STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (Resident #70) of one resident the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed. The facility did not provide Resident #70 with a written notice prior to a room change or the right to refuse on 03/27/25. This deficient practice could place residents at risk for being displaced without notice and/or reason to accommodate other individuals.Record Review of Resident #70's Face Sheet dated 07/07/2025 revealed a [AGE] year-old male re-admitted [DATE] with diagnoses including Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves) Quadriplegia (is paralysis that affects the ability to voluntarily move the upper and lower body), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) adult failure to thrive generalized anxiety disorder, and major depressive disorder recurrent. Record Review of Resident #70's quarterly MDS dated [DATE] reflected a BIMS score was unable to be obtained due to the resident being rarely or never understood, indicating severe cognitive impairment for daily decision-making skills. Record Review of Resident #70's care plan 07/07/25 revealed Resident #70 enjoyed eating in his room and did not like to participate in activities, so he spent large amounts of time in his room. Resident #70 would become agitated when he was encouraged to participate in activities. The resident was dependent on staff for all activities of daily living. Record Review of Resident #70's progress notes dated 02/04/25 to 07/08/2025 indicated no documentation or notification to resident representative about why a room change was made. During an interview on 07/07/25 at 9:19 AM with Resident #70's family member and patient representative stated she was never notified about the room change that happened in March of 2025. The family member did not understand why Resident #70 had been moved. The family member recalled there was no problem with the roommate, Resident #70 felt comfortable with the roommate, and it was hard for him to deal with the change. The family member stated Resident #70 did not like to be in the new room as it was too cold for him. Resident #70 would spend a lot of time in the dining room and wanted to sleep there because the new roommate had the temperature too cold for him. The family member stated she got no phone call, letter or verbal explanation as to why Resident #70 was moved even though she asked the nurse who was attending him at the time. In an interview on 07/08/25 at 4:30 PM with the Social Worker who stated she was responsible for giving 30 day written notices to any resident or the patient representative for any type of room change per the Room Change, Transfer and Discharge policy. The Social Worker failed to find any type of documentation that indicated the reason why Resident #70 was relocated to another room on 03/26/25. The Social Worker stated either the nurse, or she was responsible for entering the documentation and could not say why the room change was not documented. During an interview on 07/08/25 at 5:00 PM, the Interim DON said Resident #70's room change occurred before she began her role as DON and could not say why exactly his room was changed but did describe the process of a room change for a resident. The DON said either the nurse, or the Social Worker began the process, but notifications were sent by the Social Worker. The DON stated there was a form filled out and the patient representatives or family member was notified with a 30-day notice unless the resident was moved in an emergency like the room being unlivable or an altercation had occurred, and safety was a concern for one of the residents sharing a room. The facility tried to not violate the resident's right to not be relocated except for the facility's regulations. During an interview on 07/08/25 at 5:15 PM, the Administrator stated the facility tried to follow its policy of a 30-day notice before a resident was relocated into another room by sending notification, speaking to a family member/ resident representative, or make a call. The Administrator could not give an answer as to why there was no documentation of the room change for Resident #70 but did say the Social Worker would usually send out the notice and filled out the form to begin the process and usually the nurses initiate the process. The Administrator was able to produce a copy of the policy and procedures and resident rights of the facility. Review of undated Policy titled, Room Change, Transfer & Discharge revealed Room change. Facility reserves the right to change Resident's room or roommate when Facility determines it is appropriate to do so. The ombudsman, resident, and responsible party will be notified 30 days prior to a change and will provide the reasons for transfer or discharge; the statement of a right to appeal in a language the resident or legal representative understands; the date the change will take place; and record the reasons in the resident's clinical record. The facility will comply in accordance with state and federal regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who required dialysis received treatment and care in accordance with professional standards of practice for 1 of 3 residents (Resident #47) reviewed for Dialysis fistula assessment and care. The facility failed to ensure the nurses knew how and were performing the proper technique for assessing Resident #47's dialysis fistula (vascular access used in hemodialysis, which was a treatment for patients with kidney failure) for thrill (a vibration felt over the fistula or shunt) and bruit (swooshing sound cause by blood flow through the fistula or shunt). This deficient practice and failure could place residents at risk for a blockage and/or stenosis (narrowing of the veins and/or arteries) of the fistula site.Record review of Resident #47's face sheet, dated 07/08/2025, revealed a [AGE] year-old male with an original admission date of 09/30/2019, and a current admission date of 03/28/2025. Diagnoses included Alcoholic Cirrhosis of the Liver with Ascites (severe condition resulting from chronic alcohol abuse, leading to liver damage and fluid accumulation in the abdomen), Congestive Heart Failure (long term condition in which the heart cannot pump blood effectively, leading to fluid buildup in the lungs and legs), and End Stage Renal Disease (end stage kidney disease in which the kidneys can no longer function adequately, resulting in accumulation of waste products, fluids, and electrolytes, requiring dialysis). Record review of Resident #47's Quarterly MDS assessment, dated 06/13/2025, revealed a BIMS score of 15, which revealed intact cognition. MDS also revealed an active diagnosis of Dependence on Renal Dialysis. Record review of Resident #47's active physician orders, started 03/13/2024, revealed an order to assess fistula for thrill and bruit every shift. Record review of Resident #47's care plan, initiated 03/15/2024, revealed a care plan related to the need for dialysis due to End Stage Renal Disease with a goal to have no signs or symptoms of complications from dialysis. In an observation on 07/08/2025 at 10:30 AM, LVN-J was noted to have placed the stethoscope appropriately over Resident #47's fistula to listen for bruit, but LVN-J was noted to assess inaccurately above fistula for thrill. In an interview with LVN-J on 07/08/2025 at 10:35 AM, she stated the nurses were supposed to assess the dialysis fistulas each shift for thrill and bruit. She stated she had not done this because she just gets too busy or forgets. She stated she did not think any of the nurses had actually done this because Resident #47 went to dialysis, and the fistula was checked there. In an interview with Resident #47 on 07/08/2025 at 10:40 AM, he stated he was just going to be honest and tell the truth, none of the nurses ever checked his fistula. He stated he did not know they were supposed to check it at the facility since it was checked when he went to dialysis. In an interview with ADON-K on 07/08/2025 at 10:45 AM, she stated the nurses should have and were supposed to know how to assess the dialysis fistula since the orders were to assess it each shift. She stated Resident #47 had a BIMS of 15 and was intelligent, and if he stated it was not getting checked, then she knew it was not getting checked. She stated the nurses were supposed to check for the thrill and bruit because if there was not one, it could mean the fistula had a blockage. In an interview with the DON on 07/08/2025 at 3:50 PM, she stated the nurses knew how and should have been assessing Resident #47's fistula every shift for the thrill and bruit. She stated she was not sure why they had not done it, but it sounded like they were being lazy and just not taking the time to assess it. She stated if the fistula was not assessed appropriately, Resident #47 could have ended up with a blockage in the fistula, which could have stopped the blood flow through the area. She also stated she planned to in-service all the nurses over the importance of assessing the dialysis fistula every shift. Record review of the facility's policy for Writing/Obtaining Orders: Dialysis (AV shunts), no date listed, revealed Obtain orders for days of dialysis, where dialysis would be, Nephrologist name and phone number, to check for thrill and bruit each shift, and to monitor for bleeding upon return from dialysis every shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were labeled and stored in accordance with currently accepted professional principles for 3 of 6 medication carts (2nd Floor Nurse Med-Cart A, 2nd Floor Treatment Cart, 3rd Floor Nurse Med-Cart B, and 3rd Floor Treatment Cart) reviewed for labeling and storage. The facility failed to properly label from 2nd Floor Nurse-Med-Cart-A a vial of insulin Glargine (a long-acting insulin used to treat Type 1 or Type 2 Diabetes), with an open or expiration date. The facility failed to dispose of the medication from 2nd Floor Treatment Cart a container of Hemorrhoidal Pads (a pad used to treat hemorrhoids) 50% which had expired on 03/22/2025. The facility failed to dispose of the medication from 3rd Floor Nurse-Med-Cart-B a card of Promethazine (a medication used to treat nausea) 25 MG which had expired on 05/21/2025. The facility failed to keep the 3rd Floor Treatment Cart free from employee personal items on 07/07/2025 as evidenced by a large, personal, aluminum cup with a straw in it in the bottom drawer of the cart. These deficient practices could place residents at risk of receiving medications or supplies which were both expired and possibly cross-contaminated. In an observation on 07/07/2025 at 9:04 AM of the 2nd floor Nurse-Med-Cart-A it was revealed an approximately 3/4 full, discontinued, expired, and non-dated vial of insulin Glargine which had expired on 6/17/2025 and had never had an opened or expired by date written on it. In an observation on 07/07/25 at 9:13 AM of the 2nd Floor Treatment Cart it was revealed an approximately 1/2 full container of Hemorrhoidal Pads (a pad used to treat hemorrhoids) 50% which had expired on 03/22/2025. In an observation on 07/07/25 at 9:26 AM of the 3rd Floor Nurse-Med-Cart-B a card of Promethazine (a medication used to treat nausea) 25 MG tablet, with 26 tablets left, which had expired on 05/21/2025, as well as a card of Tramadol (a medication used to treat pain) 50 MG, with 9 tablets left, which had expired 06/11/2025. In an observation on 07/07/25 at 9:31 AM of the 3rd Floor Treatment Cart revealed it was not free from employee personal items on 07/07/2025 as evidenced by a large personal aluminum cup with a straw in it in the bottom drawer of the cart. In an interview with LVN-N on 07/07/2025 at 9:35 AM she stated the cup was hers in the treatment cart, and she knew that she was not supposed to have personal items in the cart with resident medications and supplies. She stated the cup could have caused cross-contamination and caused a resident or herself to be exposed to something they would not have been exposed to. In an interview with ADON-L on 07/08/25 at 9:14 AM, she stated the insulin was supposed to be dated when it was opened because it was only good for 28 days. If it was not dated, then it cannot be used because it could possibly be expired. She stated expired meds were removed from the med-carts by the floor nurses at night, as well as the ADONs checked for expired meds weekly. She stated the treatment nurse checked the treatment cart weekly for expired meds. She also stated if a resident was given an expired medication, it could have possibly made them sick, or it may be ineffective and not work. ADON-L stated the nurses' personal effects should not be in the med-carts or treatment carts because it could cause cross-contamination with the medication or the wound supplies. In an interview with LVN-M on 07/08/25 at 9:23 AM, she stated expired medications were removed from the med-carts by the floor nurses who should be checking them daily, and the narcotics were removed by the ADONs who checked the med-carts weekly. She stated if a resident was given an expired medication, it could make them sick or be ineffective and not work. In an interview with LVN-A on 07/08/25 at 9:27 AM, he stated expired medications were removed by the floor nurses who checked the carts daily, as well as by the ADONs who checked the cart weekly. He stated if the medication was a narcotic, it was removed by the ADON. He also stated if a resident was given an expired medication, it could possibly not work or possibly make them sick. Record review of the facility's Medication Administration, implemented 10/24/2022, revealed 1. Keep medication cart clean, organized, and stocked with adequate supplies; 12. Identify expiration date. If expired, notify nurse manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 5 of 10 residents (Resident #23, Resident #47, Resident #66, Resident #74, and Resident #82) reviewed for medication errors. 1. The facility failed to ensure LVN C did not document NA in place of Resident #23's blood pressure and pulse when her blood pressure altering medication was administered on 06/03/25, 06/06/25, 06/07/25, 06/08/25, 06/16/25, 06/25/25, 06/26/26, 07/06/25, 07/07/25, and 07/08/25. The facility failed to ensure LVN C did not document NA in place of Resident #23's BP, temp, pulse, resp, and O2 sats on 06/07/25, 06/16/25, 06/25/25, 06/26/25, 07/04/25, 07/05/25, and 07/06/25 when vital signs were to be documented on every day shift on Saturday (04/12/25 to 06/09/25) then every shift (began 06/13/25) per the two physician's orders. The facility failed to ensure LVN P did not document X or NA in place of Resident #23's BP, temp, pulse, resp, and O2 sats on 06/13/25, 06/14/25, 06/23/25, 06/24/25, 06/27/25, 06/28/25, and 06/29/25 when vital signs were to be documented on every shift (began 06/13/25) per the physician's order. The facility failed to ensure LVN Q did not document X in place of Resident #23's BP, temp, pulse, resp, and O2 sats on 06/16/25, 06/17/25, 06/21/25, 06/22/25, 06/25/25, 06/26/2506/30/25, 07/01/25, 07/04/25, 07/05/25, and 07/06/25 when vital signs were to be documented on every shift (began 06/13/25) per the physician's order. 2. The facility failed to clarify the blood pressure parameters for Resident #47's Midodrine (a medication used to treat hypotension, or low blood pressure) orders for June and July of 2025. The facility failed to administer Resident #47's Midodrine per the recommended and prescribed blood pressure parameters in June and July of 2025. 3. The facility failed to ensure LVN C did not document NA in place of Resident #66's blood pressure when his blood pressure altering medications were administered on 06/06/25, 06/07/25, 06/25/25, 07/04/25, 07/05/25, and 07/06/25. The facility failed to ensure LVN C did not document NA in place of Resident #66's BP, temp, pulse, resp, and O2 sats on 06/07/25 and 07/05/25 when vital signs were to be documented every day shift, every 7 days per the physician's order. 4. The facility failed to ensure MA B did not administer Resident #74's blood pressure/pulse altering medications on 06/01/25 when his blood pressure was not within the required parameters per the two physician's orders. The facility failed to ensure MA B administered Resident #74's blood pressure/pulse altering medication on 06/10/25 when his blood pressure was within the required parameters per the physician's order. The facility failed to ensure LVN Q administered Resident #74's blood pressure/pulse altering medication on 06/16/25, 06/22/25, 06/26/2507/01/25, and 07/05/25 when his blood pressure was within the required parameters per the physician's order. The facility failed to ensure LNV R administered Resident #74's blood pressure/pulse altering medication on 06/18/25 when his blood pressure was within the required parameters per the physician's order. The facility failed to ensure LVN C did not document NA in place of Resident #74's blood pressure when his blood pressure/ pulse altering medications were administered on 07/04/25, 07/05/25, and 07/06/25. The facility failed to ensure LVN C did not document NA in place of Resident #74's BP, temp, pulse, resp, and O2 sats on 06/06/25 and 07/04/25 when vital signs were to be documented every day shift, every 7 days per the physician's order. 5. The facility failed to ensure MA D administered Resident #82's blood pressure altering medication on 06/02/25 and 06/11/25, when there were no required parameters per the physician's order. The facility failed to ensure MA D administered Resident #82's blood pressure altering medications on 06/03/25, 06/07/25, 06/12/25, 06/17/25, 06/21/25, and 06/21/25 per the physician's orders. The facility failed to ensure MA B did not administer Resident #82's blood pressure altering medication on 06/14/25 when her blood pressure was not within the required parameters per the physician's order. The facility failed to ensure MA B administered Resident #82's blood pressure altering medications on 07/08/25 per the physician's order. The facility failed to ensure LVN C did not document NA in place of Resident #82's BP, temp, pulse, resp, and O2 sats on 06/03/25, 06/07/25, 06/12/25, 06/17/25, 06/21/25, 06/26/25, 07/01/25, and 07/05/25 when vital signs were to be documented upon return from dialysis every Tue, Thu, and Sat per the physician's order. The facility failed to ensure LVN C did not document NA in place of Resident #82's blood pressure when her blood pressure altering medication was administered on 07/04/25, 07/05/25, and 07/06/25. These failures could place residents who receive blood pressure/pulse altering medications at an increased risk for complications such as decreased blood pressure, decreased pulse, exacerbation of symptoms and disease process, and potential hospitalization.1. Record review of Resident #23's admission record revealed a [AGE] year-old female initially admitted to the facility on [DATE] and most recently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observations, interview, and record reviews, the facility failed to provide the required 80 square feet per resident in 89 of 89 resident rooms (Room numbers: 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 425, 426, 427, 428, 429, 430, 431) observed for room size requirement. All 89 rooms did not account for 80 square feet per resident.This failure could restrict the amount of resident care equipment and resident's personal effects that could be accommodated in these resident rooms and limit the residents' ability to move about the room.Record review of Health and Human Services Form 3740 Bed Classifications, dated 07/07/25, reflected 89 rooms with 2 beds each.Observation beginning on 07/07/25 at 9:30 am during the facility's recertification survey, this surveyor used an agency laser measuring device, obtained measurements for all existing rooms. Rooms with 2 beds measured between 149 and 156.5 square feet.In an interview on 07/07/25 at 10:50 am, the Adm provided a letter requesting a room size waiver for rooms 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 425, 426, 427, 428, 429, 430, 431. The ADM stated there had been no changes to the rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents, staff and public in 2 (Elevator 1 and Elevator 2) of 3 elevators reviewed for environment. The facility failed to maintain 2 elevators used by residents, staff, and visitors free from offensive odors. This failure could affect all residents that used common areas and place them at risk for diminished quality of life due to the lack of a well-kept environment. During an observation throughout the day beginning on 07/07/25 08:33 AM, this surveyor smelled a strong foul odor on both Elevator 1 and Elevator 2 most of the day. During an observation throughout the day beginning on 07/08/25 08:10 AM this surveyor smelled a strong foul odor on both Elevator 1 and Elevator 2. In an interview on 07/07/25 at 08:45 AM, a visitor who wished to remain anonymous stated the elevators always smelled foul and smelled of urine and feces. In an interview on 07/07/25 at 03:47 PM, the MDS Coordinator agreed that Elevator 1 and Elevator 2 smelled bad and stated they did not smell as bad as they used to. The MDS Coordinator did not elaborate on how long or what kind of foul odor was observed on Elevator 1 and Elevator 2. The MDS Coordinator stated staff have complained about the foul smells in the elevators. In an interview on 07/08/25 08:12 AM, the WCN stated both Elevator 1 and Elevator 2 smelled bad and believed it was because of the carpet that was installed in Elevator 1 and Elevator 2. The WCN stated the elevators were cleaned frequently, but they still had a foul odor. In an interview on 07/08/25 at 11:26 AM, the HS stated the carpets in Elevator 1 and Elevator 2 were shampooed daily in the morning and throughout the day as needed. The HS agreed the elevators have a foul order and stated it was because residents have accidents in them. The HS stated that the elevators are vacuumed and sprayed with shampoo cleaner throughout the day. The HS stated that staff and family members have complained about the foul odor. The HS stated there was no good reason to keep a log or keep record of when the elevators are vacuumed, cleaned, or shampooed but was going to start a log to track the cleaning. In an interview on 07/08/25 at 01:30 PM with the RD revealed the facility was working on getting an approved vendor to remove the carpet. The RD stated the elevators smelled like urine or old carpet. In an interview on 07/08/25 at 01:31 PM the ADM stated the elevators do have a foul odor and stated the elevators smelled of a combination of urine and old carpet. The ADM stated she has had a few family members complain about the foul odor. The ADM stated there was a resident that had a history of urinating in the elevator and housekeeping was cleaning the carpet daily and as needed to help with sanitation. In an interview on 07/08/25 01:32 PM, the MS stated he was aware of the elevators having a foul odor and had been working on getting a quote with an approved vendor to get the carpet taken out. In an interview on 07/08/25 02:55 PM the SW stated the previous ADM installed carpet in the elevators and there are a few residents that have a history of urinating in the elevators or are just unable to wait to go to the bathroom. The SW stated housekeeping was called over the intercom when such an incident occured. The SW stated housekeeping was seen approximately every other day, if not daily shampooing the carpets. Record review of the facility's General Housekeeping Policies not dated reflected: The facility provides sufficient housekeeping and maintenance personnel, equipment, and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. Nursing personnel are not assigned to routine housekeeping duties. All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and hazards as well as participate in ongoing education and training to maintain or increase their competency. Deodorizers are not used to cover up doors caused by unsanitary conditions or poor housekeeping practices. Odor control is achieved by prompt cleansing of bedpans, urinals, and commodes by prompt and proper care of residents and soiled linens. by good housekeeping procedures, and by approved ventilation.