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	08/18/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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F 0584 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 observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 of 5 residents (Resident #1 and #2), reviewed for functional environment. The facility failed to provide Resident #1's room with a functional overhead light fixture and an unbroken window blind. This failure could lead to residents experiencing a diminished quality of life.The findings included: Record review of Resident #1's face sheet, dated 8/15/25, reflected resident was a male age [AGE] re-admitted on [DATE] with diagnoses that included: CVA (stroke), COPD (chronic lung disease), DM (diabetes), and dementia (decline in mental ability). The RP (responsible party) was listed as: self.Record review of resident #1's MDS dated [DATE] indicated Resident 1's BIMS score was 15 which indicated no impairment in cognition.Observation and interview on 8/15/25 at 2:50 PM, Resident #1 was in his room, in bed watching TV, alert and oriented to person, place and time. There were no injuries, skin tears or bruises present. Observation reflected overhead light fixture above the bed had no light bulbs and did not function. Further observation reflected the window blind was broken with four bent panels. Resident #1 stated the overhead bed light fixture had been broken since March 2025 and had not been fixed. Resident #1 stated he wanted the overhead bed light fixture to be fixed so that nurse aides could see what they were doing when providing ADLs. Resident #1 stated he wanted the light fixture fixed so that he could read at night. Resident#1 stated the ceiling light worked but turning on the ceiling light would interfere with the roommate's sleep. Resident #1 stated that he complained numerous times to the SW and to nursing staff. The resident stated the window blind had been broken for a couple of weeks and had not been replaced. Resident #1 added he complained to the SW and the nurse aides about the window blind, and no replacement in the blind was made by the facility. Resident stated that the non-fixing of the blind and the light fixture maybe meant that they (facility) did not care. During an interview on 8/15/25 at 3:19 PM, CNA B stated Resident #1's light fixture above the bed did not work, and the blind was broken. CNA B stated, sometime in the past Resident #1 did inform nursing management about the light fixture and broken blind. During an interview on 8/15/25 at 3:35 PM, CNA C stated he had seen the broken blind and the light fixture above the bed not operating. CNA C stated he informed nurse management about 2-3 weeks ago and they (facility) were trying to fix the light fixture and blind. CNA C stated that the resident did complain to him about the light fixture and the broken blind. During an interview on 8/15/25 at 3:54 PM, the SW stated that she observed today (8/15/25) that Resident #1's window blind was broken, and the overhead light fixture was not operating and missing light bulbs. The SW stated the Maintenance log reflected work order on the light fixture which was entered on 6/17/25 and a work order on the same date for the broken blind. During an observation and interview on 8/15/25 at 4:15 PM, Resident #2 was in his room, ambulatory, eating a snack, alert and oriented to person and place. The resident stated he was not happy with the ceiling light being turned on at night when the nursing staff wanted to provide care or services to Resident#1. Resident #2 stated he complained to the Administrator, and nothing had been done to fix Resident #1's non-working bedside light fixture. Resident #2 stated the turning of the ceiling light on and off at night disturbed his sleep. During an interview on 8/15/25 at 4:34 PM, the DON stated: she observed today 8/15/25 at 2:50 PM that Resident #1's bed light fixture had no light bulbs and did not operate, and the blind was broken. The DON stated she was not aware of the latter environmental issues in Resident #1's room. The DON stated that by nursing practice the operation of the bed overhead light was important for the provision of nursing care and services. The DON stated the turning on of the ceiling light could interfere with the sleeping habit of the roommate [Resident #2]. The DON stated she was not aware of the roommate complaining. The DON stated by nursing practice the window blinds needed not to be broken to improve on a resident's quality of life. During an interview on 8/18/25 at 9:38 AM, the Administrator stated the facility hired a new maintenance director a month ago [July 2025] who had been attempting address the back log of work orders. The administrator stated she prioritized plumbing issues, and the work order for Resident #1 had not been addressed. [at time of the abbreviated survey the Maintenance Director was not available for an interview, nor the old maintenance director was available for a telephone interview] Record review of facility's Work Order log dated 6/17/25 reflected work a work order to replace/fix Resident #1's window blind and another work order dated 6/17/25 to fix LIGHT NOT WORKING.Record review of facility's Resident Rights policy dated 2018 read: Employees shall treat all residents with kindness, respect, and dignity. Thes rights include

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to provide each resident that receives food from the kitchen, food that is palatable, attractive and at a safe and appetizing temperature for 1 of 1 kitchen reviewed for safe and appetizing temperatures: The breakfast meal served on 8/15/25 did not have the required holding temperatures for the last meal trayed served from the kitchen. This failure could lead to a diminished quality of life and expose residents to food borne pathogens and illness. The findings included: Observation on 8/15/25 from 8:05 AM to 8:40 AM of kitchen reflected that the steam table did not operate. The staff attempted to heat the food by adding hot water to the steam table or keeping food items longer in the oven. Observation of food temperatures of food items on the steam table reflected the following readings[breakfast meal]: readings were taken by [NAME] A with temperatures taken at 8:07 AM (initial) and test tray temperature at 8:50 AM: Oatmeal 110 F to (not taken; no more oatmeal) Eggs 159 F (initial) to 92 F (test tray) Sausage 122F to 79 F Puree Sausage 88F to 81 F Puree Eggs 89F to 78F Mechanical Soft Eggs 120F to 80F Mechanical Soft Sausage 97F to 80F Puree Bread 71F to 70FRemarks: 3 residents did not eat form the kitchen (PEG) [Observation and interview on 8/18/25 at 8:45 AM, of kitchen reflected that the steam table was still not working. Observation further reflected the breakfast food from the oven or stove top was placed in a roaster with hot water and then transferred to a plate. During an interview on 8/15/25 at 8:15 AM, [NAME] A stated the steam table was not working since Tuesday 8/12/25. [NAME] A stated the food was cold on the steam table and served cold food to the residents. [NAME] A stated efforts were made to keep the food hot by regulation at 165 F at steam table and 135 F when served. [NAME] A stated methods used to keep the food hot was to transfer the hot food from the oven or stove on the non-working steam table and putting hot water in the steam table. [NAME] A stated from the start of the food cycle the breakfast meal met temperatures and the temperatures were recorded on the temperature log sheet; but the food quickly lost its hot temperature. [NAME] A stated she was not aware of any resident complaining of foodborne illnesses from the cold food. During telephone interview on 8/15/25 at 8:20 AM, the Ombudsman stated that residents had complained to her about the cold food served in the facility for the past two to three days (8/12/25-8/15/25) During an interview on 8/15/25 at 8:25 AM, the FSS stated the steam table was not working since Tuesday (8/12/25) and the facility made efforts to repair the steam table without success. The FSS stated cold foods were served to the residents because the facility hoped that the steam table could be repaired in a short time. The FSS stated measures taken to keep the food hot included pouring hot water into the non-working steam table and holding foods in the oven or stove top until ready to be transferred to the steam table. During a joint interview on 8/15/25 at 9:45 AM, with the Administrator and DON, the Administrator stated the steam table had not worked since Tuesday (8/12/25) and a new steam table purchased order was made on 8/14/25.[Record review of purchased order was verified.] The Administrator stated that the efforts made included to repair the steam by two different vendors; and heating from the stove, and hot water added to non-working steam table. The Administrator stated a menu review was done on 8/12/25, and decision was made not to serve cold foods as the menu substitute. The Administrator stated the facility considered catering the food and did not contract for catering. The Administrator stated the dietician was present on Wednesday (8/13/25) and did not share any recommendation. The DON stated there had been no foodborne illnesses resulting from the cold food. The Administrator stated given the surveyor's entrance and the steam table had not been replaced, her plan was to either serve cold plates or cater until a working steam table was in present in the kitchen During an interview on 8/15/25 at 10:53 AM, the DON stated that by nursing practice and as the IP the facility should not have served cold eggs and sausages for breakfast on 8/15/25 because of the risk of bacteria build up and food borne illnesses to residents. The DON stated as the IP that she preferred not to answer the question why she did not advise the facility not to serve cold foods to the residents from 8/12/25 to 8/15/25. The DON stated that no resident suffered food borne illnesses from the cold food. During telephone interview on 8/15/25 at 11:10 AM, the Dietician stated she last visited the facility on Wednesday (8/13/25) and became aware of the non-working steam table. The Dietician stated cold food should not be served to residents because of the danger of food borne illnesses. The Dietician stated she took the temperature of the lunch meal on 8/13/25 and the temperatures met regulation. The Dietician stated she recommended to the facility to place boiling water in the non-working steam table and hold hot foods on the stove or oven until the meal was to be served from the steam table. The Dietician stated the facility did not inform her that the food was cold on Thursday

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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. Based on observation, interview, 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 food temperature logs were incomplete. This failure could place residents who ate meals from the kitchen at risk for spread of infections, food contamination, and food borne illness. The findings included: Record review of facility's July Food Temperature log dated July 2025 reflected the lunch meal's temperatures not documented from 7/9/25 to 7/21/25 and 7/23/25 to 7/31/25. Further record review reflected the breakfast meal from 7/24/25 to 7/31/25 and the dinner meal from 7/30/25 to 7/31/25 were not documented. During an interview on 8/15/25 at 8:25 AM, The FSS stated that the July Food Temperature Log for the lunch meal from 7/9/25 to 7/21/25 and 7/23/25 to 7/31/25 were not documented. The FSS stated that the breakfast meal from 7/24/25 to 7/31/25 and the dinner meal from 7/30/25 to 7/31/25 were not documented. The FSS did not have an explanation for the lack of documentation involving food temperatures on the latter dates. During telephone interview on 8/15/25 at 11:10 AM, the Dietician stated that she was aware of the lack of documentation on the July 2025 Food Temperature log. The Dietician stated she verbally counseled the kitchen staff on documentation and provided an in-service on documentation of the food temperature logs. The Dietician stated her negative findings for the July 2025 documentation was written in the Sanitation Report given to the facility on 8/13/25 with a rating of unsatisfactory. Record review of facility's Quality Assurance Evaluation-Dining report dated 8/6/25 authored by the Dietician reflected a rating of unsatisfactory for incomplete food temperature logs. Record review of facility's Food Preparation and Service dated 2001 read, .The ‘danger zone' for food temperature is between 41 ‘F' and 135 ‘F'. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illnesses. Record review of facility's dietary polices did not reveal a policy on documenting food temperatures on a daily base per meals prepared. [Surveyor on 8/15/25 at 8:00 AM requested from the Administrator a policy on documenting food temperatures. At exit on 8/18/25 at 3:00 PM, the Administrator had not provided the surveyor with a policy on documenting food temperatures.]

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain dietary equipment that was in safe operation condition for 1 of 1 kitchen reviewed for steam table operation. The steam table was not operating. This failure could place residents who ate meals from the kitchen at risk for spread of infections, food contamination, and food borne illnessThe findings included: Observation on 8/15/25 from 8:05 AM to 8:40 AM of kitchen reflected that the steam table did operate. The staff attempted to heat the food by adding hot water to the steam table or keeping food items longer in the oven. Observation of food temperatures of food items on the steam table reflected hot foods were in the danger zone. During an interview on 8/15/25 at 8:15 AM, [NAME] A stated the steam table was not operating since Tuesday 8/12/25. [NAME] A stated that the food was cold on the steam table and served cold to the residents. [NAME] A stated efforts that were made to keep the food hot by regulation, 165 F at steam table and 135F when served by keeping the food on the stove until transferred to the steam table and putting hot water in the steam table. The [NAME] stated from the start of the food cycle the breakfast meal met temperatures and the temperatures were recorded on the temperature log sheet. However, [NAME] A stated that the hot food on the steam table rapidly dropped in temperature and served cold to residents. [NAME] A stated she was not aware of any resident complaining of foodborne illnesses from the cold food. During an interview on 8/15/25 at 8:25 AM, the FSS stated that the steam table was not operating since Tuesday (8/12/25) and the facility had made efforts to repair the steam table without success. The FSS stated cold foods were served to the residents because the facility hoped that the steam table could be repaired in a short time by 8/13/25. The FSS stated measures taken to keep the food hot included pouring hot water into the non-working steam table and holding foods in the oven or stove top until ready to be transferred to the steam table. During a joint interview on 8/15/25 at 9:45 AM, with the Administrator and DON, the Administrator stated the steam table has not operating since Tuesday (8/12/25) and a new steam table purchased order was made on 8/14/25. The Administrator stated that the efforts made included to repair the steam by two different vendors; and heating from the stove, and hot water added to steam table. The Administrator stated a menu review was done, and decision was made not to serve cold foods. The DON stated there had been no foodborne illnesses resulting from the cold food served from the non-operating steam table. During telephone interview on 8/15/25 at 11:10 AM, the Dietician stated that she visited the facility on Wednesday (8/13/25) and became aware of the non-operating steam table. The Dietician stated she recommended to the facility to place boiling water in the non-working steam table and hold hot foods on the stove or oven until the meal was to be served from the non-operating steam table. Observation and interview on 8/18/25 at 8:45 AM, of kitchen reflected that the steam table was still not operating. Observation further reflected the breakfast food was served off the stove top and was placed in a roaster with hot water and then transferred to a plate. [The latter option for cooking foods was made by the facility's dietician]. Surveyor Test tray of a regular meal (eggs, sausage, and waffles) reflected the holding temperature was within regulation. [NAME] A stated that if a resident complained of cold food the microwave was available to re-heat the food. [NAME] A stated she expected the arrival of the steam table this week. During an interview on 8/18/25 at 9:25 AM, the Administrator stated the arrival of the steam was expected this Wednesday 8/20/25. The Administrator stated the facility would employ the options of serving cold foods or using the roaster until the arrival of an operating steam table. Record review of facility's invoice undated reflected the purchase of a steam table. Record review of facility's policies did not reflect a policy on maintaining essential equipment to include kitchen equipment in operation condition. [Surveyor on 8/15/25 at 8:00 AM requested from the Administrator a policy on maintaining essential equipment. At exit on 8/18/25 at 3:00 PM, the Administrator had not provided the surveyor with a policy on maintaining essential equipment.]