notes [REDACTED]. R #4's physician's orders [REDACTED]. R #4's Care Plan completed [DATE] did not address scabies or chronic [MEDICAL CONDITION]. R # 4's hospital admission History and Physical dated [DATE] revealed Impression: Scabies. R #4's hospital Discharge Summary dated [DATE] revealed Final Diagnoses: [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% ([MEDICATION NAME]) Apply to body as directed topically at bedtime every Thu for Scabies for 2 Administrations repeat in 1 week. (TAR was left blank on [DATE] and [DATE] no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. XX. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED].) Apply to body topically two times a day for [MEDICAL CONDITION] apply to body after applying the [MEDICATION NAME] cream. R #4's Doctor's Progress Notes dated [DATE] revealed .Has been treated x2 at least for scabies last TX. ,[DATE] when patient was hospitalized , patient now on [MEDICATION NAME] cream with partial relief but rash persists, no clear documentation of proper decontamination after TX for scabies given .Skin Presence of indurated papules with excoriations and areas of Linchenification on both arms, shoulders, lower back, and lower abdomen, both thighs .Scabies by history scabies TX X 2 at least .Plan will proceed to provide treatment for [REDACTED]. Review of facility infection control tracking and trending log dated: -,[DATE] revealed one case of Scabies. -,[DATE] revealed two cases of Scabies. -,[DATE] revealed three cases of Scabies. -,[DATE] revealed five cases of Scabies. -,[DATE] revealed seven cases of Scabies. On [DATE] at 2:45 p.m., during initial rounds Surveyor observed a tracking raised red rash on R #4's arms and legs. There were areas on R #4's anterior lower forearms with scratch marks and bleeding and scattered bruise marks across both arms. R #4 lifted up his shirt and exposed his abdominal area which was also covered in a tracking raised red rash. R #4's legs were covered with a scabbed over rash from the knees down to his ankle areas. R #4 said he has had the rash off and on for months. R #4 said he wanted the rash treated because it itched him all the time. During interview with R #4 there was a female whom identified herself as a friend in R #4's room. The friend PP said she had been asking for treatment for [REDACTED].#4's insurance would not pay for a dermatologist visit. Surveyor observation and interview revealed R #4 shared closet space with a room-mate. (R #4's clothing was co-mingled with room-mates clothing) On [DATE] at 5:45 p.m., observation revealed R #4 sitting in the dining room at a table with two other residents. R #4 was scratching at his back and arms, R #4 placed his right arm on the table cloth several times during the meal service. On [DATE] at 6:30 p.m., interview with the DON revealed the Treatment Nurse was responsible for treating all the residents for scabies while she was in the building. On [DATE] at 9:00 a.m., interview with the DON revealed the first case of Scabies in the facility was identified (R#8) and treated in [DATE]. The DON said the Physician was notified and the room-mate was removed from the room and R #8 was placed in Contact Isolation. All nursing staff was notified of R #8's Infection Control status by shift report, Cardex and verbal instruction to staff that was currently working with resident. Surveyor asked the DON what the facility protocol was for scabies and the DON said, for scabies the isolation period was for five days. The DON said that the Scabies medication was applied for 24 hours then was rinsed off the resident. The DON said skin checks were conducted post treatment for [REDACTED]. The DON said while the resident was being treated with the Scabicide, House Keeping cleans the resident's room from top to bottom including the resident's clothing. The DON said if the resident had un-washable items such as stuffed animals or pillows, those items were thrown away. The DON said Rehab., Activity Director, and House Keeping Supervisor were notified, two isolation bins were placed in the resident room, one for linens and the other for trash. They placed an isolation cart outside the resident's room for PPE then posted a sign outside resident's door advising people to report to nurse's station prior to entering the room. The DON said for meal service, the staff double bag the meal tray before delivering the tray back to the kitchen. The resident was scheduled for the last shower of the day and Activities are provided in room. The DON said the Nurse that obtained R #4's orders for [MEDICATION NAME] on [DATE] and should have followed up with the Pharmacy to ensure the medication was delivered. On [DATE] at 9:20 a.m., interview with RN A revealed the facility's process for Scabies was starting with the assessment, then notifies the CNAs to back off for a while and take Contact Isolation precautions. RN A said he would then call the Physician and obtain an order for [REDACTED]. RN A said prior to placing resident back into the room all the curtains and all linens were washed. RN A said HSK was responsible for washing the resident's clothing. RN A said that House Keeping would take down the privacy curtains and replace with new curtains. RN A said for all un-washable items such as personal pillows, are to be bagged and then ask resident's family permission to get rid of the items. RN A said HSK emptied out resident clothing from drawers and closets for washing. RN A said he thought R #4 had an active case of Scabies. RN A said he thought Scabies in the facility was spread from improper hand washing and on clothing. RN A said the facility has not had any in-services on Scabies. (RX dosage for treatment of [REDACTED]. On [DATE] at 10:05 a.m., interview with HSK revealed she was notified if a resident had Scabies either in the morning meeting or by In-House Communication Sheet. HSK said if she was in the building at the time a resident was placed in Isolation for Scabies she would set up the Cart for PPE and place it outside resident room, then place a sign on resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	**1100 GALVESTON LAREDO, TX 78040**

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

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F 0226

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 8)
door, and notify her staff that the resident was on Contact Isolation. HSK said she wears PPE, wipes down resident's bed with disinfectant; nursing staff takes all the linens off the beds and places in a biohazard bag linen bin in the resident room. HSK said the nursing staff places resident clothing in biohazard linen bin. HSK said when the resident was off isolation; HSK conducts a deep clean of resident's room, takes down all curtains and wipes down blinds and chair with disinfectant. HSK said she did not remove clothing from resident's closet or drawers. HSK only washes clothing and linens that nursing staff place in biohazard bags.
On [DATE] at 10:15 a.m., interview with LVN B (treatment nurse) revealed she worked from 10:00 a.m.-6:00 p.m. Monday through Friday. LVN B said when she was in the building that she treated residents with orders for Scabicide. LVN B said the first action she takes if she identifies a resident has Scabies would be to notify the Charge Nurse and the Charge Nurse would notify the Physician and obtain orders. LVN B said all direct care nursing staff were notified and the resident would be placed on Contact Isolation, and HSK would be contacted to clean the resident's room. The Scabicide would be applied to the resident from neck down and left on for 12 hours and washed off. While the Scabicide was applied to the resident, all linens on the bed would be removed and placed in Biohazard bag by nursing staff. LVN B said she would then call HSK to clean the room and wash residents clothing. LVN B said 24 hours after the Scabicide treatment she would reassess the resident's skin. LVN B said if the resident that was infected with Scabies had a roommate; the roommate along with the roommate's belongings would be moved to another room until the infected resident was clear from scabies (without decontaminating the belongings). LVN B said if a resident with Scabies had un-washable items, the staff would place those items in the resident's closet or ask the family to take the items home. LVN B said that in her opinion R #4 no longer had Scabies and the Physician has ordered [MEDICATION NAME] 0.1% Cream for R #4's rash. Surveyor asked LVN B if she knew what
the indications for [MEDICATION NAME] Cream? LVN B said, No, Surveyor asked LVN B as a nurse was she supposed to know what
the indications were for Prescription drugs prior to application. LVN B said, yes, but I don't know.
(Nursing Staff said in interviews that HSK washed resident's clothing as part of scabies treatment, and HSK said Nursing staff was responsible for resident's clothing)
On [DATE] at 10:35 a.m., skin assessment by LVN B with R #4, LVN B said during skin assessment that #4 had raised red tracking rash to his bilateral upper extremities, left upper chest wall, behind ears and neck. LVN B said R #4 had dry scabbed areas to his lower extremities. LVN B described areas on R # 4's arms as open and bloody from scratching. LVN B said R #4 scratches until he bleeds.
On [DATE] at 12:25 p.m., interview with HSK revealed she was never notified of R #4 being in isolation the second time R #4 was treated in ,[DATE].
On [DATE] at 5:15 p.m., interview with Dr. XX revealed if the facility did not properly follow decontamination procedures during Scabicide treatment, there was a possibility that R #4 could have been re-infected with Scabies. Dr. XX said all the resident's clothing must be washed as well as the room decontaminated while resident was receiving Scabicide treatment. Surveyor showed Dr. XX R #4's clothing closet was shared with another resident and asked the Physician what would be the proper infection control procedure to isolate the Scabies. Dr. XX said the resident that shared the clothing closet with R #4 would also have to have the clothing washed because the Scabies bug lived on clothing and that the bug could be transmitted to another resident. Dr. XX said he ordered the [MEDICATION NAME] Cream for R #4 to reduce the [MEDICAL CONDITION] response and itching from the [MEDICAL CONDITION]. Dr. XX said he was going to re-treat R #4 with [MEDICATION
NAME] because there was no clear documentation that treatment orders were followed or effective decontamination was done. Dr. XX said he was going to place R #4 on Contact Isolation for one week.
Record review of the facility's Log of Residents with Scabies dated ,[DATE]-[DATE] identified 11 residents: R #1, R #3, R #4, R #6, R #7, R #8, R #9, R #10, R #11, R #12 and R #13.
R #5 and R #14 were not on the facility's log.
R #1:
R #1's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 100 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]., [MEDICAL CONDITIONS], Mood Disorder, and Unspecified Chest Pain.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's [DATE] Treatment Administration Record (TAR) indicated R #1 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #1's [DATE] Order Summary Report documented [DATE] at 11:26 a.m.- Discontinue [MEDICATION NAME] Cream 5%, Reason: Resident
expired.
R #3:
R #3's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility in the 600 Hall on [DATE] with the [DIAGNOSES REDACTED]. This damage is often caused by an abnormally high pressure in your eye), and [MEDICAL CONDITION]
(condition in which the bones become brittle and fragile from loss of tissue).
R #3's physician's orders [REDACTED].
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #3's physician's orders [REDACTED]. Bath to remove in 12 hours and remove per schedule. Contact isolation for one week due to Scabies.
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #6:
R #6's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 500 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #6's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #6's physician's orders [REDACTED].
R #6's [DATE] TAR indicated R #6 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE].
R #6's Order Summary dated [DATE] documented Remove from isolation- Scabies resolved.
R #7:
R #7's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 600 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]. to the brain, causing limited or no blood flow to the affected areas), [MEDICAL CONDITION] (paralysis of one side of the body), and Generalized Muscle Weakness.
R #7's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to area topically one time a day every 14 days for Scabies, as
directed for two administration- Order Date: [DATE]. The TAR did not contain an entry indicating the medication was administered on any day in [DATE].
NOTE: R #7 should have been administered [MEDICATION NAME] Cream 5% on [DATE] and then a second dose should have been
administered on [DATE].
R #7's physician's orders [REDACTED].
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day starting on the 19th
and ending the 19th for Scabies for 2 administrations, as directed. Order Date: [DATE] at 10:43 a.m. The only entry that indicated the medication was administered was on [DATE].
NOTE: There was not a second administration of [MEDICATION NAME] Cream as ordered by the physician.
R #8:
R #8's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #8's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on [DATE] at 11:51 p.m.
R #8's physician's orders [REDACTED].
R #8's physician's orders [REDACTED]. [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day every Tuesday for scabies for two administrations as directed from neck to toes. May repeat in one week if necessary.
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m.
R #8's physician's orders [REDACTED].
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m.
R #8's Order Summary Report dated [DATE] at 11:17 a.m. documented Remove from isolation, scabies resolved.

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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 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 9) R #9: R #9's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]. R #9's physician's orders [REDACTED]. Contact isolation for 48 hours due to Scabies. R #9's [DATE] TAR revealed R #9 was administered [MEDICATION NAME] Cream 5% on [DATE]. R #9's physician's orders [REDACTED]. R #12: R #12's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 600 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #12's physician's orders [REDACTED]. Contact isolation Dx- S
F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Record Review and Interview the facility failed to conduct and complete an Initial Fall Risk Assessment for one (R#4) of three Residents reviewed for Admission Assessments. R #4 had two falls while in the facility and there was no fall risk assessments done on admission or after both falls. This failure could place 38 residents identified on the Falling Star Program at risk for inaccurate assessment of each resident's functional capacity, care and services needed. Findings included: R#4's Admission Record dated 11/09/16 revealed R#4 was a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses; Scabies, Allergic contact [MEDICAL CONDITIONS] with behavioral disturbance, Muscle Weakness, Atrioventricular Block (conduction between the atria and ventricles of the heart is impaired) and Cardiac Pacemaker. R#4's Admission Minimum Data Set ((MDS) dated [DATE] revealed R#4 had severe cognitive impairment, required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene, and locomotion on and off the unit. R#4 had a wheel chair for mobility. Review of R#4's Admission Assessments revealed R #4 did not have a Fall Risk Assessment. Record review of R#4's SBAR dated 08/07/16 revealed R #4 had a change of status of a fall. Assessment (RN) or Appearance (LPN) revealed R #4 wasfound on the floor next to his bed. He complains of pain to his right rib. No ecchymosis of redness noted. Physician aware new orders given. Bed to lowest position, will continue to monitor. Record review of R#4's IDT Post Fall Review dated 08/07/16 revealed the IDT reviewed R#4's unwitnessed fall on 08/07/16. Description of fall resident noted on the floor next to his bed. He states he was going to the restroom, got up and fell . He complains of pain to his right rib. No ecchymosis or redness noted. Activity at the time of fall listed unassisted ambulation in his room from his bed. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, cognitive deficits and admitted in last 30 days. Medications that may contribute to fall listed none. The IDT Intervention recommendations reveled to orient to surrounding, keep bed at lowest position, cont with rehab, encourage to use call light to ask for assistance, Monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT was checked. Record review of R#4's Resident Event dated 08/07/16 revealed R#4 had a fall with an injury in his room. R#4 complains of pain to the right rib area. Further review revealed section Action; orient to surrounding, keep bed at lowest position, cont with rehab, encourage to use call light to. Further review of R#4's Medical Record revealed no updated Fall Risk Assessment after R#4 had a fall on 08/07/16. Record review of R#4's SBAR dated 08/28/16 reveled R#4 had a change of status of a fall. The Situation revealed fall-found on floor Resident found sitting on floor at bed side. Skin tear noted to right thumb. In house treatment provided. Resident disoriented and confused stating that it was time for him to go home. No other apparent injury. No c/o of pain at this time. Transferred back to bed. The Assessment (RN) or Appearance (LPN) reveled Dementia. Record review of R#4's IDT Post Fall Review dated 08/28/16 revealed the IDT reviewed an unwitnessed fall occurrence for R#4 on 08/28/16. The Description of Fall resident found sitting on floor at bed side. Skin tear noted to right thumb. In house treatment provided. Resident disoriented and confused stating that it was time for him to go home. No other apparent injury. No c/o pain at this time. Transferred back to bed. Activity at the time of the fall listed an unassisted transfer in his room from bed. Predisposing Disease listed [MEDICAL CONDITION], Dementia/[MEDICAL CONDITION]. Conditions that may contribute to fall listed cognitive deficits. Medications that may contribute to fall listed none. The IDT intervention recommendations revealed continue with rehab, encourage to use call bell to ask for assistance, monitor for safety. Record review of R#4's Resident Event dated 08/28/16 revealed R#4 had a fall with injury in his room. R#4 was found sitting on floor at bed side. Skin tear noted to right thumb. In house treatment provided. Resident disoriented and confused stating that it was time for him to go home. No other apparent injury. No c/o pain at this time. Transferred back to bed. Further review revealed section Action; continue with rehab, encourage to use call bell to ask for assistance, monitor for safety. Further review of R#4's Medical Record revealed no updated Fall Risk Assessment after R#4 had a fall on 08/28/16. Record review of R#4's Care Plan dated 08/31/16 revealed Revealed the following: Focus: (R#4) had an actual fall with no injury d/t Poor Balance, Unsteady gait on 08/07/16; fall on 08/28/16 sustained skin tear to rt thumb., Risk review: 08/30/16, Date Initiated: 08/16/16, Revision on: 08/30/16 Goal: (R#4) will resume usual activities without further incident through the review date. Date Initiated 08/16/16, Revision on: 08/29/16, Target Date: 08/25/16. Interventions: *Encourage resident to ask for assistance, Date Initiated: 08/16/16 *For no apparent acute injury, determine and address causative factors of the fall. Date Initiated: 08/16/16 *Observe/document/report PRN x 72 h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 08/16/16 *Offer/Assist to toilet frequently and as accepted , Date Initiated: 08/16/16 * Place frequently used items in reach, Date Initiated: 08/16/16 Record review of R#4's Kardex undated revealed R#4 had monitors for: Weigh as same time of day and record. Further review, did not reveal R#4 on a Falling Star Program since start of New Admission on his Care Plan. During an interview on 11/10/16 at 6:35 p.m. the Director of Nursing (DON) reviewed R#4's Medical Record on the computer system, the DON was unable to locate an Initial Fall Risk Assessment for R #4 and stated R#4 did not have an Initial Fall Risk Assessment. During the same interview the DON stated the Fall Risk Assessments were completed upon admission, quarterly and as needed, after each fall a resident had. The DON stated upon admission the Nursing staff completed the following Assessments which included the Fall Risk Assessment : Nursing Admission Data Collection Braden Scale for Predicting Pressure Sore Risk Elopement Risk Fall Risk Nursing Daily Skilled Charting Pain Evaluation Transfer Evaluation Review of the facility Falling Star Program list dated 11/10/16 revealed 39 residents listed in the program. Review of the facility's policy Fall Management, Revision date August 2010 Newly admitted Residents 1. Facilities will take a proactive approach for new resident and will consider new admission at risk for falls until the resident is reviewed by the IDT.

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RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) 2. Upon admission, the admitting nurse will complete the Fall Risk Assessment (see forms tab). The nurse will also complete the Initial Care Plan and address risk factors related to the resident on the Plan of Care and implement appropriate interventions as identified. If Fall Risk Assessment determines resident to be at high risk, then refer resident to Rehabilitation Services. 4. New Admissions will be placed on the Falling Star Program until reviewed by the IDT. 5. The IDT will team will meet and determine if the resident is to continue on the Falling Star Program. 6. If determined by the IDT that the resident is at risk, the Falling Star will be continued and interventions in the Plan of Care will be updated. IF the IDT determines the resident not to be at risk, the resident will be removed from the Falling Star Program. Fall Event 1. When a fall occurs, assess resident of injury. 2. Licensed Nurse will complete: Incident/Accident Report(Briggs),24 Hour Report (Briggs) and Initiate the Interdisciplinary Post Fall Review (see forms tab) 3. Communicate all resident falls to the attending physician and the resident's family and document on the IDT Post Fall Review form. The licensed nurse documents family/responsible party and physician notification on the IDT Post Fall Review form and placed the completed form in the Nurses's Notes section of the Medical Record. The nurse will communicate the resident fall to the IDT via the 24 Hour Report. 5. The IDT will review all resident fall within 24-72 hours at the morning IDT meeting to evaluate circumstances and probable cause for the fall. 6. OPTIONAL: Fall information may be added to the Electronic Care Management Board (ECMB) if so desired for tracking purposes. 7. The IDT modifies and implements a Care Plan and treatment approach to minimize repeat falls. The Care Plan will be reviewed/revised as indicated. The RCS Assignment Sheets/Care Kardexes are posted as appropriate. 8. The IDT will be responsible for placing and removing residents on/off the Falling Star Program. 9. The IDT will complete the IDT Post Fall Review. 10. The In-House Communicator form (Briggs) should be used to make referrals to appropriate IDT members. 11. The Director of Nursing or designee will document falls on the Incident/Accident Report QA&A log and the Individual Resident Fall QA&A Log as they occur and submit reports to risk management system as indicated. Risk management system reports may be used, if desired, to complete tracking/trending reports for QAPI. Resident with Potential Head Injury 1. Complete all items listed under Fall Event (items 1-10, immediately above) 2. Complete the Neurological Record per instructions. Falling Star Program 1. The Falling Star is a visual identifier/reminder program for staff to recognize and to be aware of residents determined to be at risk. 2. Visual identifiers will assist the facility staff as well as family and visitors to identify those residents that are at risk for falls, and to respond accordingly when the resident demonstrated a behavior that may be associated with an impending fall. 3. Placement on the Falling Star Program a. Newly admitted residents. b. Residents identified as risk c. IDT determination If resident is identified for the program, a falling star symbol will be placed on any or all of the location below: a. Over the bed b. On assistive devices (wheelchair, walker) c. Identification band. 4. Removal form the Falling Star Program a. Determined by the IDT (makes final decision) b. Resident without falls for 3 months c. Resident identified as not a risk When the resident is removed from the program, a nurse (or designee) will remove Falling Star Symbols from the resident room, wheelchair, etc and the Care Plan will be revised. 5. Each facility is responsible for implementing individualized interventions related to/for each resident's fall risks. 6. Residents that experience actual falls will be reviewed each week during the At-Risk Review Meeting. 7. The At-Risk Review committee members will review weekly all residents with falls for documentation, compliance, and interventions. 8. After the At-Risk Review Meeting, the IDT will perform the follow-up items assigned as indicated by the review. The facility identified 38 residents on the falling star program. According to the facility CMS Form 802 dated 11/08/16 there was 18 residents in the facility with actual falls with four resident sustaining fractures.
F 0274 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Review or revise the resident's care plan after any major change in a resident's physical or mental health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to conduct a comprehensive assessment of a resident within 14 days after the facility determined that there had been a significant change in the resident's physical or mental condition for two Residents (R#1 and R#2) of 14 reviewed for change of condition. The facility failed to conduct a comprehensive Fall Risk Assessment: 1) after R#1 fell on 19 occasions (expired [DATE] due to natural causes) and 2) after R#2 fell on two occasions and one elopement episode. This failure could place R#1, R #2, and 80 residents at risk of unmet physical and/or mental needs after a change of condition. The Findings: R#1 Record review of R#1's Face Sheet dated [DATE] revealed R#1 was a [AGE] year old male who was admitted to the facility on [DATE] and expired on [DATE] at the facility of natural causes. R#1 had [DIAGNOSES REDACTED]., Unspecified Sequelae of Unspecified [MEDICAL CONDITION] Disease, [MEDICAL CONDITION] of Knee, [MEDICAL CONDITIONS], Cardiac Arrhythmia, Other nonspecific Abnormal findings of Lung Field, and Chest Pain. Record review of R#1's Situation, Background, Assessment, Recommendation (SBAR) Communication Form and Progress Note dated [DATE], revealed R#1 had a change of status of a fall with a skin tear. The Situation revealed a fall with a skin tear. The Assessment (RN-Registered Nurse) or Appearance (LPN-Licensed Professional Nurse) revealed Resident found on bedroom floor, on his left side, he has a 2 X 2 skin tear to his left elbow, he is very confused and disoriented. Wound was cleansed, R#1 was transferred to wheelchair (W/C) and staff will continue to monitor. Record review of R#1's Resident Event dated [DATE] revealed had a fall with injury in his room, 2 X 2 skin tear to left elbow. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-unknown, First Aid-unknown, Staff training-unknown, Therapy Screen-unknown, Resident Education-unknown. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. Description of fall found on the bedroom floor, on his left side, he had a 2 x 2 skin tear to his left elbow, he is very confused and disoriented. R#1's wound was cleansed, he was transferred to his wheelchair, will continue to monitor. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations revealed R#1 was currently receiving

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F 0274 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 11) rehabilitation services at the time of the fall, to re-orient and re-direct. Monitor for safety, low bed. The Care Plan revision box was checked. Referral box to Physical Therapy (PT) and Occupational Therapy (OT) were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 was found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. The Assessment (RN) or Appearance (LPN) revealed the resident becomes more confused at night when he wakes up from sleep. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with injury in his room. R#1 was found to have an injury with reddish discoloration to left buttocks, Hematoma/bruise. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-no, First Aid-no, Staff training-no, Therapy Screen-no, Resident Education-no. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence for R#1 on [DATE]. The Description of the fall resident found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. Activity at time of fall listed unassisted transfer. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may contribute to the fall listed none. The IDT Intervention recommendations revealed R#1 was to be monitored for safety and re-direct as needed. Maintain bed at lowest position, and apply nonskid strips top bedside floor. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation was a fall. Nurses notes revealed Resident found on floor, near to w/c, resident transferred back to W/C, resident with skin tears X2 to Right (R) hand, both of them about 1 X 1 centimeters (cm), small bleeding. Skin tears treated. Head with redness to R parietal area about 1.5 x 3 cm, no skin tear. Neurological checks started. Resident moves all extremities the same as prior fall. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. Description of the fall revealed R#1 was found lying on floor on right side near the bathroom. R#1 did not verbalize and complain of pain and no distress, deformity, or bruise was visible. Activity at time of fall listed unassisted transfer. Predisposing diseases listed none. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed Psychoactives. The IDT Intervention recommendation revealed R#1 was to be monitored for safety and re-direct. MD ordered for safety release belt and family signed consent, encourage him to ask for assistance. The Care Plan revision box and equipment box were checked. Further review revealed Intervention Recommendations, If equipment was selected, describe. Listed was a safety release belt added to Care Plan. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed Resident sitting in wheelchair with safety release belt in place, reached down to grab paper. He leaned lost his balance and fell forward hitting his right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. Resident picked up by staff and examined. No other injuries noted on c/o pain voiced. The Assessment (RN) or Appearance (LPN) revealed R#1 was confused tried to pick up imaginary paper off of floor and fell forward with wheelchair and all. Nursing notes revealed R#1's MD ordered to send R#1 to emergency room (ER) for further evaluation. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury. Injury included right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. The Action taken revealed a wheelchair and Hoyer lift used. Care Plan revised-yes, First Aid-yes, Staff Training-yes, Therapy screen-unknown, and Resident education-yes. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with possible head injury. First aid was provided and R#1 was transferred to acute care. R#1's injury was on the right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. R#1 was sent to the ER for further evaluation as ordered by R#1's MD. Activity at the time of the fall listed reaching up and down. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and vision deficits. Medications that may contribute to the fall listed Psychoactives and Diuretics. The IDT's Intervention recommendations revealed R #1's X-Ray and CT Scan Negative, no fractures. No new orders from ER, Neuro checks done, continue with safety release belt. Apply Tab alarm to wheelchair, and refer to Rehab for evaluation. The Care Plan Revision and equipment were checked. If equipment was selected, describe look at wheelchair. Refer to Physical and Occupational therapy was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 had a fall. The Assessment (RN) or Appearance (LPN) revealed resident was confused. Nursing notes revealed resident fell from wheelchair-no injuries noted. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed Fall Occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with no injury. Resident confused and disoriented while in the dining room, he proceeded to get up out of his wheelchair without locking the wheels. Wheelchair rolled back and fell down to the floor. No injuries noted no skin tears noted at this time. Predisposing diseases listed were Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may contribute to the fall are listed as Psychoactives. The IDT did not list any Intervention recommendations and Care Plan revision box was not checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall without injuries. The Situation listed a fall without injuries. Assessment (RN) or Appearance (LVN) revealed R #1 was restless with notable anxiety. Nurse's notes revealed Resident found on floor laying on right side next to WC in common lobby area. Assisted x 3 safely to WC without complications. No injuries noted upon assessment with resident verbalizing no pain when asked. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence with no injury R#1 had on [DATE] (should be [DATE]) in his bedroom. Description of fall anxious with restlessness noted. Confused calling out for wife. Resident found 0120 AM laying left sided on landing mat on floor next to bed. Bed in lowest position. No injuries or pain noted upon assessment. Resident transferred to bed safely with assist x 2. Will continue to monitor and assess. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed and wheelchair, Landing mat, bed at lowest position, continue with rehab, monitor for safety. Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] without injuries. Assessment (RN) or Appearance (LPN) revealed restless, anxious, confused as he wants to get up and walk. Nursing notes revealed resident found on floor at hallway entrance next to nurses station laying on left side beside WC. Assisted safely back to wc with assist x 3. No injuries noted at time and patent does not express pain. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of Fall revealed R#1 found on floor at hallway entrance next to nurses station laying on left side beside WC. Assisted safely back to WC with assist x3. No injuries noted at this time and patient does not express pain. Will continue to monitor and assess. Activity at time of fall listed R#1 sitting in his wheelchair. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations listed tab alarm cord must be shorten, continue with safely release belt. Monitor for safety, re-direct, continue with rehab. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with an injury at the nurse's station. Injury details revealed R#1 hit his head and had a hematoma on the right side. R #1 was sent to the local ER via ambulance. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a fall, hit his head and had a hematoma on the right side, was transferred to acute care. Resident very disoriented, tried getting up from wheelchair and fell forwards, restraint belt was in place. Resident hit his head and had decreased LOC, blood pressure ,[DATE]. Dr. was notified and orders to transfer resident to ER were given. Activity at time of fall listed as sitting in wheelchair. Predisposing diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may

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F 0274 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 12) contribute to the fall listed Psychoachives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed and wheelchair, landing mat, bed at lowest position, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. Mental status change revealed decreased consciousness (sleepy, lethargic). Assessment (RN) or Appearance (LPN) revealed R#1 with anxiety and restlessness. Nursing notes revealed resident found on floor inside his merry walker, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. R#1 was sent to the ER. Record review of R#1's Resident Event dated [DATE] revealed R#1 had an unwitnessed fall with an injury at the nurse's station. Description of fall resident found on floor inside his merry walker, on his right side, resident transferred to his bed, laceration to Right (R) forehead 4 cm, laceration x 2 to R arm, laceration x 1 Left (L) hand, cleansed with N/s pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP (Responsible Party) request resident was transferred to ER for further evaluation. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a witnessed fall, first aid was provided. The injury revealed R#1 had laceration to R forehead 4 cm, laceration x2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. Resident found on floor inside her merry walker, on his right side, resident transferred to his bed, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP request, resident was transferred to ER for further evaluation. Activity at time of fall revealed R #1 was standing still in his Merry walker. Predisposing Diseases [MEDICAL CONDITION] and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, rehab to re-evaluate equipment for safety, and fall prevention, re-orient and re-direct. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a skin tear on [DATE]. The Situation revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Assessment (RN) or Appearance (LPN) revealed R#1 was restless. Record review of R#1's Resident Event dated [DATE] revealed R#1 obtained a skin tear to the right elbow and left elbow. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1' s witnessed fall occurrence on [DATE]. Description of fall revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Activity at time of fall revealed R#1 was trying to climb out of his Merry Walker. Predisposing Diseases [MEDICAL CONDITION] Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Diabetic Agents. The IDT's Intervention recommendations revealed continue with rehab, re-evaluate equipment for safety, re-direct and re-orient. The Care Plan revision box was checked. Referrals to OT and PT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change in status of a fall. The Situation revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Assessment (RN) or Appearance (LPN) revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Nurse's notes revealed the same statement as previous but indicated the family and MD aware. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in the dining room. Description of fall revealed R#1 slipped off of the dining room chair on to the floor. No visible injuries noted. Resident with increased anxiety and anxiolytic provided. Hospice nurse in to see resident, no new orders by physician. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE] with no injuries. Description of fall revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Activity at time of fall revealed R#1 was seated in a stationary chair in the dining room. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with rehab, monitor for safety while in dining room. The Care Plan box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 had a fall during the night shift on [DATE] at 10:52 p.m. without new injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was restless, anxious and confused. Nursing notes revealed new orders for [MEDICATION NAME] and [MEDICATION NAME] with orders to give [MEDICATION NAME] providing hard copies are available by MD. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with no injury. Description of fall resident fell over on left side with Merry Walker. Assisted out of Merry Walker x 3 using gait belt safely placed into Merry Walker. No injuries noted at this time. Will continue to monitor and assess. The Action taken, R#1 was placed in front of nurse's station throughout shift to continue monitoring him. Record review of R#1's Minimum Data Set (MDS) 60 day scheduled assessment dated [DATE] revealed R#1 had (2) two falls with no injury (no evidence of any injury is noted on the physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the residents behavior is noted after the fall). Further review revealed R#1 had (1) one fall with injury (except major) - skin tears, abrasions, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall related injury that causes the resident to complain of pain) . Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 had a fall x 1 without injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was anxious, restless and confused. Nursing notes revealed resident found laying right side on landing mat next to bed with bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in his bedroom. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injuries. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Activity at time of fall revealed R#1 was unassisted transfer while on his bed. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, low bed, and landing mat. The Care Plan revision box was checked. Referral to PT and OT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 was found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Assessment (RN) or Appearance (LPN) revealed restlessness. Nurse's notes revealed R#1 was transferred to bed. Is now resting. Rise and fall of chest noted. No s/s of distress. Record review of R#1's Resident Event dated [DATE] revealed R#1 was found on the floor with no injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Resident transferred to bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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 0274 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 13) Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's fall occurrence on [DATE] without injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Activity at the time of fall revealed R#1 was in his wheelchair and reaching up and down. Predisposing Diseases [MEDICAL CONDITION] Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed tab alarm, safety release belt, monitor for safety, encourage to ask for assistance. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident experienced fall no visible injuries noted. No c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Treatment: resident with ESHD (Early Stage Hodgkin's Disease) with episodes of [MEDICAL CONDITION], v/s monitored. Advance Care Planning revealed R#1 had a DNR (Do Not Resuscitate) status and was on Hospice services. Assessment (RN) or Appearance (LPN) revealed resident experienced fall no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode. Resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Nurse's notes revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury. Description of fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injury. Description of the fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Activity at time of fall revealed R#1 was sitting in his wheelchair in the hallway. Predisposing Disease listed [MEDICAL CONDITION] and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed tab alarm while in wheelchair, monitor for safety. Record review of R#1's MDS Quarterly assessment dated [DATE] revealed R#1 had (2) two falls with no injury. Further review revealed R#1 had (0) no falls with injury. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident found on the floor in his room. Bed was in lowest and fall pad in place. No visible injuries, v/s wnl (vital signs within normal limits). Assessment (RN) or Appearance (LPN) revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall in his room with no injury. Description of fall revealed R#1 was observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's fall occurrence on [DATE] without injury. The Description of fall revealed R#1 observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Activity at time of fall revealed R#1 had a fall in his room; he was sitting on his bed and had an unassisted transfer. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with low bed and landing mat, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall with injury on [DATE]. The Situation revealed fall with injury, skin tear to right elbow with no other injury noted and on pain verbalized at this time. Assessment (RN) or Appearance (LPN) revealed R#1 calmer up to WC as opposed to the restlessness of being in bed. Cleansed skin tear with normal saline, pat dry area with gauze and covered tear with dry gauze and secured with tape however patient keeps picking at dressing eventually taking it off. Will continue to monitor and assess. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury in his room. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's unwitnessed fall occurrence with injury on [DATE]. Injury included a skin tear to right elbow. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Activity at time of fall revealed R#1 was in bed and had an unassisted transfer. Predisposing Disease listed [MEDICAL CONDITIONS], and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, and history of falls. Medications that may contribute to the fall listed Psychoactives and None. The IDT's Intervention recommendations revealed low bed at lowest position, landing mat, continue with tab alarm to bed. The Care Plan revision box was checked. Referral box to Restorative Nursing was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] with injury. The Situation revealed R#1 had a fall with injury, skin tears to left arm. Assessment (RN) or Appearance (LPN) revealed R#1 took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Will continue to monitor. Record review of R#1's Resident event dated [DATE] revealed R#1 had a fall with an injury in the hall. Description of the fall revealed took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Action taken revealed monitor for safety, continue w/safety release belt, and Tab alarm, re-direct and re-orient to surroundings. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence with injury on [DATE]. The injury revealed two skin tears to left arm. The Description of the fall revealed resident took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Activity at time of fall revealed R#1 was in his wheelchair in the lobby and had an unassisted ambulation. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed none.The IDT's Intervention recommendations revealed monitor for safety, continue with safety release belt, and Tab alarm, re-direct and re-orient to surroundings. The Care Plan revision box was checked. Referral box for PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for two (R#1 and R#2) of three Residents who were reviewed for care plans. The facility failed to incorporate the Interdisciplinary (IDT) Team's intervention recommendations for: 1) R#1's falls which were addressed by the IDT in R#1's Care Plan and 2) R#2's falls which were addressed by the IDT in R#2's Care Plan to ensure all staff were made aware of the resident's needs. This failure could affect R #1, R#2 and all 80 residents who reside in the facility and are at risk for not having accurate information provided to all staff to ensure the residents receive proper care and are aware of the needs of each resident. The findings were: R#1 Record review of R#1's Face Sheet dated [DATE] revealed R#1 was admitted to the facility on [DATE] and expired on [DATE] at the facility of natural causes. R#1 had [DIAGNOSES REDACTED]., Unspecified Sequelae of Unspecified [MEDICAL CONDITION]

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 14) Disease, [MEDICAL CONDITION] of Knee, [MEDICAL CONDITIONS], Cardiac Arrhythmia, Other nonspecific Abnormal findings of Lung Field, and Chest Pain. Record review of R#1's Situation, Background, Assessment, Recommendation (SBAR) Communication Form and Progress Note dated [DATE], revealed R#1 had a change of status of a fall with a skin tear. The Situation revealed a fall with a skin tear. The Assessment (RN-Registered Nurse) or Appearance (LPN-Licensed Professional Nurse) revealed Resident found on bedroom floor, on his left side, he has a 2X2 skin tear to his left elbow, he is very confused and disoriented. Wound was cleansed, R#1 was transferred to wheelchair (W/C) and staff will continue to monitor. Record review of R#1's Resident Event dated [DATE] revealed had a fall with injury in his room, 2X2 skin tear to left elbow. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-unknown, First Aid-unknown, Staff training-unknown, Therapy Screen-unknown, Resident Education-unknown. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. R#1 was found on the bedroom floor, on his left side, he had a 2x2 skin tear to his left elbow, he is very confused and disoriented. R#1's wound was cleansed, he was transferred to his wheelchair, will continue to monitor. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations revealed R#1 was currently receiving rehabilitation services at the time of the fall, to re-orient and re-direct. Monitor for safety, low bed. The Care Plan revision box was checked. Referral box to Physical Therapy (PT) and Occupational Therapy (OT) were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 was found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. The Assessment (RN) or Appearance (LPN) revealed the resident becomes more confused at night when he wakes up from sleep. Record review of R#1's Resident Event dated [DATE] revealed R #1 had a fall with injury in his room. R#1 was found to have an injury with reddish discoloration to left buttocks, Hematoma/bruise. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-no, First Aid-no, Staff training-no, Therapy Screen-no, Resident Education-no. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence for R #1 on [DATE]. The Description of the fall resident found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. Activity at time of fall listed unassisted transfer. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may contribute to the fall listed none. The IDT Intervention recommendations revealed R#1 was to be monitored for safety and re-direct as needed. Maintain bed at lowest position, and apply nonskid strips top bedside floor. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation was a fall. Nurses notes revealed Resident found on floor, near to w/c, resident transferred back to w/c, resident with skin tears X2 to R hand, both of them about 1 X 1 cm, small bleeding. Skin tears treated. Head with redness to R parietal area about 1.5 x 3 cm, no skin tear. Neurological checks started. Resident moves all extremities the same as prior fall. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. Description of the fall revealed R#1 was found lying on floor on right side near the bathroom. R#1 did not verbalize and complain of pain and no distress, deformity, or bruise was visible. Activity at time of fall listed unassisted transfer. Predisposing diseases listed none. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed Psychoactives. The IDT Intervention recommendation revealed R#1 was to be monitored for safety and re-direct. MD ordered for safety release belt and family signed consent, encourage him to ask for assistance. The Care Plan revision box and equipment box were checked. Further review revealed Intervention Recommendations, If equipment was selected, describe. Listed was a safety release belt added to Care Plan. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed Resident sitting in wheelchair with safety release belt in place, reached down to grab paper. He leaned lost his balance and fell forward hitting his right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. Resident picked up by staff and examined. No other injuries noted on c/o pain voiced. The Assessment (RN) or Appearance (LPN) revealed R#1 was confused tried to pick up imaginary paper off of floor and fell forward with wheelchair and all. Nursing notes revealed R#1's MD ordered to send R#1 to emergency room (ER) for further evaluation. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury. Injury included right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. The Action taken revealed a wheelchair and Hoyer lift used. Care Plan revised-yes, First Aid-yes, Staff Training-yes, Therapy screen-unknown, and Resident education-yes. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with possible head injury. First aid was provided and R#1 was transferred to acute care. R#1's injury was on the right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. R#1 was sent to the ER for further evaluation as ordered by R#1's MD. Activity at the time of the fall listed reaching up and down. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and vision deficits. Medications that may contribute to the fall listed Psychoactives and Diuretics. The IDT's Intervention recommendations revealed R#1's X-Ray and CT Scan Negative, no fractures. No new orders from ER, Neuro checks done, continue with safety release belt. Apply Tab alarm to wheelchair, and refer to Rehab for evaluation. The Care Plan Revision and equipment were checked. If equipment was selected, describe look at wheelchair. Refer to Physical and Occupational therapy was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 had a fall. The Assessment (RN) or Appearance (LPN) revealed resident was confused. Nursing notes revealed resident fell from wheelchair-no injuries noted. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed Fall Occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with no injury. Resident confused and disoriented while in the dining room, he proceeded to get up out of his wheelchair without locking the wheels. Wheelchair rolled back and fell down to the floor. No injuries noted no skin tears noted at this time . Predisposing diseases listed were Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may contribute to the fall are listed as Psychoactives. The IDT did not list any Intervention recommendations and Care Plan revision box was not checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall without injuries. The Situation listed a fall without injuries. Assessment (RN) or Appearance (LVN) revealed R #1 was restless with notable anxiety. Nurse's notes revealed Resident found on floor laying on right side next to WC in common lobby area. Assisted x 3 safely to WC without complications. No injuries noted upon assessment with resident verbalizing no pain when asked. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence with no injury R#1 had on [DATE] (should be [DATE]) in his bedroom. Description of fall anxious with restlessness noted. Confused calling out for wife. Resident found 0120 AM laying left sided on landing mat on floor next to bed. Bed in lowest position. No injuries or pain noted upon assessment. Resident transferred to bed safely with assist x 2. Will continue to monitor and assess. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed and wheelchair, Landing mat, bed at lowest position, continue with rehab, monitor for safety. Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] without injuries. Assessment (RN) or Appearance (LPN) revealed restless, anxious, confused as he wants to get up and walk. Nursing notes revealed resident found on floor at hallway entrance next to nurses station laying on left side beside wc. Assisted safely back to wc with assist x 3. No injuries noted at time and patent does not express pain. Will continue to monitor and assess.

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F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 15) Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of Fall revealed R#1 found on floor at hallway entrance next to nurses station laying on left side beside WC. Assisted safely back to WC with assist x 3. No injuries noted at this time and patient does not express pain. Will continue to monitor and assess. Activity at time of fall listed R#1 sitting in his wheelchair. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations listed tab alarm cord must be shorten, continue with safely release belt. Monitor for safety, re-direct, continue with rehab. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with an injury at the nurse's station. Injury details revealed R#1 hit his head and had a hematoma on the right side. R #1 was sent to the local ER via ambulance. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a fall, hit his head and had a hematoma on the right side, was transferred to acute care. Resident very disoriented, tried getting up from wheelchair and fell forwards, restraint belt was in place. Resident hit his head and had decreased LOC, blood pressure ,[DATE]. Dr. was notified and orders to transfer resident to ER were given. Activity at time of fall listed as sitting in wheelchair. Predisposing diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoachives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed and wheelchair, landing mat, bed at lowest position, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. Mental status change revealed decreased consciousness (sleepy, lethargic). Assessment (RN) or Appearance (LPN) revealed R#1 with anxiety and restlessness. Nursing notes revealed resident found on floor inside his merry walker, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. R#1 was sent to the ER. Record review of R#1's Resident Event dated [DATE] revealed R#1 had an unwitnessed fall with an injury at the nurse's station. Description of fall resident found on floor inside his merry walker, on his right side, resident transferred to his bed, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleansed with N/s pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP (Responsible Party) request resident was transferred to ER for further evaluation. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a witnessed fall, first aid was provided. The injury revealed R#1 had laceration to R forehead 4 cm, laceration x2 to R arm, laceration x1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. Resident found on floor inside her merry walker, on his right side, resident transferred to his bed, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP request, resident was transferred to ER for further evaluation. Activity at time of fall revealed R #1 was standing still in his Merry walker. Predisposing Diseases [MEDICAL CONDITION] and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, rehab to re-evaluate equipment for safety, and fall prevention, re-orient and re-direct. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a skin tear on [DATE]. The Situation revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Assessment (RN) or Appearance (LPN) revealed R#1 was restless. Record review of R#1's Resident Event dated [DATE] revealed R#1's obtained a skin tear to the right elbow and left elbow. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE]. Description of fall revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Activity at time of fall revealed R#1 was trying to climb out of his Merry Walker. Predisposing Diseases [MEDICAL CONDITION] Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Diabetic Agents. The IDT's Intervention recommendations revealed continue with rehab, re-evaluate equipment for safety, re-direct and re-orient. The Care Plan revision box was checked. Referrals to OT and PT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change in status of a fall. The Situation revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Assessment (RN) or Appearance (LPN) revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Nurse's notes revealed the same statement as previous but indicated the family and MD aware. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in the dining room. Description of fall revealed R#1 slipped off of the dining room chair on to the floor. No visible injuries noted. Resident with increased anxiety and anxiolytic provided. Hospice nurse in to see resident, no new orders by physician. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE] with no injuries. Description of fall revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Activity at time of fall revealed R#1 was seated in a stationary chair in the dining room. Predisposing Diseases listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with rehab, monitor for safety while in dining room. The Care Plan box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 had a fall during the night shift on [DATE] at 10:52 p.m. without new injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was restless, anxious and confused. Nursing notes revealed new orders for [MEDICATION NAME] and [MEDICATION NAME] with orders to give [MEDICATION NAME] providing hard copies are available by MD. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with no injury. Description of fall resident fell over on left side with Merry Walker. Assisted out of Merry Walker x 3 using gait belt safely placed into Merry Walker. No injuries noted at this time. Will continue to monitor and assess. The Action taken, R#1 was placed in front of nurse's station throughout shift to continue monitoring him. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 had a fall x 1 without injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was anxious, restless and confused. Nursing notes revealed resident found laying right side on landing mat next to bed with bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in his bedroom. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injuries. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest position. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse ' s station for frequent monitoring. Activity at time of fall revealed R#1 was unassisted transfer while on his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 16) bed. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, low bed, and landing mat. The Care Plan revision box was checked. Referral to PT and OT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 was found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Assessment (RN) or Appearance (LPN) revealed restlessness. Nurse's notes revealed R#1 was transferred to bed. Is now resting. Rise and fall of chest noted. No s/s of distress. Record review of R#1's Resident Event dated [DATE] revealed R#1 was found on the floor with no injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Resident transferred to bed. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's fall occurrence on [DATE] without injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Activity at the time of fall revealed R#1 was in his wheelchair and reaching up and down. Predisposing Diseases [MEDICAL CONDITION] Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed tab alarm, safety release belt, monitor for safety, encourage to ask for assistance. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident experienced fall no visible injuries noted. No c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Treatment: resident with ESHD (Early Stage Hodgkin's Disease) with episodes of [MEDICAL CONDITION], v/s monitored. Advance Care Planning revealed R#1 had a DNR (Do Not Resuscitate) status and was on Hospice services. Assessment (RN) or Appearance (LPN) revealed resident experienced fall no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode. Resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Nurse's notes revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury. Description of fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injury. Description of the fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced [MEDICAL CONDITION] episode, resident was already in bed being assessed further when [MEDICAL CONDITION] occurred. Activity at time of fall revealed R#1 was sitting in his wheelchair in the hallway. Predisposing Disease listed [MEDICAL CONDITION] and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed tab alarm while in wheelchair, monitor for safety. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident found on the floor in his room. Bed was in lowest and fall pad in place. No visible injuries, v/s wnl (vital signs within normal limits). Assessment (RN) or Appearance (LPN) revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall in his room with no injury. Description of fall revealed R#1 was observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1' s fall occurrence on [DATE] without injury. The Description of fall revealed R#1 observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Activity at time of fall revealed R#1 had a fall in his room; he was sitting on his bed and had an unassisted transfer. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with low bed and landing mat, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall with injury on [DATE]. The Situation revealed fall with injury, skin tear to right elbow with no other injury noted and on pain verbalized at this time. Assessment (RN) or Appearance (LPN) revealed R#1 calmer up to WC as opposed to the restlessness of being in bed. Cleansed skin tear with normal saline, pat dry area with gauze and covered tear with dry gauze and secured with tape however patient keeps picking at dressing eventually taking it off. Will continue to monitor and assess. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury in his room. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1' s unwitnessed fall occurrence with injury on [DATE]. Injury included a skin tear to right elbow. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Activity at time of fall revealed R#1 was in bed and had an unassisted transfer. Predisposing Disease listed [MEDICAL CONDITIONS], and Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, and history of falls. Medications that may contribute to the fall listed Psychoactives and None. The IDT's Intervention recommendations revealed low bed at lowest position, landing mat, continue with tab alarm to bed. The Care Plan revision box was checked. Referral box to Restorative Nursing was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] with injury. The Situation revealed R#1 had a fall with injury, skin tears to left arm. Assessment (RN) or Appearance (LPN) revealed R#1 took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Will continue to monitor. Record review of R#1's Resident event dated [DATE] revealed R#1 had a fall with an injury in the hall. Description of the fall revealed took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Action taken revealed monitor for safety, continue w/safety release belt, and Tab alarm, re-direct and re-orient to surroundings. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence with injury on [DATE]. The injury revealed two skin tears to left arm. The Description of the fall revealed resident took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Activity at time of fall revealed R#1 was in his wheelchair in the lobby and had an unassisted ambulation. Predisposing Disease listed Dementia/[MEDICAL CONDITION]. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed none . The IDT's Intervention recommendations revealed monitor for safety, continue with safety release belt, and Tab alarm, re-direct and re-orient to surroundings. The Care Plan revision box was checked. Referral box for PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status and was found on the floor on [DATE] with no injury. The Situation revealed resident found sitting on floor in hall, 2 minor skin tears from old wounds, Home treatment provided. No other apparent injuries. Resident continues with confusion. Transferred back to bed. Was up to chair prior incident with safety release belt. Assessment (RN) or Appearance (LPN) revealed R#1 had confusion. Record review of R#1's Resident Event dated [DATE] revealed R#1 was found on the floor in the hall with no injury. Description of fall revealed resident found sitting on floor in hall. 2 minor skin tears from old
F 0283 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide proper discharge planning and communication, of the resident's health status and summary of the resident's stay.** **Provide proper discharge planning and communication, of the resident's health status and summary of the resident's stay.**

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F 0283 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 17) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review the facility failed to complete a Discharge Summary that gave a recapitulation of the resident's stay in the facility or a final summary of the resident's status at discharge for 1 of 1 Closed Record Sampled Resident (R#1) reviewed for discharge. R#1 expired on [DATE]. The facility failed to provide a discharge summary that is available for release to authorized persons and agencies. This failure affected one of one closed record sampled resident of a resident who expired and has the potential to affect all 80 residents by placing them at risk of not having a final summary of the resident's status. The findings: Record review of R#1's Face Sheet dated [DATE] revealed R#1 was admitted to the facility on [DATE] and expired on [DATE] at the facility of natural causes. R#1 had [DIAGNOSES REDACTED]., Unspecified Sequelae of Unspecified [MEDICAL CONDITION] Disease, [MEDICAL CONDITION] of Knee, [MEDICAL CONDITIONS], Cardiac Arrhythmia, Other nonspecific Abnormal findings of Lung Field, and Chest Pain. Review of R#1's Death Certificate revealed he expired on [DATE] of Natural Causes. Record review on [DATE] of R#1's closed record revealed he expired on [DATE]. Further review of the closed record revealed there was no discharge summary that gave a recapitulation of the resident's stay in the facility or a final summary of the resident's status at discharge. During an interview on [DATE] at 5:57 p.m. Medical Records (MR) stated the facility's procedure was when a resident discharged , MR would send the resident's Physician the History and Plan (H&P) and Discharge Summary Form. The Physician fills it out in his office and when the Discharge Summary if ready, the Physician calls MR or she calls the Physician to inquire if the Discharge Summary is ready. MR stated the last time she called the Physician was two weeks ago and the Discharge Summary for R #1 was not ready. MR stated the facility's policy was that the Physician had up to 30 days to conduct a Discharge Summary. MR stated the Physician had two other residents that been waiting for Discharge Summary from same Physician. Review of facility's Policy on Closure of a Medical Record:Discharge, Revision Date: [DATE] Policy All Medical records of discharged residents shall be completed within 30 days of discharge. All clinical information pertaining to the resident's stay shall be centralized in the resident's medical record, and maintained in the Medical Records Department. Procedure 1. When the resident is discharged , retrieve the medical record form the nursing station. 2. Check the thinned files of on-house residents and remove any portion of the medial record of resident's stay, previously thinned. 3. Using current correct discharge chart order, remove portions form the chart holder, placing records parts in chronological order per policy. Insert any portions from the thinned files, using strict chronological order to place records in sections form admission through discharge. Secure charts in order using clips or other method when completed. 4. Remove the Face Sheet, resident index card or admission record copy form 'in house file, Kardex' , or binder, and enter discharge date , time, and location to which resident was released. Place the copy in the :discharged file for permanent retention. 5. Enter the date of discharge into the Disease Index Log, OP5 0501.11 A2, to ensure the current resident census is always reflected. The codes will be entered upon receipt of the completed discharge summary form provided by the attending physician. 6. Upon completion of the medical record discharge audit, notify each department of any deficiencies, noted with a copy of the audit form. Date audit copy, when provide, with a completion date to ensure record is completed for filling within 30 days of discharge. Retain original audit with record until all areas have been completed, using the form to cross off each area as completed. 7. Place record in pending file until all areas have been completed. 8. When the completed physician's discharge summary form is returned, code and index all discharge diagnoses. 9. When all areas are completed, conduct a final review of the discharged record contents to ensure accurate and complete documentation. File the record in the permanent storage area. According to the facility's Centers for Medicare and Medicaid Services (CMS) 672 dated [DATE], the facility census was 80 residents.
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with the comprehensive assessment and plan of care for one Resident (R #5) of one residents reviewed for indwelling urinary catheter care. R #5's urinary catheter drainage bag and tubing were on the floor. These failures could place four residents with indwelling urinary catheters at risk of urinary tract infections, other complications and a diminished quality of life. The findings included: R #5's Face Sheet dated 11/09/16 documented an [AGE] year-old female originally admitted to the facility on [DATE] and then re-admitted on [DATE] with the [DIAGNOSES REDACTED]., Pain, and Urinary Tract Infection [MEDICAL CONDITION]. R #5's Physician order [REDACTED]. R #5's Annual Minimum (MDS) data set [DATE] documented R #5 had: -Rarely/never made self understood -Sometimes understood others -Long term memory problem -Moderately impaired cognitive skills for daily decision making -Had an Indwelling Catheter. R #5's Indwelling Catheter Care Plan revised 10/14/16 documented Anchor catheter to prevent excess tension, observe/record/report to MD (Medical Doctor) for s/sx (signs/symptoms) of UTI, position catheter bag and tubing below the level of the bladder . Observation upon initial rounds on 11/08/16 at 2:41 p.m. revealed R #5 lay in bed with her eyes closed and her Indwelling Urinary Catheter and tubing was on the floor on the left side of her bed. The urine within the tubing and the Indwelling Urinary Catheter drainage bag was more than 3/4's full with cloudy urine dark amber in color with visible sediment. The catheter drainage bag was dated 10/22/16 on the back of the bag. At 2:49 p.m., Registered Nurse (RN) A and Licensed Vocational Nurse (LVN) D walked into R #5's bedroom and were discussing her care. RN A picked up R #5's Indwelling Urinary Catheter drainage bag from the floor and hung it on the left lower aspect of the bed frame. Both nurses walked out of the room simultaneously. At 2:52 p.m., Restorative Aide (RA) E entered R #5's room and emptied 1200 ml (milliliters) of strong foul odor urine. Interview with LVN D on 11/08/16 at 5:57 p.m. confirmed she witnessed R #5's catheter drainage bag on the floor when she was conducting change of shift rounds with RN A. LVN D responded (RN A) picked up the catheter off the floor. LVN D said the catheter drainage bag should not have been on the floor. LVN D said The catheter and urine could become contaminated and the resident could get a urinary infection [MEDICAL CONDITION]. LVN D said R #5's catheter drainage bag had not been cleaned or changed since it was found on the floor. LVN D said she would change the catheter drainage bag and tubing. Observation of R #5 on 11/08/16 at 6:28 p.m. revealed R #5 had the same catheter drainage bag that was dated 10/22/16. Review of the facility's Indwelling Catheter Care Policy and Procedure dated 12/2009 documented Care and maintenance of indwelling catheters is essential to prevent infection and/or complications . Review of the facility's Indwelling Urinary Catheter (Foley) Care and Management Procedures dated 10/02/15 documented .Don't place the drainage bag on the floor to reduce the risk of contamination and subsequent Catheter-Associated UTI (CAUTI).

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 18) Special Considerations:-Empty the drainage bag regularly when it becomes on-half to two thirds full to prevent undue traction on the urethra from the weight of urine in the bag . According to the facility's Centers for Medicare and Medicaid Services (CMS) Form 672 dated 11/08/16 documented 4 residents with Indwelling Urinary Catheters.
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one resident (R #5) of one resident reviewed for indwelling urinary catheters received appropriate treatment and services to prevent urinary tract infections and/or other complications. R #5's urinary catheter drainage bag and tubing were on the floor. This failure could place four residents in the facility that had indwelling urinary catheters at risk for not receiving appropriate treatment to prevent urinary tract infections and prevent complications. The findings included: R #5's Face Sheet dated 11/09/16 documented an [AGE] year-old female originally admitted to the facility on [DATE] and then re-admitted on [DATE] with the [DIAGNOSES REDACTED]., Pain, and Urinary Tract Infection [MEDICAL CONDITION]. R #5's Physician order [REDACTED]. R #5's Annual Minimum (MDS) data set [DATE] documented R #5 had: -Rarely/never made self understood -Sometimes understood others -Long term memory problem -Moderately impaired cognitive skills for daily decision making -Had an Indwelling Catheter. R #5's Indwelling Catheter Care Plan revised 10/14/16 documented Anchor catheter to prevent excess tension, observe/record/report to MD (Medical Doctor) for s/sx (signs/symptoms) of UTI, position catheter bag and tubing below the level of the bladder . Observation upon initial rounds on 11/08/16 at 2:41 p.m. revealed R #5 lay in bed with her eyes closed and her Indwelling Urinary Catheter and tubing was on the floor on the left side of her bed. The urine within the tubing and the Indwelling Urinary Catheter drainage bag was more than 3/4's full with cloudy urine dark amber in color with visible sediment. The catheter drainage bag was dated 10/22/16 on the back of the bag. At 2:49 p.m., Registered Nurse (RN) A and Licensed Vocational Nurse (LVN) D walked into R #5's bedroom and were discussing her care. RN A picked up R #5's Indwelling Urinary Catheter drainage bag from the floor and hung it on the left lower aspect of the bed frame. Both nurses walked out of the room simultaneously. At 2:52 p.m., Restorative Aide (RA) E entered R #5's room and emptied 1200 ml (milliliters) of strong foul odor urine. Interview with LVN D on 11/08/16 at 5:57 p.m. confirmed she witnessed R #5's catheter drainage bag on the floor when she was conducting change of shift rounds with RN A. LVN D responded (RN A) picked up the catheter off the floor. LVN D said the catheter drainage bag should not have been on the floor. LVN D said The catheter and urine could become contaminated and the resident could get a urinary infection [MEDICAL CONDITION]. LVN D said R #5's catheter drainage bag had not been cleaned or changed since it was found on the floor. LVN D said she would change the catheter drainage bag and tubing. Observation of R #5 on 11/08/16 at 6:28 p.m. revealed R #5 had the same catheter drainage bag that was dated 10/22/16. Review of the facility's Indwelling Catheter Care Policy and Procedure dated 12/2009 documented Care and maintenance of indwelling catheters is essential to prevent infection and/or complications . Review of the facility's Indwelling Urinary Catheter (Foley) Care and Management Procedures dated 10/02/15 documented .Don't place the drainage bag on the floor to reduce the risk of contamination and subsequent Catheter-Associated UTI (CAUTI). Special Considerations:-Empty the drainage bag regularly when it becomes on-half to two thirds full to prevent undue traction on the urethra from the weight of urine in the bag . According to the facility's Centers for Medicare and Medicaid Services (CMS) Form 672 dated 11/08/16 documented 4 residents with Indwelling Urinary Catheters.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free of accident hazards in attempt to prevent injury from falls, for three Residents (R#1, R #2, and R #4) of 14 residents reviewed for accidents and hazards. R #1 had 19 falls and the facility did not conduct a Fall Risk Assessment following each fall as per the facility's Policy and Procedure. R#2 did not have a bed or chair tab alarm and a Landing Mat in place as per the Interdisciplinary Team (IDT) intervention recommendations. Fall Risk assessments were not completed after each fall as per the facility's policy and procedure to determine his current level of fall risk. R #4 did not have a low bed as per the Interdisciplinary intervention recommendations. R #4 did not have any Fall Risk Assessments throughout his residence in the facility. These failures could affect 18 residents with history of falls at risk for serious injury or death. The findings included: R#1 Record review of R#1's Face Sheet dated [DATE] revealed R#1 was an [AGE] year old male who was admitted to the facility on [DATE] and expired on [DATE] at the facility of natural causes. R#1 had [DIAGNOSES REDACTED]., Unspecified Sequelae of Unspecified Cerebrovascular Disease, Osteoarthritis of Knee, Insomnia, Edema, Cardiac Arrhythmia, Other nonspecific Abnormal findings of Lung Field, and Chest Pain. Record review of R#1's Situation, Background, Assessment, Recommendation (SBAR) Communication Form and Progress Note dated [DATE], revealed R#1 had a change of status of a fall with a skin tear. The Situation revealed a fall with a skin tear. The Assessment (RN-Registered Nurse) or Appearance (LPN-Licensed Professional Nurse) revealed Resident found on bedroom floor, on his left side, he has a 2X2 skin tear to his left elbow, he is very confused and disoriented. Wound was cleansed, R#1 was transferred to wheelchair (W/C) and staff will continue to monitor. Record review of R#1's Resident Event dated [DATE] revealed had a fall with injury in his room, 2 X 2 skin tear to left elbow. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-unknown, First Aid-unknown, Staff training-unknown, Therapy Screen-unknown, Resident Education-unknown. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. Description of fall found on the bedroom floor, on his left side, he had a 2 x 2 skin tear to his left elbow, he is very confused and disoriented. R#1's wound was cleansed, he was transferred to his wheelchair, will continue to monitor. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations revealed R#1 was currently receiving rehabilitation services at the time of the fall, to re-orient and re-direct. Monitor for safety, low bed. The Care Plan

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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 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 19) revision box was checked. Referral box to Physical Therapy (PT) and Occupational Therapy (OT) were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 was found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. The Assessment (RN) or Appearance (LPN) revealed the resident becomes more confused at night when he wakes up from sleep. Record review of R#1's Resident Event dated [DATE] revealed R #1 had a fall with injury in his room. R#1 was found to have an injury with reddish discoloration to left buttocks, Hematoma/bruise. Further review revealed section Action; no interventions were put into place. Action- Assistive device-no, Care Plan Revisions-no, First Aid-no, Staff training-no, Therapy Screen-no, Resident Education-no. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence for R#1 on [DATE]. The Description of the fall resident found on floor laying on his left side next to his bed. He tried to get out of bed without assistance when he lost his balance and fell to the floor. Activity at time of fall listed unassisted transfer. Predisposing Disease listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may contribute to the fall listed none. The IDT Intervention recommendations revealed R#1 was to be monitored for safety and re-direct as needed. Maintain bed at lowest position, and apply nonskid strips top bedside floor. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation was a fall. Nurses notes revealed Resident found on floor, near to w/c, resident transferred back to w/c, resident with skin tears X 2 to R hand, both of them about 1 X 1 cm, small bleeding. Skin tears treated. Head with redness to R parietal area about 1.5 x 3 cm, no skin tear. Neurological checks started. Resident moves all extremities the same as prior fall. Record review of R#1's Interdisciplinary (IDT) Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall R#1 had on [DATE]. Description of the fall revealed R#1 was found lying on floor on right side near the bathroom. R#1 did not verbalize and complain of pain and no distress, deformity, or bruise was visible. Activity at time of fall listed unassisted transfer. Predisposing diseases listed none. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed Psychoactives. The IDT Intervention recommendation revealed R#1 was to be monitored for safety and re-direct. MD ordered for safety release belt and family signed consent, encourage him to ask for assistance. The Care Plan revision box and equipment box were checked. Further review revealed Intervention Recommendations, If equipment was selected, describe. Listed was a safety release belt added to Care Plan. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed Resident sitting in wheelchair with safety release belt in place, reached down to grab paper. He leaned lost his balance and fell forward hitting his right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. Resident picked up by staff and examined. No other injuries noted on c/o pain voiced. The Assessment (RN) or Appearance (LPN) revealed R#1 was confused tried to pick up imaginary paper off of floor and fell forward with wheelchair and all. Nursing notes revealed R#1's MD ordered to send R#1 to emergency room (ER) for further evaluation. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury. Injury included right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. The Action taken revealed a wheelchair and Hoyer lift used. Care Plan revised-yes, First Aid-yes, Staff Training-yes, Therapy screen-unknown, and Resident education-yes. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with possible head injury. First aid was provided and R#1 was transferred to acute care. R#1's injury was on the right side of face orbital outer aspect causing a 1 cm laceration as well as a large hematoma noted above his right eye. R#1 was sent to the ER for further evaluation as ordered by R#1's MD. Activity at the time of the fall listed reaching up and down. Predisposing Diseases listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls and vision deficits. Medications that may contribute to the fall listed Psychoactives and Diuretics. The IDT's Intervention recommendations revealed R #1's X-Ray and CT Scan Negative, no fractures. No new orders from ER, Neuro checks done, continue with safety release belt. Apply Tab alarm to wheelchair, and refer to Rehab for evaluation. The Care Plan Revision and equipment were checked. If equipment was selected, describe look at wheelchair. Refer to Physical and Occupational therapy was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall. The Situation revealed R#1 had a fall. The Assessment (RN) or Appearance (LPN) revealed resident was confused. Nursing notes revealed resident fell from wheelchair-no injuries noted. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed Fall Occurrence R#1 had on [DATE]. The Description of the fall revealed it was witnessed with no injury. Resident confused and disoriented while in the dining room, he proceeded to get up out of his wheelchair without locking the wheels. Wheelchair rolled back and fell down to the floor. No injuries noted no skin tears noted at this time. Predisposing diseases listed were Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait and history of falls. Medications that may contribute to the fall are listed as Psychoactives. The IDT did not list any Intervention recommendations and Care Plan revision box was not checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall without injuries. The Situation listed a fall without injuries. Assessment (RN) or Appearance (LVN) revealed R #1 was restless with notable anxiety. Nurse's notes revealed Resident found on floor laying on right side next to WC in common lobby area. Assisted x 3 safely to WC without complications. No injuries noted upon assessment with resident verbalizing no pain when asked. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence with no injury R#1 had on [DATE] (should be [DATE]) in his bedroom. Description of fall anxious with restlessness noted. Confused calling out for wife. Resident found 0120 AM laying left sided on landing mat on floor next to bed. Bed in lowest position. No injuries or pain noted upon assessment. Resident transferred to bed safely with assist x 2. Will continue to monitor and assess. Activity at time of fall listed unassisted transfer. Predisposing Diseases listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed and wheelchair, Landing mat, bed at lowest position, continue with rehab, monitor for safety. Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] without injuries. Assessment (RN) or Appearance (LPN) revealed restless, anxious, confused as he wants to get up and walk. Nursing notes revealed resident found on floor at hallway entrance next to nurses station laying on left side beside WC. Assisted safely back to wc with assist x 3. No injuries noted at time and patent does not express pain. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of Fall revealed R#1 found on floor at hallway entrance next to nurses station laying on left side beside WC. Assisted safely back to WC with assist x 3. No injuries noted at this time and patient does not express pain. Will continue to monitor and assess. Activity at time of fall listed R#1 sitting in his wheelchair. Predisposing Diseases listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations listed tab alarm cord must be shorten, continue with safely release belt. Monitor for safety, re-direct, continue with rehab. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with an injury at the nurse's station. Injury details revealed R#1 hit his head and had a hematoma on the right side. R #1 was sent to the local ER via ambulance. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a fall, hit his head and had a hematoma on the right side, was transferred to acute care. Resident very disoriented, tried getting up from wheelchair and fell forwards, restraint belt was in place. Resident hit his head and had decreased LOC, blood pressure ,[DATE]. Dr. was notified and orders to transfer resident to ER were given. Activity at time of fall listed as sitting in wheelchair. Predisposing diseases listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoachives and Narcotics. The IDT's Intervention recommendations listed tab alarm to bed

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	675396	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 20) and wheelchair, landing mat, bed at lowest position, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. Mental status change revealed decreased consciousness (sleepy, lethargic). Assessment (RN) or Appearance (LPN) revealed R#1 with anxiety and restlessness. Nursing notes revealed resident found on floor inside his merry walker, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. R#1 was sent to the ER. Record review of R#1's Resident Event dated [DATE] revealed R#1 had an unwitnessed fall with an injury at the nurse's station. Description of fall resident found on floor inside his merry walker, on his right side, resident transferred to his bed, laceration to Right (R) forehead 4 cm, laceration x 2 to R arm, laceration x 1 Left (L) hand, cleansed with N/s pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP (Responsible Party) request resident was transferred to ER for further evaluation. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed an unwitnessed fall occurrence R#1 had on [DATE]. Description of fall revealed R#1 had a witnessed fall, first aid was provided. The injury revealed R#1 had laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape. Resident found on floor inside her merry walker, on his right side, resident transferred to his bed, laceration to R forehead 4 cm, laceration x 2 to R arm, laceration x 1 L hand, cleanse with N/S pat dry, cover with dry dressing, secure with tape, resident moves all extremities the same as prior fall, as per RP request, resident was transferred to ER for further evaluation. Activity at time of fall revealed R #1 was standing still in his Merry walker. Predisposing Diseases listed CVA (Cerebrovascular accident) and Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, rehab to re-evaluate equipment for safety, and fall prevention, re-orient and re-direct. The Care Plan revision box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a skin tear on [DATE]. The Situation revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Assessment (RN) or Appearance (LPN) revealed R#1 was restless. Record review of R#1's Resident Event dated [DATE] revealed R#1 obtained a skin tear to the right elbow and left elbow. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE]. Description of fall revealed resident obtained a skin tear to right elbow that has been cleansed with normal saline, pat dry, covered with gauze and secured with tape. No other injuries noted at this time. Skin tears occurred from numerous attempts to escape Merry Walker. Will continue to monitor and assess. Activity at time of fall revealed R#1 was trying to climb out of his Merry Walker. Predisposing Diseases listed CVA and Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives and Diabetic Agents. The IDT's Intervention recommendations revealed continue with rehab, re-evaluate equipment for safety, re-direct and re-orient. The Care Plan revision box was checked. Referrals to OT and PT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change in status of a fall. The Situation revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Assessment (RN) or Appearance (LPN) revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Nurse's notes revealed the same statement as previous but indicated the family and MD aware. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in the dining room. Description of fall revealed R#1 slipped off of the dining room chair on to the floor. No visible injuries noted. Resident with increased anxiety and anxiolytic provided. Hospice nurse in to see resident, no new orders by physician. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed a witnessed fall occurrence R#1 had on [DATE] with no injuries. Description of fall revealed resident slipped off of the chair in the dining room, no visible injuries noted, c/o pain unable to determine where pain was due to wounds that already exist merit residents c/o pain. Activity at time of fall revealed R#1 was seated in a stationary chair in the dining room. Predisposing Diseases listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with rehab, monitor for safety while in dining room. The Care Plan box was checked. Referral box to PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 had a fall during the night shift on [DATE] at 10:52 p.m. without new injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was restless, anxious and confused. Nursing notes revealed new orders for Trazodone and Seroquel with orders to give Lorazepam and Ambien PRN providing hard copies are available by MD. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a witnessed fall with no injury. Description of fall resident fell over on left side with Merry Walker. Assisted out of Merry Walker x 3 using gait belt safely placed into Merry Walker. No injuries noted at this time. Will continue to monitor and assess. The Action taken, R#1 was placed in front of nurse's station throughout shift to continue monitoring him. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 had a fall x 1 without injuries. Assessment (RN) or Appearance (LPN) revealed R#1 was anxious, restless and confused. Nursing notes revealed resident found laying right side on landing mat next to bed with bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury in his bedroom. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injuries. Description of fall revealed resident observed and noted laying right side on landing mat next to bed at lowest positions. No pain verbalized with no injuries noted. Transferred resident to WC with assist x 2 and wheeled to front of nurse's station for frequent monitoring. Activity at time of fall revealed R#1 was unassisted transfer while on his bed. Predisposing Disease listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed monitor for safety, continue with rehab, low bed, and landing mat. The Care Plan revision box was checked. Referral to PT and OT box were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed R#1 was found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Assessment (RN) or Appearance (LPN) revealed restlessness. Nurse's notes revealed R#1 was transferred to bed. Is now resting. Rise and fall of chest noted. No s/s of distress. Record review of R#1's Resident Event dated [DATE] revealed R#1 was found on the floor with no injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Resident transferred to bed. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's fall occurrence on [DATE] without injury. Description of fall revealed found sitting on floor by nursing station. Resident was sitting on wheel chair prior to fall. No apparent injury. No s/s (signs or symptoms) of any distress of pain. Activity at the time of fall revealed R#1 was in his wheelchair and reaching up and down. Predisposing Diseases listed CVA and Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed none. The IDT's Intervention recommendations revealed tab alarm, safety release belt, monitor for

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F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 21) safety, encourage to ask for assistance. The Care Plan revision box was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident experienced fall no visible injuries noted. No c/o pain, however, shortly after fall, resident experienced syncope episode, resident was already in bed being assessed further when syncope occurred. Treatment: resident with ESHD (Early Stage Hodgkin's Disease) with episodes of syncope, v/s monitored. Advance Care Planning revealed R#1 had a DNR (Do Not Resuscitate) status and was on Hospice services. Assessment (RN) or Appearance (LPN) revealed resident experienced fall no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced syncope episode. Resident was already in bed being assessed further when syncope occurred. Nurse's notes revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with no injury. Description of fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced syncope episode, resident was already in bed being assessed further when syncope occurred. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence on [DATE] without injury. Description of the fall revealed resident experienced fall with no visible injuries noted, no c/o pain, however, shortly after fall, resident experienced syncope episode, resident was already in bed being assessed further when syncope occurred. Activity at time of fall revealed R#1 was sitting in his wheelchair in the hallway. Predisposing Disease listed Vertigo and Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed history of falls and cognitive deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed tab alarm while in wheelchair, monitor for safety. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE]. The Situation revealed resident found on the floor in his room. Bed was in lowest and fall pad in place. No visible injuries, v/s wnl (vital signs within normal limits). Assessment (RN) or Appearance (LPN) revealed the same statement as mentioned previously. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall in his room with no injury. Description of fall revealed R#1 was observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's fall occurrence on [DATE] without injury. The Description of fall revealed R#1 observed on the floor in his room. Resident rolled out of bed, Bed was in lowest and fall pad in place. No visible injuries noted. V/S wnl. Activity at time of fall revealed R#1 had a fall in his room; he was sitting on his bed and had an unassisted transfer. Predisposing Disease listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait, history of falls, cognitive deficits and vision deficits. Medications that may contribute to the fall listed Psychoactives. The IDT's Intervention recommendations revealed continue with low bed and landing mat, continue with rehab, monitor for safety. The Care Plan revision box was checked. Referral box to PT and OT was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall with injury on [DATE]. The Situation revealed fall with injury, skin tear to right elbow with no other injury noted and on pain verbalized at this time. Assessment (RN) or Appearance (LPN) revealed R#1 calmer up to WC as opposed to the restlessness of being in bed. Cleansed skin tear with normal saline, pat dry area with gauze and covered tear with dry gauze and secured with tape however patient keeps picking at dressing eventually taking it off. Will continue to monitor and assess. Record review of R#1's Resident Event dated [DATE] revealed R#1 had a fall with an injury in his room. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's unwitnessed fall occurrence with injury on [DATE]. Injury included a skin tear to right elbow. Description of fall revealed resident observed on floor laying next to bed on landing mat. Aided to WC with assist x 3. Skin tear to right elbow noted at this time. No other injury noted and no pain verbalized at this time. Activity at time of fall revealed R#1 was in bed and had an unassisted transfer. Predisposing Disease listed Hypotension, CVA, and Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait, and history of falls. Medications that may contribute to the fall listed Psychoactives and None. The IDT's Intervention recommendations revealed low bed at lowest position, landing mat, continue with tab alarm to bed. The Care Plan revision box was checked. Referral box to Restorative Nursing was checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status of a fall on [DATE] with injury. The Situation revealed R#1 had a fall with injury, skin tears to left arm. Assessment (RN) or Appearance (LPN) revealed R#1 took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Will continue to monitor. Record review of R#1's Resident event dated [DATE] revealed R#1 had a fall with an injury in the hall. Description of the fall revealed took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Action taken revealed monitor for safety, continue w/safety release belt, and Tab alarm, re-direct and re-orient to surroundings. Record review of R#1's IDT Post Fall Review dated [DATE] revealed the IDT reviewed R#1's witnessed fall occurrence with injury on [DATE]. The injury revealed two skin tears to left arm. The Description of the fall revealed resident took off his safety release belt, attempted to walk and landed on the floor on his left side. He has two 2 x 0.2 skin tears in his left arm. No other injury noted, no pain noted or verbalized. Activity at time of fall revealed R#1 was in his wheelchair in the lobby and had an unassisted ambulation. Predisposing Disease listed Dementia/Alzheimer's Disease. Conditions that may contribute to the fall listed unsteady gait, history of falls, and cognitive deficits. Medications that may contribute to the fall listed none.The IDT's Intervention recommendations revealed monitor for safety, continue with safety release belt, and Tab alarm, re-direct and re-orient to surroundings. The Care Plan revision box was checked. Referral box for PT and OT were checked. Record review of R#1's SBAR dated [DATE] revealed R#1 had a change of status and was found on the floor on [DATE] with no injury. The Situation revealed resident found sitting on floor in hall, 2 minor skin tears from old wounds, Home treatment provided. No other apparent injuries. Resident continues with confusion. Transferred back to bed. Was up to chair prior incident with safety release belt. Assessment (RN) or Appearance (LPN) revealed R#1 had confusion. Record review
F 0441 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of disease and infection for 13 Residents (R #1, R #3, R #4, R #5, R #6, R #7, R #8, R #9, R #10, R #11, R #12, R #13 and R #14) of 14 Residents reviewed for Infection Control. The facility failed to provide services when it: 1.) failed to follow the physician's orders [REDACTED].#4 and R #7. R #4 had bleeding wounds to both arms. 2.) failed to implement and follow appropriate measures and the facility's policy and procedures to prevent the re-infection and isolation of scabies for R #1, R #3, R #5, R #6, R #7, R #8, R #9, R #12, R #13, and R #14. 3) failed to clarify R #10 and R #11's orders for [MEDICATION NAME] Cream 1% as an effective treatment for [REDACTED]. These failures resulted in an Immediate Jeopardy (IJ) situation identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. These failures could affect 80 residents residing in the facility for serious infection control and risk of contracting scabies. According to the facility's list of residents treated for [REDACTED]. 4.) R #5's Indwelling Urinary Catheter drainage bag was on the floor. These failures could affect four residents with indwelling urinary catheters by compromising care and risk factors for infection. The findings included: Facility Infection Prevention Manual for Long Term Care (revised ,[DATE]) Titled Scabies Care revealed Purpose: To adequately treat cases of scabies and prevent transmission to others. Policy: Any resident with positive evidence of

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 22) Scabies (Sarcoptes scabiei) must be treated upon physician's orders [REDACTED].TO AVOID REINFESTATION A. Clean ALL clothing, bedclothes, etc. that have been in recent contact with the resident. Transport these items in plastic bags. Wash clothes and bedding in HOT soapy water (allow time between loads for full recovery of hot water) and dry on HOT cycle of dryer. Place unwashable clothing and articles in a plastic bag and seal for 7 days (the mites do not survive for more than ,[DATE] days without contact with the body). B. Wipe down beds, pillows, mattresses, furniture, etc. with a germicidal solution. E. Contact precautions for associates consist of wearing gloves and gown if in close contact with an infested person or things .This is necessary before treatment and for ,[DATE] hours after treatment. Hand hygiene is the best technique for protection of oneself and others .PROCEDURE .G. While treatment is being done, have bed stripped (place bedding in a plastic bag before sending to laundry); all washable clothing, etc. that has been in recent contact with the resident should be placed in a plastic bag to be washed. Unwashable items should be placed in a plastic bag and sealed for 7 days (label bag with name, date, etc.) H. Be sure the resident has CLEAN clothing and CLEAN bedding; make sure infested items have been removed from the room. I All furniture, mattresses, pillows, etc. should be wiped down with a germicidal solution. J. Have the resident bathe thoroughly after the time indicated on the product. Make sure the resident has clean clothes and that bed linens are changed again . R #4 R #4's Admission Record dated [DATE] revealed R #4 was a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses; Scabies, Allergic contact dermatitis, Vascular dementia with behavioral disturbance, Muscle Weakness, Atrioventricular Block (conduction between the atria and ventricles of the heart is impaired) and Cardiac Pacemaker. R #4's admission MDS dated [DATE] revealed R #4 had severe cognitive impairment, required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene, and locomotion on and off the unit. R #4 had a wheel chair for mobility. R #4 was not assessed as having a rash. R #4's Care Plan completed [DATE] did not address scabies or chronic dermatitis. R #4's Head to Toe Skin Checks dated [DATE] R #4 had an existing rash. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's In-House Communicator dated [DATE] (provided by) House Keeping Supervisor (HKS) revealed Place in contact isolation DX: (Scabies) R #4's physician's orders [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% Apply to affected areas topically one time only for scabies until [DATE] apply from neck to toes and remove by bathing 12 hours later may repeat in one week if necessary. (TAR was left blank on [DATE]/ no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. ([MEDICATION NAME] was not given as ordered [DATE]). Written correspondence from DON dated [DATE] revealed (R #4) was admitted on [DATE] with RX of Scabies. Order for [MEDICATION NAME] obtained on [DATE]. Treatment not given due to the fact that this med did not arrive from our Pharmacy. On [DATE] same order for [MEDICATION NAME] was resubmitted and med arrived and administered on [DATE]. On [DATE] [MEDICATION NAME] was reordered and reapplied due to a resurgent of Scabies again. Then as per MD order [MEDICATION NAME] was reapplied on [DATE]. As per MD Scabies subsided. On [DATE] (Dr. XX) ordered [MEDICATION NAME] 1% Cream and [MEDICATION NAME] Cream for Dermatitis and on [DATE] MD ordered [MEDICATION NAME] 10 mg. R #4's physician's orders [REDACTED]. R #4's physician progress notes [REDACTED]. R #4's physician's orders [REDACTED]. R #4's Care Plan completed [DATE] did not address scabies or chronic dermatitis. R # 4's hospital admission History and Physical dated [DATE] revealed Impression: Scabies. R #4's hospital Discharge Summary dated [DATE] revealed Final Diagnoses: [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% ([MEDICATION NAME]) Apply to body as directed topically at bedtime every Thu for Scabies for 2 Administrations repeat in 1 week. (TAR was left blank on [DATE] and [DATE] no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. XX. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED].) Apply to body topically two times a day for dermatitis apply to body after applying the [MEDICATION NAME] cream. R #4's Doctor's Progress Notes dated [DATE] revealed .Has been treated x2 at least for scabies last TX. ,[DATE] when patient was hospitalized , patient now on [MEDICATION NAME] cream with partial relief but rash persists, no clear documentation of proper decontamination after TX for scabies given .Skin Presence of indurated papules with excoriations and areas of Linchenification on both arms, shoulders, lower back, and lower abdomen, both thighs .Scabies by history scabies TX X 2 at least .Plan will proceed to provide treatment for [REDACTED]. Review of facility infection control tracking and trending log dated: -,[DATE] revealed one case of Scabies. -,[DATE] revealed two cases of Scabies. -,[DATE] revealed three cases of Scabies. -,[DATE] revealed five cases of Scabies. -,[DATE] revealed seven cases of Scabies. On [DATE] at 2:45 p.m., during initial rounds Surveyor observed a tracking raised red rash on R #4's arms and legs. There were areas on R #4's anterior lower forearms with scratch marks and bleeding and scattered bruise marks across both arms. R #4 lifted up his shirt and exposed his abdominal area which was also covered in a tracking raised red rash. R #4's legs were covered with a scabbed over rash from the knees down to his ankle areas. R #4 said he has had the rash off and on for months. R #4 said he wanted the rash treated because it itched him all the time. During interview with R #4 there was a female whom identified herself as a friend in R #4's room. The friend PP said she had been asking for treatment for [REDACTED].#4's insurance would not pay for a dermatologist visit. Surveyor observation and interview revealed R #4 shared closet space with a room-mate. (R #4's clothing was co-mingled with room-mates clothing) On [DATE] at 5:45 p.m., observation revealed R #4 sitting in the dining room at a table with two other residents. R #4 was scratching at his back and arms, R #4 placed his right arm on the table cloth several times during the meal service. On [DATE] at 6:30 p.m., interview with the DON revealed the Treatment Nurse was responsible for treating all the residents for scabies while she was in the building. On [DATE] at 9:00 a.m., interview with the DON revealed the first case of Scabies in the facility was identified (R#8) and treated in [DATE]. The DON said the Physician was notified and the room-mate was removed from the room and R #8 was placed in Contact Isolation. All nursing staff was notified of R #8's Infection Control status by shift report, Cardex and verbal instruction to staff that was currently working with resident. Surveyor asked the DON what the facility protocol was for scabies and the DON said, for scabies the isolation period was for five days. The DON said that the Scabies medication was applied for 24 hours then was rinsed off the resident. The DON said skin checks were conducted post treatment for [REDACTED]. The DON said while the resident was being treated with the Scabicide, House Keeping cleans the resident's room from top to bottom including the resident's clothing. The DON said if the resident had un-washable items such as stuffed animals or pillows, those items were thrown away. The DON said Rehab., Activity Director, and House Keeping Supervisor were notified, two isolation bins were placed in the resident room, one for linens and the other for trash. They placed an isolation cart outside the resident's room for PPE then posted a sign outside resident's door advising people to report to nurse's station prior to entering the room. The DON said for meal service, the staff double bag the meal tray before delivering the tray back to the kitchen. The resident was scheduled for the last shower of the day and Activities are provided in room. The DON said the Nurse that obtained R #4's orders for [MEDICATION NAME] on [DATE] and should have followed up with the Pharmacy to ensure the medication was delivered. On [DATE] at 9:20 a.m., interview with RN A revealed the facility's process for Scabies was starting with the assessment,

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	675396	A. BUILDING _____ B. WING _____	**11/10/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	**1100 GALVESTON LAREDO, TX 78040**

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

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F 0441

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 23)
then notifies the CNAs to back off for a while and take Contact Isolation precautions. RN A said he would then call the Physician and obtain an order for [REDACTED]. RN A said he would apply the [MEDICATION NAME] 1% from neck down at 8:00 p.m.
or 9:00 p.m., and then in the morning after resident had breakfast, rinse the medicine off. RN A said prior to placing resident back into the room all the curtains and all linens were washed. RN A said HSK was responsible for washing the resident's clothing. RN A said that House Keeping would take down the privacy curtains and replace with new curtains. RN A said for all un-washable items such as personal pillows, are to be bagged and then ask resident's family permission to get rid of the items. RN A said HSK emptied out resident clothing from drawers and closets for washing. RN A said he thought R #4 had an active case of Scabies. RN A said he thought Scabies in the facility was spread from improper hand washing and on clothing. RN A said the facility has not had any in-services on Scabies. (RX dosage for treatment of [REDACTED].
On [DATE] at 10:05 a.m., interview with HSK revealed she was notified if a resident had Scabies either in the morning meeting or by In-House Communication Sheet. HSK said if she was in the building at the time a resident was placed in Isolation for Scabies she would set up the Cart for PPE and place it outside resident room, then place a sign on resident door, and notify her staff that the resident was on Contact Isolation. HSK said she wears PPE, wipes down resident's bed with disinfectant; nursing staff takes all the linens off the beds and places in a biohazard bag linen bin in the resident room. HSK said the nursing staff places resident clothing in biohazard linen bin. HSK said when the resident was off isolation; HSK conducts a deep clean of resident's room, takes down all curtains and wipes down blinds and chair with disinfectant. HSK said she did not remove clothing from resident's closet or drawers. HSK only washes clothing and linens that nursing staff place in biohazard bags.
On [DATE] at 10:15 a.m., interview with LVN B (treatment nurse) revealed she worked from 10:00 a.m.-6:00 p.m. Monday through Friday. LVN B said when she was in the building that she treated residents with orders for Scabicide. LVN B said the first action she takes if she identifies a resident has Scabies would be to notify the Charge Nurse and the Charge Nurse would notify the Physician and obtain orders. LVN B said all direct care nursing staff were notified and the resident would be placed on Contact Isolation, and HSK would be contacted to clean the resident's room. The Scabicide would be applied to the resident from neck down and left on for 12 hours and washed off. While the Scabicide was applied to the resident, all linens on the bed would be removed and placed in Biohazard bag by nursing staff. LVN B said she would then call HSK to clean the room and wash residents clothing. LVN B said 24 hours after the Scabicide treatment she would reassess the resident's skin. LVN B said if the resident that was infected with Scabies had a roommate; the roommate along with the roommate's belongings would be moved to another room until the infected resident was clear from scabies (without decontaminating the belongings). LVN B said if a resident with Scabies had un-washable items, the staff would place those items in the resident's closet or ask the family to take the items home. LVN B said that in her opinion R #4 no longer had Scabies and the Physician has ordered [MEDICATION NAME] 0.1% Cream for R #4's rash. Surveyor asked LVN B if she knew what
the indications for [MEDICATION NAME] Cream? LVN B said, No, Surveyor asked LVN B as a nurse was she supposed to know what
the indications were for Prescription drugs prior to application. LVN B said, yes, but I don't know.
(Nursing Staff said in interviews that HSK washed resident's clothing as part of scabies treatment, and HSK said Nursing staff was responsible for resident's clothing)
On [DATE] at 10:35 a.m., skin assessment by LVN B with R #4, LVN B said during skin assessment that #4 had raised red tracking rash to his bilateral upper extremities, left upper chest wall, behind ears and neck. LVN B said R #4 had dry scabbed areas to his lower extremities. LVN B described areas on R # 4's arms as open and bloody from scratching. LVN B said R #4 scratches until he bleeds.
On [DATE] at 12:25 p.m., interview with HSK revealed she was never notified of R #4 being in isolation the second time R #4 was treated in ,[DATE].
On [DATE] at 5:15 p.m., interview with Dr. XX revealed if the facility did not properly follow decontamination procedures during Scabicide treatment, there was a possibility that R #4 could have been re-infected with Scabies. Dr. XX said all the resident's clothing must be washed as well as the room decontaminated while resident was receiving Scabicide treatment. Surveyor showed Dr. XX R #4's clothing closet was shared with another resident and asked the Physician what would be the proper infection control procedure to isolate the Scabies. Dr. XX said the resident that shared the clothing closet with R #4 would also have to have the clothing washed because the Scabies bug lived on clothing and that the bug could be transmitted to another resident. Dr. XX said he ordered the [MEDICATION NAME] Cream for R #4 to reduce the inflammatory response and itching from the dermatitis. Dr. XX said he was going to re-treat R #4 with [MEDICATION NAME] because there was no clear documentation that treatment orders were followed or effective decontamination was done. Dr. XX said he was going to place R #4 on Contact Isolation for one week.
Record review of the facility's Log of Residents with Scabies dated ,[DATE]-[DATE] identified 11 residents: R #1, R #3, R #4, R #6, R #7, R #8, R #9, R #10, R #11, R #12 and R #13.
R #5 and R #14 were not on the facility's log.
R #1:
R #1's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 100 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]., Osteoarthritis, Insomnia, Mood Disorder, and Unspecified Chest Pain.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's [DATE] Treatment Administration Record (TAR) indicated R #1 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #1's [DATE] Order Summary Report documented [DATE] at 11:26 a.m.- Discontinue [MEDICATION NAME] Cream 5%, Reason: Resident
expired.
R #3:
R #3's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility in the 600 Hall on [DATE] with the [DIAGNOSES REDACTED]. This damage is often caused by an abnormally high pressure in your eye), and Osteoporosis (condition in which the bones become brittle and fragile from loss of tissue).
R #3's physician's orders [REDACTED].
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #3's physician's orders [REDACTED]. Bath to remove in 12 hours and remove per schedule. Contact isolation for one week due to Scabies.
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #6:
R #6's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 500 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #6's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #6's physician's orders [REDACTED].
R #6's [DATE] TAR indicated R #6 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE].
R #6's Order Summary dated [DATE] documented Remove from isolation- Scabies resolved.
R #7:
R #7's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 600 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]. to the brain, causing limited or no blood flow to the affected areas), [DIAGNOSES REDACTED] (paralysis of one side of the body), and Generalized Muscle Weakness.
R #7's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to area topically one time a day every 14 days for Scabies, as
directed for two administration- Order Date: [DATE]. The TAR did not contain an entry indicating the medication was administered on any day in [DATE].
NOTE: R #7 should have been administered [MEDICATION NAME] Cream 5% on [DATE] and then a second dose should have been
administered on [DATE].
R #7's physician's orders [REDACTED].
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day starting on the 19th
and ending the 19th for Scabies for 2 administrations, as directed. Order Date: [DATE] at 10:43 a.m. The only entry that indicated the medication was administered was on [DATE].
NOTE: There was not a second administration of [MEDICATION NAME] Cream as ordered by the physician.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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F 0441 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 24) R #8: R #8's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #8's physician's orders [REDACTED]. Contact isolation for one week due to Scabies. R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on [DATE] at 11:51 p.m. R #8's physician's orders [REDACTED]. R #8's physician's orders [REDACTED]. [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day every Tuesday for scabies for two administrations as directed from neck to toes. May repeat in one week if necessary. R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m. R #8's physician's orders [REDACTED]. R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m. R #8's Order Summary Report dated [DATE] at 11:17 a.m. documented Remove from isolation, scabies resolved. R #9: R #9's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]. R #9's physician's orders [REDACTED]. Contact isolation for 48 hours due to Scabies. R #9's [DATE] TAR revealed R #9 was administered [MEDICATION NAME] Cream 5% on [DATE]. R #9's physician's orders [REDACTED]. R #12: R #12's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 600 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #12's physician's orders [REDACTED]. Contact isolation Dx- Scabies. R #12's physician's orders [REDACTED]. Contact isolation Dx- Scabies. R #12's physician's orders [REDACTED]. R #12's [DATE] TAR revealed R #12 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE]. R #13: R #13's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 200 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #13's physician's orders [REDACTED]. Contact isolation for 7 days Dx- Scabies. R #13's physician's orders [REDACTED]. Contact isolation Dx- Scabies. R #13's [DATE] TAR revealed R #14 no entry to indicate R #13 was administered the [MEDICATION NAME] Cream 5% as ordered on [DATE] and [DATE]. R #13's physician's orders [REDACTED]. R #14: R #14's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 200 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #14's physician's orders [REDACTED]. Repeat application as instructed within two weeks of initial application. Contact isolation until Scabies resolved. R #14's Physician order [REDACTED]. R #10: R #10's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility in the 400 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #10's physician's orders [REDACTED]. Place on contact isolation due to scabies. R #10's [DATE] TAR revealed R #10 was administered [MEDICATION NAME] Cream 5% on [DATE]. R #10's physician's orders [REDACTED]. Bathe in 12 hours to remove cream. R #10's [DATE] TAR revealed there was no entry to indicate R #10 was administered [MEDICATION NAME] Cream 5% as ordered in [DATE]. R #10's physician's orders [REDACTED]. R #10's physician's orders [REDACTED]. Repeat in one week if needed and apply entire body topically as needed for scabies until [DATE] 11:59 p.m. Contact isolation X 1 week for Scabies. This order was Confirmed by (the DON). R #10's [DATE] TAR revealed R #10 was administered [MEDICATION NAME] Cream 1% on [DATE]. R #10's physician's orders [REDACTED]. R #11: R #11's Face Sheet dated [DATE] documented
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest, practicable physical, mental, and psychosocial well-being of each resident for 13 Residents (R #1, R #3, R #4, R #5. R #6 R #7, R #8, R #9, R #10, R #11, R #12, R #13 and R #14) of 14 Residents reviewed Infection Control. The Administrator failed to: 1) Implement policies and procedures for Scabies Treatment and Control. 2) Supervise the DON by using the Infection Control tracking and trending and Quality Assurance process, making rounds, and following up with scabies containment. The DON was aware that R #4 was infected with Scabies but failed to ensure effective interventions were in place to protect R #4 from re-infestation, and containment of disease to protect other residents from infection. 3) Implement and follow appropriate measures and the facility's policy and procedures to prevent the re-infection and isolation of scabies for R #1, R #3, R #5, R #6, R #7, R #8, R #9, R #12, R #13, and R #14. The DON failed to: 1) Implement policies and procedures for Scabies Control and re-infestation. 2) Put effective measures into place to ensure staff followed up with Physician Orders. 3) Supervise the nursing staff to ensure that the nursing staff was consistently following up with Physician Orders, Pharmacy Orders and Scabies treatment for [REDACTED]. Findings were: These failures resulted in an Immediate Jeopardy (IJ) situation identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. These failures could affect 80 residents residing in the facility for serious infection control and risk of contracting scabies. According to the facility's list of residents treated for [REDACTED]. R #4 R #4's Admission Record dated [DATE] revealed R #4 was a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses; Scabies, Allergic contact [MEDICAL CONDITIONS] with behavioral disturbance, Muscle Weakness, Atrioventricular Block (conduction between the atria and ventricles of the heart is impaired) and Cardiac Pacemaker. R #4's admission MDS dated [DATE] revealed R #4 had severe cognitive impairment, required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene, and locomotion on and off the unit. R #4 had a wheel chair for mobility. R #4 was not assessed as having a rash. R #4's Care Plan completed [DATE] did not address scabies or chronic [MEDICAL CONDITION]. R #4's Head to Toe Skin Checks dated [DATE] R #4 had an existing rash. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's In-House Communicator dated [DATE] (provided by) House Keeping Supervisor (HKS) revealed Place in contact isolation DX: (Scabies)

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	675396	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	1100 GALVESTON LAREDO, TX 78040

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 25) R #4's physician's orders [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% Apply to affected areas topically one time only for scabies until [DATE] apply from neck to toes and remove by bathing 12 hours later may repeat in one week if necessary. (TAR was left blank on [DATE]/ no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. ([MEDICATION NAME] was not given as ordered [DATE]). Written correspondence from DON dated [DATE] revealed (R #4) was admitted on [DATE] with RX of Scabies. Order for [MEDICATION NAME] obtained on [DATE]. Treatment not given due to the fact that this med did not arrive from our Pharmacy. On [DATE] same order for [MEDICATION NAME] was resubmitted and med arrived and administered on [DATE]. On [DATE] [MEDICATION NAME] was reordered and reapplied due to a resurgent of Scabies again. Then as per MD order [MEDICATION NAME] was reapplied on [DATE]. As per MD Scabies subsided. On [DATE] (Dr. XX) ordered [MEDICATION NAME] 1% Cream and [MEDICATION NAME] Cream for [MEDICAL CONDITION] and on [DATE] MD ordered [MEDICATION NAME] 10 mg. R #4's physician's orders [REDACTED]. R #4's physician progress notes [REDACTED]. R #4's physician's orders [REDACTED]. R #4's Care Plan completed [DATE] did not address scabies or chronic [MEDICAL CONDITION]. R # 4's hospital admission History and Physical dated [DATE] revealed Impression: Scabies. R #4's hospital Discharge Summary dated [DATE] revealed Final Diagnoses: [REDACTED]. R #4's TAR dated ,[DATE] revealed [MEDICATION NAME] Cream 5% ([MEDICATION NAME]) Apply to body as directed topically at bedtime every Thu for Scabies for 2 Administrations repeat in 1 week. (TAR was left blank on [DATE] and [DATE] no initials as applied) [MEDICATION NAME] Cream 5% was initialed as applied on [DATE]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED]. XX. R #4's physician's orders [REDACTED]. R #4's physician's orders [REDACTED].) Apply to body topically two times a day for [MEDICAL CONDITION] apply to body after applying the [MEDICATION NAME] cream. R #4's Doctor's Progress Notes dated [DATE] revealed .Has been treated x2 at least for scabies last TX. ,[DATE] when patient was hospitalized , patient now on [MEDICATION NAME] cream with partial relief but rash persists, no clear documentation of proper decontamination after TX for scabies given .Skin Presence of indurated papules with excoriations and areas of Linchenification on both arms, shoulders, lower back, and lower abdomen, both thighs .Scabies by history scabies TX X 2 at least .Plan will proceed to provide treatment for [REDACTED]. Review of facility infection control tracking and trending log dated: -,[DATE] revealed one case of Scabies. -,[DATE] revealed two cases of Scabies. -,[DATE] revealed three cases of Scabies. -,[DATE] revealed five cases of Scabies. -,[DATE] revealed seven cases of Scabies. On [DATE] at 2:45 p.m., during initial rounds Surveyor observed a tracking raised red rash on R #4's arms and legs. There were areas on R #4's anterior lower forearms with scratch marks and bleeding and scattered bruise marks across both arms. R #4 lifted up his shirt and exposed his abdominal area which was also covered in a tracking raised red rash. R #4's legs were covered with a scabbed over rash from the knees down to his ankle areas. R #4 said he has had the rash off and on for months. R #4 said he wanted the rash treated because it itched him all the time. During interview with R #4 there was a female whom identified herself as a friend in R #4's room. The friend PP said she had been asking for treatment for [REDACTED].#4's insurance would not pay for a dermatologist visit. Surveyor observation and interview revealed R #4 shared closet space with a room-mate. (R #4's clothing was co-mingled with room-mates clothing) On [DATE] at 5:45 p.m., observation revealed R #4 sitting in the dining room at a table with two other residents. R #4 was scratching at his back and arms, R #4 placed his right arm on the table cloth several times during the meal service. On [DATE] at 6:30 p.m., interview with the DON revealed the Treatment Nurse was responsible for treating all the residents for scabies while she was in the building. On [DATE] at 9:00 a.m., interview with the DON revealed the first case of Scabies in the facility was identified (R#8) and treated in [DATE]. The DON said the Physician was notified and the room-mate was removed from the room and R #8 was placed in Contact Isolation. All nursing staff was notified of R #8's Infection Control status by shift report, Cardex and verbal instruction to staff that was currently working with resident. Surveyor asked the DON what the facility protocol was for scabies and the DON said, for scabies the isolation period was for five days. The DON said that the Scabies medication was applied for 24 hours then was rinsed off the resident. The DON said skin checks were conducted post treatment for [REDACTED]. The DON said while the resident was being treated with the Scabicide, House Keeping cleans the resident's room from top to bottom including the resident's clothing. The DON said if the resident had un-washable items such as stuffed animals or pillows, those items were thrown away. The DON said Rehab., Activity Director, and House Keeping Supervisor were notified, two isolation bins were placed in the resident room, one for linens and the other for trash. They placed an isolation cart outside the resident's room for PPE then posted a sign outside resident's door advising people to report to nurse's station prior to entering the room. The DON said for meal service, the staff double bag the meal tray before delivering the tray back to the kitchen. The resident was scheduled for the last shower of the day and Activities are provided in room. The DON said the Nurse that obtained R #4's orders for [MEDICATION NAME] on [DATE] and should have followed up with the Pharmacy to ensure the medication was delivered. On [DATE] at 9:20 a.m., interview with RN A revealed the facility's process for Scabies was starting with the assessment, then notifies the CNAs to back off for a while and take Contact Isolation precautions. RN A said he would then call the Physician and obtain an order for [REDACTED]. RN A said prior to placing resident back into the room all the curtains and all linens were washed. RN A said HSK was responsible for washing the resident's clothing. RN A said that House Keeping would take down the privacy curtains and replace with new curtains. RN A said for all un-washable items such as personal pillows, are to be bagged and then ask resident's family permission to get rid of the items. RN A said HSK emptied out resident clothing from drawers and closets for washing. RN A said he thought R #4 had an active case of Scabies. RN A said he thought Scabies in the facility was spread from improper hand washing and on clothing. RN A said the facility has not had any in-services on Scabies. (RX dosage for treatment of [REDACTED]. On [DATE] at 10:05 a.m., interview with HSK revealed she was notified if a resident had Scabies either in the morning meeting or by In-House Communication Sheet. HSK said if she was in the building at the time a resident was placed in Isolation for Scabies she would set up the Cart for PPE and place it outside resident room, then place a sign on resident door, and notify her staff that the resident was on Contact Isolation. HSK said she wears PPE, wipes down resident's bed with disinfectant; nursing staff takes all the linens off the beds and places in a biohazard bag linen bin in the resident room. HSK said the nursing staff places resident clothing in biohazard linen bin. HSK said when the resident was off isolation; HSK conducts a deep clean of resident's room, takes down all curtains and wipes down blinds and chair with disinfectant. HSK said she did not remove clothing from resident's closet or drawers. HSK only washes clothing and linens that nursing staff place in biohazard bags. On [DATE] at 10:15 a.m., interview with LVN B (treatment nurse) revealed she worked from 10:00 a.m.-6:00 p.m. Monday through Friday. LVN B said when she was in the building that she treated residents with orders for Scabicide. LVN B said the first action she takes if she identifies a resident has Scabies would be to notify the Charge Nurse and the Charge Nurse would notify the Physician and obtain orders. LVN B said all direct care nursing staff were notified and the resident would be placed on Contact Isolation, and HSK would be contacted to clean the resident's room. The Scabicide would be applied to the resident from neck down and left on for 12 hours and washed off. While the Scabicide was applied to the resident, all linens on the bed would be removed and placed in Biohazard bag by nursing staff. LVN B said she would then call HSK to clean the room and wash residents clothing. LVN B said 24 hours after the Scabicide treatment she would reassess the resident's skin. LVN B said if the resident that was infected with Scabies had a roommate; the roommate along with the roommate's belongings would be moved to another room until the infected resident was clear from scabies (without

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	675396	A. BUILDING _____ B. WING _____	**11/10/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RETAMA MANOR/LAREDO SOUTH	**1100 GALVESTON LAREDO, TX 78040**

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 0490

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 26)
decontaminating the belongings). LVN B said if a resident with Scabies had un-washable items, the staff would place those items in the resident's closet or ask the family to take the items home. LVN B said that in her opinion R #4 no longer had Scabies and the Physician has ordered [MEDICATION NAME] 0.1% Cream for R #4's rash. Surveyor asked LVN B if she knew what
the indications for [MEDICATION NAME] Cream? LVN B said, No, Surveyor asked LVN B as a nurse was she supposed to know what
the indications were for Prescription drugs prior to application. LVN B said, yes, but I don't know.
(Nursing Staff said in interviews that HSK washed resident's clothing as part of scabies treatment, and HSK said Nursing staff was responsible for resident's clothing)
On [DATE] at 10:35 a.m., skin assessment by LVN B with R #4, LVN B said during skin assessment that #4 had raised red tracking rash to his bilateral upper extremities, left upper chest wall, behind ears and neck. LVN B said R #4 had dry scabbed areas to his lower extremities. LVN B described areas on R # 4's arms as open and bloody from scratching. LVN B said R #4 scratches until he bleeds.
On [DATE] at 12:25 p.m., interview with HSK revealed she was never notified of R #4 being in isolation the second time R #4 was treated in ,[DATE].
On [DATE] at 5:15 p.m., interview with Dr. XX revealed if the facility did not properly follow decontamination procedures during Scabicide treatment, there was a possibility that R #4 could have been re-infected with Scabies. Dr. XX said all the resident's clothing must be washed as well as the room decontaminated while resident was receiving Scabicide treatment. Surveyor showed Dr. XX R #4's clothing closet was shared with another resident and asked the Physician what would be the proper infection control procedure to isolate the Scabies. Dr. XX said the resident that shared the clothing closet with R #4 would also have to have the clothing washed because the Scabies bug lived on clothing and that the bug could be transmitted to another resident. Dr. XX said he ordered the [MEDICATION NAME] Cream for R #4 to reduce the [MEDICAL CONDITION] response and itching from the [MEDICAL CONDITION]. Dr. XX said he was going to re-treat R #4 with [MEDICATION
NAME] because there was no clear documentation that treatment orders were followed or effective decontamination was done. Dr. XX said he was going to place R #4 on Contact Isolation for one week.
Record review of the facility's Log of Residents with Scabies dated ,[DATE]-[DATE] identified 11 residents: R #1, R #3, R #4, R #6, R #7, R #8, R #9, R #10, R #11, R #12 and R #13.
R #5 and R #14 were not on the facility's log.
R #1:
R #1's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 100 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]., [MEDICAL CONDITIONS], Mood Disorder, and Unspecified Chest Pain.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's physician's orders [REDACTED]. Contact isolation for Scabies.
R #1's [DATE] Treatment Administration Record (TAR) indicated R #1 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #1's [DATE] Order Summary Report documented [DATE] at 11:26 a.m.- Discontinue [MEDICATION NAME] Cream 5%, Reason: Resident
expired.
R #3:
R #3's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility in the 600 Hall on [DATE] with the [DIAGNOSES REDACTED]. This damage is often caused by an abnormally high pressure in your eye), and [MEDICAL CONDITION]
(condition in which the bones become brittle and fragile from loss of tissue).
R #3's physician's orders [REDACTED].
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #3's physician's orders [REDACTED]. Bath to remove in 12 hours and remove per schedule. Contact isolation for one week due to Scabies.
R #3's [DATE] TAR indicated R #3 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #6:
R #6's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 500 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #6's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #6's physician's orders [REDACTED].
R #6's [DATE] TAR indicated R #6 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE].
R #6's Order Summary dated [DATE] documented Remove from isolation- Scabies resolved.
R #7:
R #7's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 600 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED]. to the brain, causing limited or no blood flow to the affected areas), [MEDICAL CONDITION] (paralysis of one side of the body), and Generalized Muscle Weakness.
R #7's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to area topically one time a day every 14 days for Scabies, as
directed for two administration- Order Date: [DATE]. The TAR did not contain an entry indicating the medication was administered on any day in [DATE].
NOTE: R #7 should have been administered [MEDICATION NAME] Cream 5% on [DATE] and then a second dose should have been
administered on [DATE].
R #7's physician's orders [REDACTED].
R #7's [DATE] TAR indicated [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day starting on the 19th
and ending the 19th for Scabies for 2 administrations, as directed. Order Date: [DATE] at 10:43 a.m. The only entry that indicated the medication was administered was on [DATE].
NOTE: There was not a second administration of [MEDICATION NAME] Cream as ordered by the physician.
R #8:
R #8's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #8's physician's orders [REDACTED]. Contact isolation for one week due to Scabies.
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on [DATE] at 11:51 p.m.
R #8's physician's orders [REDACTED].
R #8's physician's orders [REDACTED]. [MEDICATION NAME] Cream 5%- Apply to affected area topically one time a day every Tuesday for scabies for two administrations as directed from neck to toes. May repeat in one week if necessary.
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m.
R #8's physician's orders [REDACTED].
R #8's [DATE] TAR revealed R #8 was administered [MEDICATION NAME] Cream 5% on Monday, [DATE] at 11:59 p.m.
R #8's Order Summary Report dated [DATE] at 11:17 a.m. documented Remove from isolation, scabies resolved.
R #9:
R #9's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED].
R #9's physician's orders [REDACTED]. Contact isolation for 48 hours due to Scabies.
R #9's [DATE] TAR revealed R #9 was administered [MEDICATION NAME] Cream 5% on [DATE].
R #9's physician's orders [REDACTED].
R #12:
R #12's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on the 600 Hall on [DATE] with the [DIAGNOSES REDACTED].
R #12's physician's orders [REDACTED]. Contact isolation Dx- Scabies.
R #12's physician's orders [REDACTED]. Contact isolation Dx- Scabies.
R #12's physician's orders [REDACTED].
R #12's [DATE] TAR revealed R #12 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE].
R #13:
R #13's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 200 Hall on [DATE] with the [DIAGNOSES REDACTED].

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RETAMA MANOR/LAREDO SOUTH	**1100 GALVESTON LAREDO, TX 78040**

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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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 27) R #13's physician's orders [REDACTED]. Contact isolation for 7 days Dx- Scabies. R #13's physician's orders [REDACTED]. Contact isolation Dx- Scabies. R #13's [DATE] TAR revealed R #14 no entry to indicate R #13 was administered the [MEDICATION NAME] Cream 5% as ordered on [DATE] and [DATE]. R #13's physician's orders [REDACTED]. R #14: R #14's Face Sheet dated [DATE] documented an [AGE] year-old male admitted to the facility on the 200 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #14's physician's orders [REDACTED]. Repeat application as instructed within two weeks of initial application. Contact isolation until Scabies resolved. R #14's Physician order [REDACTED]. R #10: R #10's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility in the 400 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #10's physician's orders [REDACTED]. Place on contact isolation due to scabies. R #10's [DATE] TAR revealed R #10 was administered [MEDICATION NAME] Cream 5% on [DATE]. R #10's physician's orders [REDACTED]. Bathe in 12 hours to remove cream. R #10's [DATE] TAR revealed there was no entry to indicate R #10 was administered [MEDICATION NAME] Cream 5% as ordered in [DATE]. R #10's physician's orders [REDACTED]. R #10's physician's orders [REDACTED]. Repeat in one week if needed and apply entire body topically as needed for scabies until [DATE] 11:59 p.m. Contact isolation X 1 week for Scabies. This order was Confirmed by (the DON). R #10's [DATE] TAR revealed R #10 was administered [MEDICATION NAME] Cream 1% on [DATE]. R #10's physician's orders [REDACTED]. R #11: R #11's Face Sheet dated [DATE] documented an [AGE] year-old female admitted to the facility on the 400 Hall on [DATE] with the [DIAGNOSES REDACTED]. R #11's physician's orders [REDACTED]. Contact isolation Dx. (Diagnosis)- Scabies. R #11's [DATE] TAR revealed R #11 was administered [MEDICATION NAME] Cream 5% on [DATE]. R #11's physician's orders [REDACTED]. Contact isolation for Scabies. R #11's physician's orders [REDACTED]. Contact isolation for Scabies. R #11's [DATE] TAR revealed R #11 was administered [MEDICATION NAME] Cream 5% on [DATE] and [DATE]. R #11's physician's orders [REDACTED]. Contact isolation for Scabies. R #11's [DATE] TAR revealed R #11 was administered [MEDICATION NAME] Cream 5% on [DATE]. R #11's physician's orders [REDACTED]. Leave for 12 hours then bath to remove cream. X 1 dose only.