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	11/20/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (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
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to assist in offering nutrition and hydration based on the residents comprehensive assessment. The facility failed to ensure the resident was offered a therapeutic diet and prepare and serve food in a form to meet individual resident's needs for 1 of 6 residents (Resident #1) reviewed for dietary requirements.The facility failed to ensure residents received their prescribed therapeutic diet.This deficient practice could result in residents losing weight, feeling abnormally hungry or weak and a reduced quality of life.Findings included:Record review of Resident #1's admission record dated 10/01/2025 reflected an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Parkinson's Disease without Dyskinesia (Parkinson's Disease without involuntary, erratic body movements), without mention of fluctuations, Gastro-Esophageal Reflux Disease, without Esophagitis (stomach contents flow back into the esophagus but do not cause inflammation), Dysphagia, Oropharyngeal Phase (swallowing disorder), Chronic Respiratory Failure, Unspecified whether with Hypoxia or Hypercapnia (a condition where the lungs are unable to exchange oxygen and carbon dioxide over an extended period of time), Type 2 Diabetes Mellitus, without complications (a condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), Chronic Obstructive Pulmonary Disease (a lung condition that causes persistent airflow obstruction or breathlessness), Unspecified, Cognitive Communication Deficit (a difficulty in communication caused by impairment in brain functions like memory, attention and problem solving rather than language or speech problems), Vascular Dementia, Unspecified severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (a major neurocognitive disorder due to vascular disease that has not yet reached a specified level of severity), Other Lack of Coordination, Gastronomy Status (the presence of a gastronomy tube or opening in the stomach, which serves as an artificial entrance for delivering nutrition, medication and other fluids directly into the stomach or intestines when oral intake is not possible), and Legal Blindness, as Defined in America (a condition where visual acuity is 20/200 or worse in the better eye and a visual field angle of less than 20 degrees). Record review of Resident #1's quarterly MDS dated [DATE] reflected she had a BIMS score of 11, indicating moderate cognitive impairment and was highly visually impaired. Resident #1 required all food and medications to be delivered through a G-Tube placed in her abdomen. Record review of Resident #1's swallow study dated 12/19/2024 was performed by a registered speech therapist and indicated Resident #1 demonstrated no overt signs and symptoms of aspiration across the food consistencies provided during the test. She tolerated a pureed diet and G-Tube feedings appropriately. The speech therapist recommended a pureed diet with thin liquids, followed by swallow precautions, which were 1:1 assistance from staff while sitting upright, small bites of food and sips of liquid with no straw. Recommendations also included crushing medications and placing them in apple sauce or via G-Tube.Record review of Resident #1's Swallowing/Nutritional Status indicated she held food in her mouth and/or cheeks and had residual food in her mouth after meals. Her diet orders revealed she received a mechanically altered regular diet with pureed texture, mildly thick liquids, with fortified cereal at breakfast and sugar free nutritional shakes at every meal. She received 51% or more of her nutrition through tube feeding and received 501cc or more of her daily fluid intake through tube feeding.Record review of Resident #1's revised Care Plan dated 08/28/2025 indicated she was receiving hospice services related to Parkinson's Disease, COPD and Gastronomy Status with problem conditions of coughing and vomiting. Record review of Resident #1's revised care plan dated 08/28/2025 also reflected a focus of nutritional problems related to Parkinson's Disease, low vision and dysphagia with a goal of not developing complications related to obesity, including skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, and impaired mobility. Interventions were medications as ordered, monitoring/documenting/reporting to doctor signs and symptoms of dysphagia (holding food in mouth, several attempts at swallowing, coughing, pocketing food, and choking), nutritional supplements as ordered, resident needs assistance with all meals, RD to evaluate and make diet changes and weights as ordered. Resident #1 had a focus of potential for fluid deficit related to nutrition/hydration via tube feeding with a goal to be free from symptoms of dehydration and maintain moist mucous membranes and good skin turgor. Interventions were encourage resident to drink fluids of choice and monitor/document/report to MD signs and symptoms of dehydration, decreased or no urinary output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tone, new onset confusion