STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455713	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing & Rehab Center	50 Briggs St San Antonio, TX 78224

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interviews, and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 2 of 4 residents (Resident #3 and Resident #4) reviewed for quality of care. 1. The facility failed to ensure Resident #3 received wound care on 3/18/2025 and 3/19/2025 when the Treatment Nurse failed to re-approach or assess the reason for a refusal to complete wound care throughout the shift and failed to pass along to the next shift when a dressing change was refused on 3/18/2025. In addition, the Treatment Nurse failed to attempt wound care the following day which resulted in missed wound care on 3/18/2025 and 3/19/2025. 2. The facility failed to ensure Resident #4 received wound care on 3/18/2025 when the Treatment Nurse failed to attempt wound care multiple times and failed to pass along to the next shift when Resident #4 missed wound care on 3/18/2025. These deficient practices could affect residents who receive wound care treatments by placing them at risk for receiving inadequate treatments resulting in the worsening of the wounds. The findings included: 1. Record review of Resident #3's face sheet dated 3/19/2025 revealed an [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: dementia, cellulitis or right lower limb (bacterial infection of the skin), peripheral vascular disease (narrowing, blockage or spasms in the blood vessels), chronic venous insufficiency peripheral (weak and malfunctioning valves to veins in legs leading to blood pooling in the legs), and lymphedema (swelling of the tissues). Record review of Resident #3's quarterly MDS dated [DATE] revealed a BIMs score of 4 which indicated a severe cognitive impairment with no symptoms of delirium or behaviors and no history of rejections of care. The assessment revealed the resident was dependent on staff for transfers and most ADL care. Record review of Resident #3's left lateral calf wound assessment dated [DATE] by the Treatment Nurse revealed a venous wound which measured 16 cm x 6 cm x 0.1 cm depth with moderate exudate (drainage) and no odor. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's right lateral calf wound assessment dated [DATE] by the Treatment Nurse revealed the wound were venous skin injuries first identified 9/17/2025 and were 15 cm x 5.5 cm x 01 cm depth that were moist with moderate exudate (drainage) and no odor. Record review of Resident #3's Care Plan last revised on 3/13/2025 revealed he had behavioral symptoms which included refusing medications at intervals with interventions which included explain importance of medications using terms/gestures the resident can understand and repeat PRN and re-approach at intervals, praise when medications are taken. Record review of Resident #3's Care Plan last revised on 3/13/2025 revealed he had behavior symptoms which included resists care including wound care, skin assessments, showers with interventions which included: reiterate the purpose and advantages of treatment, assess resident's resistance to care (expectations, cognitive status, attitude, motivation, lack of understanding, pain/tolerance, fear of financial burdens, etc.). Record Review of Resident #3's Care Plan last revised on 3/13/2025 revealed the resident had open lesions to bilateral calves related to lymphedema and exacerbated (made worst by) venous disease without relevant interventions. Record review of Resident #3's March 2025 TAR revealed: -Cleanse left lateral calf ulcer with normal saline, pat dry, apply collagen within wound bed margins, cover with hydrofera blue foam, secure with super absorbent dressing, kerlix wrap and tape every other day. The wound care was scheduled every other day on 3/16/2025 wound care was documented as completed by a charge nurse and on 3/18/2025 wound care was marked as not administered and refused by the Treatment Nurse on 3/18/2025 at 1:04 p.m. -Cleanse right lateral calf ulcer with normal saline, pat dry, apply collagen within wound bed margins, cover with hydrofera blue foam, secure with super absorbent dressing, kerlix wrap and tape every other day. The wound care was scheduled every other day on 3/16/2025 which was marked as completed by a charge nurse and on 3/18/2025 wound care was marked as not administered/refused by the treatment nurse on 3/18/2025 at 1:04 p.m. During an observation and interview on 3/18/2025 at 2:12 p.m. with the Treatment Nurse, Resident #3 was observed in bed with his lower legs covered with a sheet. An observation of his lower legs revealed both lower legs from the knee to the foot were wrapped in kerlix bandages dated 3/16/2025 . The Treatment Nurse stated the dates on the dressings were 3/16/2025. The Treatment Nurse did not discuss wound care with the resident while in the room. The Treatment Nurse stated Resident #3 received wound care every other day but had refused on 3/18/2025. During an interview on 3/18/2025 at 2:25 p.m., the Treatment Nurse stated she was the facility wound care nurse. She stated her normal working hours were Monday-Friday from 8:00 a.m. to 5:00 p.m. She stated the nurses perform wound care on the weekends and when she was not at the facility. She stated she had already completed all wound care for the day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/19/2025 at 1:02 p.m., Resident #3 was awake/alert and talkative in bed. His legs were wrapped in kerlix dressing still dated 3/16/2025 and had not been changed. There was a moderate amount of red/brown drainage on a bed covering underneath his legs. No odor was detected. Resident #3 stated he was supposed to have wound care every other day, but no one shows up to do it. He stated he wanted his wounds changed but they would not do it. He stated he got confused and did not really know if he had ever refused. He was unable to recall when he was last approached for wound care or who approached him. During an interview on 3/19/2025 at 3:49 p.m., LVN A stated she was the regular charge nurse assigned to Resident #3. She stated Resident #3 sometimes gets in a mood but he does not refuse wound care for her. She stated the Treatment Nurse does not tell her when there was a resident who refused wound care or wound care was not done except for one occasion (date unknown). She stated on that occasion the wound care nurse left a piece of paper at the nurses' station with the word refused on it but did not talk to her about it. LVN A stated the Treatment Nurse just leaves and does not communicate what wounds still need to be done. She stated she had four residents on her assignment with wounds and had not seen a pattern of old dressings or worsening wounds. She stated the one resident who sometimes refused for the Treatment Nurse was Resident #3. During an interview on 3/19/2025 at 4:26 p.m., the Treatment Nurse stated Resident #3 had wound care ordered for 3/16/2025 as every other day treatment. She stated wound care refusals were normal for the resident and it was a behavior. She stated she approaches him by talking to him first thing in the morning. She stated she can tell by talking to him if he is in a good mood or if he will refuse. The Treatment Nurse stated sometimes she will ask if she can come back later and sometimes, he will say yes and sometimes he will say no. She stated she was trained to attempt three separate times. She stated she would approach and ask to do it and would educate him on why it needed to be done. She stated she did not have another approach. The Treatment Nurse stated he would refuse all times a day, it was not a time-of-day issue. She stated he was either in a good mood or a bad mood. She stated she does not document the attempts or the approaches. She stated she did not know why but it was probably because she had never really thought about it. The Treatment Nurse stated she was not aware of Resident #3's competence. She stated he appeared alert and oriented. The Treatment Nurse stated yes she does tell the charge nurse when resident refuses wound care, but she does not tell them every time, mostly because she knows Resident #3 was comfortable with her and wanted only her to do the wound care. She stated she could not remember the last time she notified the charge nurse of a resident refusal. She stated she knows she did not tell the oncoming shift or the charge nurse yesterday (3/18/2025) when he refused. She stated she typically leaves the facility at 5:00. At the end of the interview 5:04 p.m., she stated she had not approached Resident #3 about wound care today. She stated his next schedule wound care was 3/20/2025 although she did state his would care could be completed as needed. The Treatment Nurse stated she had not decided if she was going to approach Resident #3 for wound care today. During an interview on 3/20/2025 at 12:13 p.m., the Wound Care Physician stated she was aware of Resident #3's occasional wound care refusals. She stated at times the resident would refuse to let her see his wounds. She stated his wounds were stable and not worsening but he had little chance for healing due to disease process, comorbidities and refusals of turning, refusals of air mattress and refusals to offload his wounds. The Wound Care Physician stated staff revisit the resident when wound care was refused and knows that the Treatment Nurse does revisit. She stated Resident #3 took about 10-15 minutes of coaxing for compliance. She stated she did not have concerns about wound care at this facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #4's face sheet dated 3/19/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: peripheral vascular disease (narrowing, blockage or spasms in the blood vessels, chronic osteomyelitis right ankle and foot (infection of the bone) and type 2 diabetes mellitus with diabetic kidney complication . Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMs score of 3 which indicated a severe cognitive impairment with inattentive (easily distracted, difficulty focusing) behaviors that fluctuated. The assessment revealed the resident had no history of rejection of care. The assessment revealed the resident required substantial assistance for transfers and substantial to dependent care for ADLs. Record review of Resident #4's Care Plan initiated on 2/26/2025 revealed the resident had behavioral symptoms not directed to others such as screaming, disruptive sounds and crying stating she wants to go home. Wound care refusals were not part of the care plan. Record review of Resident #4's physician order summary for March 2025 revealed: -2/25/2025 Dialysis-sent to {dialysis company name} Tuesday, Thursday and Saturday chair time 9:50 a.m. (time dialysis starts). -3/16/2025 Right BKA (wound care), clean with normal saline, pat dry, cover with ABD pad, wrap with kerlix once a day scheduled 8:00 a.m.-5:00 p.m. Record review of Resident #4's March 2025 TARS revealed: -3/18/2025-Right BKA (wound care) not administered, resident unavailable dated 3/18/2025 at 2:39 p.m. signed by the Treatment Nurse. During an observation and interview on 3/19/2025 at 3:36 p.m. of peri-care revealed Resident #4 had a dressing to her right leg stump which was dated 3/17/2025 and was clean, dry, and intact. The Treatment Nurse was standing nearby with wound care supplies while the CNA completed peri-care. The Treatment Nurse stated the dressing was dated 3/17/2025. She removed the dressing, and the surgical wound edges were well approximated without redness or swelling (indications of healing without s/s infection). The Treatment Nurse stated Resident #4's dressing to her surgical amputation incision was not changed on 3/18/2025. The Treatment Nurse stated Resident #4 was at dialysis on 3/18/2025 and did not return unil dinner time. She stated she documented the missing treatment in the EMR. Resident #4 was not interviewable due to cognitive impairment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/2025 at 4:26 p.m., the Treatment Nurse stated she reviewed Resident #4's dialysis time and realized the resident was back from dialysis when she signed the medical record as not available. She stated Resident #4 usually returned from dialysis around lunch time or shortly after. The Treatment Nurse stated she asked Resident #4 one time to do wound care and Resident #4 told her she was not feeling well, so she passed it off to night shift. The Treatment Nurse stated she usually prints out the wound care order and writes please offer to resident on the paper and leaves it at the nurse's station but was not sure that was done. She stated she did not communicate or talk to the nurses about dressing, and she did not notify anyone it was not changed. The Treatment Nurse stated she marked the dressing as unavailable and did not change the dressing. She stated she did not notify the physician because she does not typically notify the physician for refusals. The Treatment Nurse stated she was unable to revisit the wound care because she had a lot going on. During an interview on 3/19/2025 at 10:08 a.m., the ADON stated the facility had not had a DON for about one week. She stated the DON was responsible for supervision of the Treatment Nurse and wound care. The ADON stated without the DON, it would now become her responsibility. She stated her expectation was to approach a resident multiple times when they refuse wound care. She stated the refusals should be communicated and documented. She stated each resident can have PRN wound care orders for nonscheduled times. The ADON stated if a resident did not want to work with the Treatment Nurse, the charge nurse could complete the wound care. She stated she would only expect a notification of missed wound care to the physician on weekly rounds unless it was a new wound or a wound that had changed. The ADON stated if the Treatment Nurse was not in the facility when Resident #4 returned from dialysis, she would expect the charge nurse to complete the wound care. She stated the Treatment Nurse should communicate verbally with the charge nurse if wound care could not be completed. She stated this was to prevent a lapse in care. The ADON stated Resident #3 had periodic chronic refusals of wound care. She stated she had witnessed the Treatment Nurse's approach. She stated she had instructed the Treatment Nurse to approach Resident #3 first thing in the morning. She stated both his regular physician and wound care physician were aware of his refusals of care. She stated it had been discussed in IDT meetings and morning meetings. She stated they had changed his schedule multiple times and noticed the weekend nurses were most successful. She stated the resident was very particular and it took about 3 hours to convince his to complete wound care. The ADON stated Resident #3 had days where he appeared alert and oriented and had times where he was confused. She stated they all try to work with him to complete wound care. The ADON stated the Treatment Nurse should communicate with the charge nurse each time he refused wound care so the night shift could try. She stated this was to prevent a lapse in care. Record review of the Treatment Nurse's Nurse Proficiency skills list dated 3/03/2025 revealed she had been checked off as satisfactory for dressing changes. Record review of a facility policy titled Dressing-Change-Clean dated 12/2017 revealed: It is the policy of this home to provide clean dressing changes utilizing Standard Precautions.