STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Retama Manor Nursing Center/Jourdanton		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 Highway 97e Jourdanton, TX 78026	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which are complete; and accurately documented for 2 of 9 residents (Resident #1 and #2) reviewed for documentation. Resident #1's and Resident #2's electronic medical record did not contain complete and accurate documentation that CNA A (night shift) and CNA B (day shift) recorded in the March 2025 POC (records system) that both residents were given peri-care on 3/17/25 (night) and 3/18/25 (day). This failure could result in residents' records not accurately documenting interventions, monitoring, and information provided to the charge nurse or DON involving shift documentation of peri-care given to residents. The findings included: Record review of Resident #1's face sheet, dated 3/24/25, reflected resident was a female age 65 admitted on [DATE] with diagnoses that included: schizoid affective (a mental health condition that includes symptoms both schizophrenia and mood disorders), gerd (a chronic disease that occurs when stomach acid or bile flows into the food pipe and irritates the lining), and epilepsy (a seizure disorder). The RP was listed as a family member. Record review of Resident #1's quarterly MDS dated [DATE] reflected that the resident's BIMS score was 3 (severely impaired in cognition). Section GG reflected the resident required extensive assistance for toileting by one staff member because the resident was incontinent of bowel and bladder (section H). Record review of Resident #1's skin assessment dated [DATE] reflected that resident had excess moisture to abdominal folds. Record review of Resident #1's CP, undated, reflected in toileting the resident required substantial/maximal assistance. Record review of Resident #1's Nurse Notes dated from 3/17/25 to 3/18/25 did not reflect that the resident refused incontinent care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455549	A. Building B. Wing	03/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's POC for peri-care dated March 2025 reflected peri-care given every shift and documented; except on 3/17/25 (night shift) and 3/18/25 (day shift) not documented by CNA A and CNA B. Observation and interview on 3/21/25 at 4:40 PM, Resident #1 was sitting in a W/C (wheelchair) in the hall, verbally vocal. There were no injuries, skin tears or bruises present. The resident's mental state was one of verbal aggression. The resident was alert and oriented to person only. Resident #1 stated, .I can reach my call light .they take too long to respond .left wet sometimes .no skin breakdown or skin [concerns]. During an interview on 3/24/25 at 11:24 AM, RN C stated: the Resident #1's refusal of care could explain the redness to the abdominal folds on the last skin assessment (3/17/25). RN C stated, no evidence existed that staff (CNA A and CNA B) refused to provide the resident with peri-care. However, RN stated that documentation was not present on 3/17/25 (night shift: 7:00 PM to 7:00 AM) and 3/18/25 (day shift (7:00 AM-7:00 PM) that resident refused peri-care or that peri-care was given. RN C stated that documentation needed to exist to back-up that refusal was made by the resident; or that peri-care was not necessary. RN C stated that documentation was necessary for continuity of care between shifts. During telephone interview on 3/24/25 at 11:30 AM, CNA A stated that she forgot to document on 3/18/25 that peri-care was given to both Resident #1 and Resident #2 because she was too involved with other residents. CNA A stated documentation was important in POC so as to show that services were given to the residents. During telephone interview on 3/24/25 at 2:05 PM, CNA B (night shift 7:00 AM to 7:00 PM) stated peri-care was given to both Resident #1 and Resident #2, but documentation was not done because she was involved in getting residents ready for the breakfast meal. CNA B stated documentation was required to show that services were given. During an interview on 3/24/25 at 1:40 PM, the ADON stated CNAs were required to document peri-care to serve as evidence that the service was given. Also, the ADON stated documentation was needed as a means of communications between shifts and evidence of continuity of care. The ADON stated that she could not provide an explanation for the lack of documentation for Resident #1 and Resident #2 on 3/17/25 and 3/18/25. Record review of Resident #2' face sheet, dated 3/24/25, reflected resident was a male age 71 readmitted on [DATE] with diagnoses that included: cerebral palsy (a group of disorders that affect movement, muscle tone and coordination due to damage to the developing brain), post-polio (a condition that causes gradual muscle weakness and muscle atrophy), and dementia (memory loss). The RP was listed as a family member. Record review or Resident #2's quarterly MDS dated [DATE], reflected the resident's BIMS score was 5 (severely impaired in cognition). In the area of toileting the resident required substantial/maximum assistance by one nursing staff. Record review of Resident #2's CP, undated, in the ADL section for toileting reflected substantial/maximum assistance. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's skin assessment dated [DATE] reflected, pinkness on the left ankle. Record Review of Resident #2's POC for March 2025 reflected: no documentation for 3/17/25 (night) and 3/18/25 (morning) involving peri-care. Observation and interview on 3/21/25 at 4:48 PM, Resident #2 was sitting on a W/C being prepared for the dinner meal. Resident was impaired to upper and lower extremities. The resident had difficulty in speech. There were no injuries, skin tears or bruises present. Mental status was one of happiness. The resident was alert and oriented to person only. The Resident stated, .call light works .yes, they come [to provide peri-care] . yes, [not left soiled]. Record review of facility's policy titled Charting and Documentation, dated revised July 2017, read: All services provided to the resident .shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .