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	10/25/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents (Resident #1) reviewed for pressure ulcers. The facility failed to implement treatment orders for Resident #1's wounds for 5 of 9 wounds for 12 to 13 days; did not document on the TAR if treatment was provided to 5 of 9 wounds for 13 days; and did not complete a weekly wound assessment on 10/09/2025 for 5 of 9 wounds. This failure could hinder the healing of the residents' existing pressure ulcers or lead to the development of additional skin injuries. The findings included: Record review of Resident #1's admission Record (face sheet), dated 10/24/2025, revealed he was [AGE] years old, admitted to the facility on [DATE] with diagnoses which included osteomyelitis (infection of the bone marrow), pressure ulcers (bed sores), paraplegia (partial paralysis), intracranial injury (injury to part of the brain), peripheral vascular disease (narrowing of the blood vessels in the arms and legs due to plaque buildup); and was discharged on 10/20/2025. Record review of Resident #1's MDS, an admission assessment dated [DATE], revealed a BIMS score of 15 out of 15 which indicated his cognitive skills for daily decision making were not impaired; had not rejected care and he was admitted with six stage 3 pressure ulcers (severe form of skin breakdown that involves full-thickness tissue loss, extending into the subcutaneous fat layer), one stage 4 pressure ulcer (severe form of skin breakdown that extends through the skin and underlying tissues, exposing muscle, tendon, and bone) and one unstageable deep tissue injury (condition that affects the underlying layers of skin and soft tissues, often resulting from sustained pressure or shear forces, leading to tissue damage and tissue death). Record review of Resident #1's care plans dated 10/17/2025, revealed a care plan for the focus area of Pressure ulcer actual or at risk due to admitted with pressure ulcers, paraplegia that was initiated 10/03/2025 for the following wounds: sacrum (bottom area) stage 4, right heel stage 3, right hallux (big toe) abrasion (wound caused by rubbing or scraping the skin), left lateral (outer) thigh stage 3, left lateral foot (outer side of the foot) stage 3, left hallux deep tissue injury, right lateral malleolus (outer bony prominences on the ankle) stage 3 and left groin stage 3. Under interventions was to conduct weekly wound assessments and treatments as ordered. Record review of Resident #1's admission Weekly Head to Toe Skin Check, dated 10/03/2025 completed by Treatment Nurse LVN C, revealed he had 9 wounds on:1. Left rear thigh stage 3 pressure ulcer with 30% slough (type of dead tissue that forms in a wound bed) that measured 9 cm x 5 cm x 2 cm.2. Left lower rear leg stage 3 pressure ulcer with 20% slough that measured 1.5 cm x 3.5 cm x 1.5 cm.3. Right heel stage 3 pressure ulcer with 20% slough that measured 3.5 cm x 5.5 cm x 0.8 cm.4. Sacrum stage 4 pressure ulcer with serosanguinous drainage (light pink, thin watery fluid that is common in stages of wound healing) that measured 26 cm x 29 cm x 7 cm.5. Groin stage 3 pressure ulcer that measured 1 cm x 1.5 cm x 0.8 cm.6. Left hallux deep tissue injury that measured 1 cm x 2 cm x 0.8 cm.7. Left lateral foot stage 3 pressure ulcer with 20% slough that measured 3.2 cm x 2.5 cm x 0.8 cm.8. Right hallux that measured 4 cm x 2 cm x 0.8 cm. 9. Right lateral malleolus stage 3 pressure ulcer that measured 1 cm x 1 cm x 0.8 cm. Record review of Resident #1's Physician Order Summary Report, dated 10/24/2025, revealed there were treatment orders with a start date of 10/03/2025 for the wounds on his left rear thigh, left lower rear leg, sacrum and left lateral foot. The treatment orders for the wounds on the groin and right hallux had a start date of 10/14/2025; and the wounds on the right heel, left hallux, and right lateral malleolus had a start date of 10/15/2025. An antibiotic, Levaquin oral 750 mg tablet, was ordered on 10/20/25 and was to be administered once daily for osteomyelitis. Record review of Resident #1's October 2025 TARs revealed it was not documented that he received wound care to the wounds on his right heel, groin, left hallux deep tissue injury, left hallux abrasion and right lateral malleolus until 10/15/2025. Record review of Resident #1's Wound Assessments dated 10/09/2025, completed by Treatment Nurse LVN C, revealed there was an assessment for the wounds on his left lower rear leg, sacrum, left hallux, and left lateral foot; but there was no assessment for the wounds on his left rear thigh, right heel, groin, right hallux and right lateral malleolus. Record review of Resident #1's Wound Assessments dated 10/13/2025, completed by Treatment Nurse LVN C, revealed there was a wound assessment for all 9 wounds which had the following measurements:1. Left rear thigh stage 3 pressure ulcer with 20% slough that measured 9 cm x 5 cm x 2 cm.2. Left lower rear leg stage 3 pressure ulcer with 20% slough that measured 1.5 cm x 3.5 cm x 1.5 cm.3. Right heel stage 3 pressure ulcer with 20% slough that

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (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 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that it was free of pests and rodents for 1 of 7 residents (Resident #1) reviewed for pest control program. The facility failed to ensure Resident #1 was not found with maggots in his right stage 3 heel wound on 10/16/25. Resident #1 refused an ER referral when the maggots were found and was sent to the emergency room a day after the maggots were discovered. An IJ was identified on 10/23/25. The IJ template was provided to the facility on [DATE] at 3:25 p.m. While the IJ was removed on 10/25/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility's need to monitor the implementation and effectiveness of its Plan of Removal. This failure could place residents at risk of experiencing a diminished quality of life, infections and/or death. The findings include: Record review of Resident #1's face sheet, dated 10/21/25, reflected a 32 -year-old male who was admitted to the facility on [DATE] and discharged AMA on 10/20/2025. Resident #1 had diagnoses which included: osteophyte, right foot (bone spur) ,osteophyte (a bony outgrowth) right ankle and left foot and ankle, pressure ulcer to left buttock stage 3, pressure ulcer left hip stage 3, paraplegia (loss of impairment in both lower limes), amputation at level between elbow and wrist, open wound of lower back and pelvis, pressure ulcer to left buttock stage 3, pressure ulcer of right buttock stage 4, and pressure ulcer right heel stage 3. The RP was listed as the resident. Record review of Resident#1's admission MDS, dated [DATE], reflected a BIMS score of 12, indicative of moderate impairment in cognition. The ADLs for: B/B was catheter for blader; bowel was incontinent. Transfer was total assistance; and bed mobility was supervision. Assistive device was listed as motorized W/C. ROM was documented as impairment to lower body. Record review of Resident #1's skin assessment on admissions, dated 10/3/25, reflected a right heel pressure ulcer with measurements of 3.5 x5.5x08 full thickness stage 3 20% slough (puss) serosanguinous (mix of blood and serum) and drainage. Record review of Resident #1's NP A' skin assessment on 10/13/25 of the right heel reflected the following measurements: 3.5 Length by 5.5 Width by 0.8 Depth.Record review of Resident #1's CP, dated 10/16/25, reflected .Reports of having live maggots in his right heel wounds. Interventions listed in the CP included: education to the residents, MD notified, sent to ER on [DATE] for any treatment, and daily wound treatment and weekly skin assessments. The CP documented to notify the physician as needed when resident refused wound care.Record review of Resident #1's physician orders, dated 10/15/25, read: . Wound care to right heel stage 3 pressure injury, cleanse with normal saline, pat dry, apply medihoney, (calcium) alginate, cover with dry dressing daily. Record review of Resident #1's Nurse Note, dated 10/16/25 at 6:00 a.m., authored by RN A, reflected: Multiple wounds with purulent drainage. Record review of Resident #1's SBAR note, dated 10/16/25 at 9:23 p.m., authored by LVN D, reflected .Wound to right heel is noted with live maggots falling from wound site. Resident is noted with history of refusing wound care and non-compliance of staying outdoors in wheelchair for long periods of time. Wound site is cleaned and wound care provided. [MD call center] on call notified of finding and recommendation to send to ED for eval (evaluation) and treatment.Record review of Resident #1's SBAR noted, dated 10/17/25 at 12:17 p.m., authored by the DON, reflected .maggots noted to patient wounds on feet [right heel] .wound care provided. persuaded patient to go to hospital with education of the outcome if not getting treatment for maggots in his wounds [right heel] . [arrived at hospital at 2:44 p.m.] Record review of Resident #1's Nurse Note, dated 10/17/22 at 12:22 p.m., authored by the DON, reflected . Resident (#1) stated ' I know my body and I don't really need to go to the hospital, I'm used to having maggots and they come whenever [I] skip wound care, I should have told y'all that happens.' Record review of Resident #1's Hospital records reflected Resident #1 was sent to the hospital for refusing care and now has maggots on 10/17/25. Record review of Resident #1's AMA sheet, dated 10/20/25, reflected the signed resident sheet with 3 witnesses present (DON, LVN C and RN K). Reason for AMA: resident wanted to be independent.Observation on 10/22/25 at 10:20 a.m., revealed some flies in Resident #2's room while observing wound care given to Resident #2 by LVN C. [flies in the room had the potential of landing on the resident's wound or laying eggs throughout the room and later infecting the resident's wounds] Observation of Resident #1's room on 10/22/25 at approximately 12:15 p.m. reflected that the screen was not fully adjusted to the frame, potentially allowing for flies/gnats to enter. There were no flies or gnats observed. During an interview on 10/21/25 at 12:30 p.m., the DON stated: Resident #1 was discovered with maggots