

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/03/2025
NAME OF PROVIDER OR SUPPLIER  Retama Manor Nursing Center/San Antonio West		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, and record reviews, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 2 of 4 residents (Resident #2 and Resident #3) reviewed for clinical records.1. The facility failed to ensure Resident #2's output was documented in his medical record on 6/9/25 and 6/19/25. 2. The facility failed to ensure Resident #3's output was documented in his medical record on 6/9/25 and 6/19/25. 3. The facility failed to ensure Resident #3's complete VS were documented in his medical record on 6/29/25. This failure could place residents at risk of not receiving the care and services needed. Findings included: 1. Record review of Resident #2's admission Record, dated 7/1/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood) , Chronic Kidney Disease (condition in which kidneys are damaged and cannot filter blood) , Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar) , and Neuromuscular Dysfunction of the Bladder (lack bladder control due to a brain, spinal cord or nerve problem) . Record review of Resident #2's Care Plan, revised 1/12/25, revealed: [Resident #2] has suprapubic Catheter. Record Output qshift [sic]. Record review of Resident #2's June MAR, dated 7/3/25, revealed .Record Output every shift. was blank for 6/9/25 and 6/19/25, 10:00 pm - 6:00 am shift. Record review of Resident #2's Progress Notes from 6/9/25 to 6/19/25 did not reveal notes regarding Resident #2's output. During an interview with Resident #2 on 7/3/25 at 1:22 pm, Resident #2 said his catheter drainage bag was emptied 3 times a day without fail. 2. Record review of Resident #3's admission Record, dated 7/1/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Multiple Sclerosis (disease that damages the nervous system) . Record review of Resident #3's Care Plan, revised 5/28/25, revealed: [Resident #3] has suprapubic Catheter. Monitor and document intake and output. Record review of Resident #3's June MAR, dated 7/3/25, revealed .Record Output every shift. was blank for 6/9/25 and 6/19/25, 10:00 pm - 6:00 am shift. Record review of Resident #3's Progress Notes from 6/9/25 to 6/19/25 did not reveal notes regarding Resident #3's output. During an interview with Resident #3 on 7/1/25 at 1:23 pm, Resident #3 said the staff emptied his catheter drainage bag whenever they wanted. Telephone interview attempted on 7/2/25 at 2:00 pm with LVN A was unsuccessful. Telephone interview attempted on 7/3/25 at 3:37 pm with LVN B was unsuccessful. Telephone interview attempted on 7/3/25 at 1:58 pm with CNA C was unsuccessful. Telephone interview attempted on 7/3/25 at 2:02 pm with LVN B was unsuccessful. 3. Record review of Resident #3's Change in Condition Evaluation, dated 6/29/25, revealed the resident had a fever. Further review of the evaluation revealed: .Are these the most recent vital signs taken after the change in condition occurred? Yes, the Vital Signs Evaluation section reflected Resident #3's blood pressure was 132/76, dated 6/29/25; pulse was 67, dated 6/17/25; respiratory rate was 20, dated 6/23/25; and temperature was 97.6, dated 6/23/25. Record review of Resident #3's Progress Notes for 6/29/25 did not reveal notes regarding Resident #3's vital signs. During a telephone interview with Resident #3 on 7/2/25 at 11:44 am, Resident #3 said that RN E did assess his VS on 6/29/25 before he left to the hospital. During a telephone interview on 7/2/25 at 10:52 am, RN E said he assessed Resident #3 on 6/29/25 before he left to the hospital. RN E further stated the assessment included a complete set of vital signs: temperature, pulse, respiratory rate, and blood pressure, which were all within normal limits. RN E said he was sure he documented the vital signs in Resident #3's record. During an interview on 7/3/25 at 1:08 pm, the DON said she expected nurses to document all resident assessments, including vital signs, in the residents' record. The DON further stated documentation of assessments was important for follow up, so that changes in condition could be identified, adding that nurses coming in during the following shift may not receive pertinent information. During an interview on 7/3/25 at 3:00 pm, the Administrator said she expected nurses to use their judgement to decide what needed to be documented. The Administrator further stated she expected assessments, including vital signs, to be documented according to the facility's policy. Record review of the facility's policy, Charting and Documentation, Qtr 3, 2018, revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, 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 ? The following information is to be documented in the resident medical record: a. Objective</p>		