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| 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 09/04/2025 |
| 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) |
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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed during the complaint investigation. The facility failed to ensure that Resident #1's treatment administration record noted treatments on 8.13.2025, 8.18.2025, and 8.24.2025 as required by the orders noted on the electronic medical record. This failure could place residents at risk of not receiving necessary care and services or receiving care and services more often than ordered. Findings include: During an observation and interview on 09/02/2025 at 1:00 PM, Resident #1 was observed with bandages on her right leg covering a below the knee amputation. She stated, they are supposed to change her amputation wound daily but they don't always do it daily. Record review of Resident #1's admission record, dated 09.02.2025, reflected a [AGE] year-old female who was readmitted to the facility on 07.21.2025 with diagnoses of other osteonecrosis of the right foot, encounter for orthopedic after care following a surgical amputation, immunodeficiency, type 2 diabetes mellitus with hyperglycemia, atrial fibrillation, cirrhosis of the liver, and chronic kidney disease, muscle weakness (generalized). Record review of Resident #1's MDS assessment completed on 08.07.2025 revealed a BIMS score of 12 which suggests moderate impairment of the resident's cognitive function. Resident #1 was coded as dependent for transfers and needing substantial/maximal assistance to roll left/right or move from sitting to lying. Resident #1 was coded as having a functional limitation in range of motion on one side of the lower extremity and uses a manual wheelchair to ambulate. Resident #1 was coded as having falls since Admission/Entry. Record review of Resident #1's Comprehensive Care Plan, dated 08.14.2025, reflected potential complications related to the below the knee amputation of the right leg that required surgical wound care as ordered by the physician. Record review of Resident #1's order administration record revealed that wound care for the below knee amputation of the right leg was to be performed four times each week on Monday, Wednesday, Friday, and Sunday. Record review of Resident #1's treatment administration record for the month of August revealed staff had failed to mark completion of wound care treatment on 08.13.2025, 08.18.2025, and 08.24.2025. During an interview on 09.03.25 at 12:55 PM, LVN A revealed that Wound Care Nurse B would have usually performed the wound care for Resident #1. LVN A stated, Wound Care Nurse B was absent on one of the days but could not remember which day, so she performed the care, but must have failed to mark completed on the treatment administration record. LVN A stated, she was not sure why Wound Care Nurse B did not mark completed for the days she administered care. During an interview on 09.04.25 at 12:55 PM, the DON revealed that the treatment administration record was not marked as completed on 08.13.2025, 08.18.2025, and 08.24.2025. She stated that implications for not marking the treatment as completed was that We can't say that it was done. That's the issue.</p> |

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.

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