STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34957 Based on observations, interviews, and record review, the facility failed to store, prepare, and distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for food service safety. The facility failed to have two overhead ceiling light covers in the cooking area free from numerous dead brown insects. The facility failed to ensure the ceiling vent in the dishwashing area was free from a black substance throughout the vent. These failures could place residents who eat meals from the kitchen at risk for spread of infections, food contamination, and food borne illness. The findings included: During an observation on 4/30/25 at 10:30 AM of the kitchen reflected: two overhead ceiling lights with brown dead insects. Further observation of the kitchen reflected the overhead vent in the washing area had a black substance on the vent. During a joint interview on 4/30/25 at 10:42 AM, the Administrator stated, she saw the vent had a black substance and she saw brown spots on two light ceiling fixtures. The Administrator stated the findings in the kitchen were not homelike and cooking happens in the kitchen. The DON stated, as the IP, he saw brown objects on the overhead covers; and the vent was dirty. The DON stated, as the IP, the kitchen should not be that way because: we cook in the kitchen, and because it could place residents at risk for infections and food borne illnesses. During interview on 4/30/25 at 11:00 AM, the Dietician stated, she was not aware of dead brown insects on two overhead ceiling light fixtures in the kitchen. Also, the Dietician stated she was not aware of a black substance on the ceiling vent in the dish washing room. The Dietician stated the kitchen should be in good repair and sanitized. The Dietitian stated, the kitchen staff should submit work orders for environmental concerns and the staff should manage sanitation problems. (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
	675002	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/25 at 11:30 AM, the FSS stated,: he had not checked on the overhead ceiling light fixtures; but today (4/30/25) after the state surveyor's visit to the kitchen he saw brown spots on the ceiling light fixtures. The FSS stated he was aware of the dust in the ceiling vent in the dishwashing area in the kitchen. The FSS stated the dust could fall on clean dishes. Record review of the facility's policy titled Sanitation Inspection dated 2025 read: .All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies, and insects . Record review of the facility's policy titled, Housekeeping dated 2024 read: It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 16 rooms, reviewed for functional environment. The facility failed to provide Resident #1 with functional bedside and overhead lights for a minimum of 30 days. This failure could lead to residents experiencing a diminished quality of life. The findings included: Record review of Resident #1's face sheet, dated 4/29/25, reflected the resident was a 75 -year-old male who was readmitted on [DATE] with diagnoses that included: peripheral vascular disease (heart disease), chronic kidney disease, amputation of left BKA (below the knee amputation), and diabetes. The RP was listed as: the resident. Record review of Resident#1's admissions MDS, dated [DATE], reflected: BIMS score was 9, which indicated moderate cognitive deficits. Resident #1's ADLs included: catheter care, services for incontinence of bowel, and total assistance for transfer and mobility due to resident's impairment to lower extremity. Observation and interview on 4/29/25 at 11:27 AM, Resident #1 was in bed, Foley catheter, and with a pressure release boot on his right foot. Resident was alert and oriented to self and place. Observation reflected the overhead lights in the resident's room did not work. Resident #1 stated, .the light near the bed does not work . Resident #1 stated the lights have not worked for five months. Resident #1 stated the lights needed to work so the CNAs could better see when providing ADLs at night. Resident #1 stated that he complained to nursing staff about the lights and was ignored. Resident #1 stated, I need the lights on so that I can see at night what I am eating. The resident stated the lack of lighting at night had not resulted in any care issues, but he was not happy the lights did not work. During an interview on 4/29/25 at 11:48 AM, the DON turned on the switch for both the overhead and bedside lights and they did not turn on. The DON stated the lights needed to work for visibility during resident care and it helped with the resident's quality of life. The DON stated the facility did not have a maintenance director for a couple of weeks .we rely on maintenance support from another facility The DON stated the issue of the lights not working had not been reported to him. The DON stated the lack of lighting in Resident #1's room at night had not resulted in any negative outcome to the resident; and no negative outcome had been reported to nursing management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/25 at 12:01 PM, the Administrator stated, the lights in the room did not turn on. The Administrator stated no one reported the lights being out. The Administrator stated the facility had been without a maintenance director for few weeks. The Administrator stated work orders were maintained manually and a sister facility provided maintenance service until the facility hired a new Maintenance Director. During interview on 4/29/25 at 12:07 PM, RN A stated, a work order was put in about two weeks ago to address the non-working lights in Resident #1's room but it had been not fixed because the facility had no maintenance director. RN A stated the lights in Resident #1's room needed to work because she and nursing staff had to see what they were doing when providing treatment and ADLs at night. The RN stated the lack of lighting at night had not resulted in any negative outcome to the resident. During interview on 4/29/25 at 12:13 PM, CNA B stated Resident #1's light had been out for over one month. CNA A stated the light issue in Resident #1's room and was reported but nothing was done. CNA B stated the lights were required especially during night meals and care. CNA B stated, Resident #1 had complained and I did report it to maintenance. CNA B stated there were not negative outcomes to the resident resulting from the lights not working except for a diminished quality of life. During an interview on 4/29/25 at 1:21 PM, the interim Maintenance Director stated,: he could not locate the facility's work order log. The interim Maintenance Director stated, the former Maintenance Director resigned two weeks ago for personal issues. The interim Maintenance Director stated he was not aware of the lights not working in Resident #1's room [ROOM NUMBER] and he had not received a work order from nursing. The interim Maintenance Director stated he created in the past a manual log for work orders and the said manual log was missing. The interim Maintenance Director stated, he visited the facility once per week to check on manual work orders. The interim Maintenance Director stated he was not aware of a general maintenance policy maintained by the facility. Record review of facility's Supervision, Maintenance Services dated revised May 2008 read: .The Maintenance Director is responsible for scheduling preventative maintenance services .