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	05/08/2025

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 4 of 4 residents (Resident #2, Resident #3, Resident #4, Resident #5) reviewed for accurate assessments: Resident #2's BIMS & PHQ assessment dated [DATE] were completed during the time when resident was hospitalized , and resident interview was not completed. Resident #3's BIMS & PHQ assessments dated 10/15/2024 were completed during the time when resident was hospitalized , and resident interview was not completed. Resident #4's BIMS & PHQ assessments dated 03/03/2025 were completed during the time when resident was hospitalized , and resident interview was not completed. Resident #5's BIMS & PHQ assessments dated 03/31/2025 were completed during the time when resident was hospitalized , and resident interview was not completed. This failure could place residents at risk for inaccurate assessments due to completing assessments without resident interview. The findings included: Record review of Resident #2's face sheet, dated 05/07/2025, revealed a [AGE] year-old female, originally admitted on [DATE] and re-admitted to the facility on [DATE] with diagnoses of anemia, Atrial fibrillation (irregular heart rate that causes poor blood flow), Vitamin B deficiency, GERD (a digestive disease in which the stomach produces bile), anxiety, edema, lymphedema, Hypertension (high blood pressure), Alcoholic polyneuropathy (disorder that impacts nerve function), morbid obesity, Hyperlipidemia (high cholesterol). Record review of Resident #2's census data revealed resident was hospitalized from [DATE]-[DATE]. Record review of Resident #2's BIMS & PHQ assessments revealed they were completed on 3/27/25 during the time resident was hospitalized . (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's face sheet, dated 05/07/2025 revealed an [AGE] year-old female, originally admitted on [DATE], and re-admitted on [DATE] with diagnoses of dementia, psychotic disturbance, anxiety, lumbar fracture, cognitive communication deficit, dyspepsia (indigestion), GERD (a digestive disease in which the stomach produces bile), Afib (irregular heart rate that causes poor blood flow), Hyperlipidemia (high cholesterol). Record review of Resident #3's census data revealed resident was hospitalized from [DATE]-[DATE]. Record review of Resident #3's BIMS & PHQ assessments revealed they were completed on 10/15/24 during the time resident was hospitalized . Record review of Resident #4's face sheet, dated 05/07/2025 revealed a [AGE] year-old male, originally admitted on [DATE] and re-admitted [DATE] with diagnoses of osteomyelitis (bone infection) of left ankle and foot, schizoaffective (mental health) disorder, anxiety, irritable bowel syndrome, hemorrhoids, viral hepatitis (inflammation of the liver), neuralgia (pain caused by nerve damage), insomnia, overactive bladder. Record review of Resident #4's census data revealed resident was hospitalized from [DATE]-[DATE]. Record review of Resident #4's BIMS & PHQ assessments revealed they were completed on 3/3/25 during the time resident was hospitalized . Record review of Resident #5's face sheet, dated 05/07/2025 revealed a [AGE] year-old male, originally admitted on [DATE] and re-admitted on [DATE] with diagnoses of cerebral infarction, insomnia, osteoarthritis, chronic kidney disease, benign prostatic hyperplasia (prostate gland enlargement that can cause urination difficulty), GERD (digestive disease in which the stomach produces bile), hypertension (high blood pressure), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should). Record review of Resident #5's census data revealed resident was hospitalized from [DATE]-[DATE]. Record review of Resident #5's BIMS & PHQ assessments revealed they were completed on 3/31/25 during the time resident was hospitalized . In an interview with SW on 05/07/25 at 10:15 a.m., SW revealed that she completed the BIMS and PHQ assessments while residents were in the hospital because the MDS Nurse told her they were due. SW stated she did not know how to complete the discharge assessments if the resident was not present for interview. In an interview with the Administrator on 05/07/25 at 10:20 a.m., Administrator revealed expectations for SW was to complete assessments accurately and if resident is in the hospital, should be coded as not assessed. Administrator stated she believed SW completed the assessments correctly and that error was due to inaccurate data entry. Requested facility policy for Resident Assessments on 5/9/25 at 8:30 a.m. Administrator stated they do not have a specific policy for Resident Assessments.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (100/200 hall crash cart) out of 2 crash carts and 1 (Resident #18) out of 5 residents reviewed for medical records. 1. Facility night nurses did not initial on the crash cart supply verification sheet after checking supplies inside the 100/200 hall crash cart on 04/08/2025, 04/09/2025, 04/10/2025, 04/16/2025, 04/17/2025, and 04/18/2025. 2. Facility medication aide-C did not document exact times when she administered Resident #18's medications on the resident's medication administration record. This failure placed residents at risk for missed treatment and medications which could result in decline in heal and well-being. Findings included: 1. Observation on 05/06/2025 at 4:00 p.m. revealed there were two crash carts located at the 100/200 hall nursing station and 300/400 hall nursing station, and inside the crash carts had all supplies per the crash cart supply verification such as Ambu bag with mask (tool that is used to deliver positive pressure ventilation to any subject with insufficient or ineffective breaths), backboard, blood pressure cuff, and so on. Record review of Daily Emergency/Crash Cart Supply Verification Sheet, from 04/01/2025 to 04/30/2025, revealed there were no nurse's initials on 04/08/2025, 04/09/2025, 04/10/2025, 04/16/2025, 04/17/2025, and 04/18/2025 (total 6 days) on the sheet of the 100/200 hall crash cart. Interview on 05/06/2025 at 4:08 p.m. with ADON acknowledged there were no nurse's initials on 04/08/2025, 04/09/2025, 04/10/2025, 04/16/2025, 04/17/2025, and 04/18/2025 (total 6 days) on the Daily Emergency/Crash Cart Supply Verification Sheet of the 100/200 hall crash cart from 04/01/2025 to 04/30/2025. ADON said night nurse should check the supplies inside the crash cart per the sheet and initial if the crash cart had all supplies every day. ADON said she found out which night nurses worked at those dates and what reason they did not initial. Further interview with ADON on 05/06/2025 at 4:14 p.m., ADON called the night nurses with the surveyor, but the nurses did not answer the phone so left message. Further interview on 05/08/2025 at 10:30 a.m. with ADON stated the night nurses called to ADON on 05/08/2025 and said they checked the supplies inside the 100/200 hall crash carts per the sheet, and no issues were noted. However, they said they forgot initialing on the sheet on 04/08/2025, 04/09/2025, 04/10/2025, 04/16/2025, 04/17/2025, and 04/18/2025 (total 6 days). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/2025 at 12:31 p.m. with DON stated night nurses should have initialed on 04/08/2025, 04/09/2025, 04/10/2025, 04/16/2025, 04/17/2025, and 04/18/2025 on the Daily Emergency/Crash Cart Supply Verification Sheet of the 100/200 crash cart because they said they checked, and all supplies were inside the crash cart per the facility policy. If night nurses did not initial on the sheet, the facility might have no supplies in the crash cart, and it caused if nurses had some emergencies, nurses could not use necessary supplies. DON said she had the responsibility to monitor facility crash carts and sheets regarding if nurses document on the sheets. Record review of facility policy, titled Crash Cart / Emergency Cart, dated 1/10/2017, revealed Charge nurses will be responsible for enduring the cart is appropriately stocked and will check this daily and as needed. 2. Record review of Resident #18's face sheet, dated 05/08/2025, revealed the resident was [AGE] years old female, originally admitted on [DATE], and re-admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus (not control blood sugars in the body), hypertension (high blood pressures), hyperlipidemia (high fat in the body), cellulitis (skin infection), and kidney failure (the kidneys lose the ability to remove water and balance fluids). Record review of Resident #18's quarterly MDS, dated [DATE], revealed the resident's BIMS was 13 out of 15, which indicated the resident's cognitive was intact and was independent to most activities of daily life such as sit to stand, chair-to-bed, and toilet transfer. Record review of Resident #18's physician order, dated 12/19/2024, revealed the resident had the order of Carvedilol tablet 25 mg one tablet by mouth twice a day for hypertension - hold for systolic blood pressure less than 110 or pulse less than 60. Record review of Resident #18's medication administration record from 04/01/2025 to 04/30/2025 revealed the resident's Carvedilol 25 mg for hypertension was scheduled at 8:00 am and 8:00 pm. Further record review of the resident's medication administration record from 04/01/2025 to 04/30/2025 revealed on 04/08/2025, charted time was 12:13 pm but administered on time, on 04/09/2025, charted time was 11:43 pm but administered on time, and on 04/13/2025, charted time was 11:32 pm but administered on time, and there were no exact times when Resident #18 received it at those dates. Interview on 05/07/2025 at 4:24 p.m. with medication aide-C stated she administered Resident #18's Carvedilol 25 mg on time between 8 and 9 am on 04/08/2025, 04/09/2025, and 04/13/2025, but she was so busy, she did not chart on the resident's medication administration record after Resident #18 took it. Medication aide-C stated she charted after she completed passing all medications to 100/200 hall residents. Further interview with medication aide-C stated she should have charted right away after Resident #18 took her Carvedilol 25 mg by mouth to give accurate information regarding what time the resident was receiving her blood pressure medications per the facility policy. Interview on 05/07/2025 at 4:41 p.m. with ADON stated there were no exact times when Resident #18 received her Carvedilol 25 mg at 04/08/2025, 04/09/2025, and 04/13/2025 on the resident's medication administration record, and medication aide-C should have charted what time the resident took it on the medication administration record by clicking the time on the computer right away after Resident #18 took it per the facility policy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/2025 at 12:31 p.m. with DON stated medication aide-C should have charted what time Resident #18 took her Carvedilol 25 mg by mouth on the medication administration record by clicking the time on the computer right away after the resident took it per the facility policy. If the medication aide did not chart exact time when Resident #18 received her blood pressure medications on the medication administration record, the resident might receive her medications at an incorrect time because the medication administration record was one of communication methods among health care professionals such as physician, nurse practitioner, and charge nurses. DON had responsibility to oversee residents had accurate medication administration records. Record review of the facility policy, titled Medication - Administration, dated 12/2017, revealed . 8. Medications are administered within 60 minutes of scheduled time, unless otherwise specifically by the physician. The resident's MAR (medication administration record) is initialed by the person administering a medication, in the space provided under the date and on the line for that specific medication dose administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 7 (Residents #6-12) of 9 residents reviewed for infection control. 1. The facility failed to implement the required elements for transmission based precautions, including signage and readily available PPE, for Residents #6-11. 2. The facility failed to don appropriate PPE while performing an invasive procedure on Resident #12. These failures could cause the spread of infection and illness. Findings included: Record review of Resident #6's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included dementia (a progress disorder that impairs the thought processes, such as memory, thinking, reasoning, and decision-making); colostomy (a surgically created opening in the abdomen for output of stool) status; viral hepatitis C (a viral infection causing liver dysfunction); and unspecified intestinal obstruction. Record review of the quarterly MDS submitted 4/18/2025 revealed a BIMS score of 4, indicating severe cognitive impairment. This MDS also confirmed the presence of an ostomy (surgically created opening in the abdomen; question H0100). Review of Resident #6's EMR contained a physician's order dated 4/2/2024 for EBP precautions. The resident's comprehensive care plan revealed a focus area dated 4/4/2024 indicating Resident #6 required EBP during contact r/t colostomy. During an observation on 5/7/2025 at 10:14 AM, no signage was present on the exterior of Resident #6's room to indicate EBP precautions. Record review of Resident #7's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included dementia and left heel pressure ulcer stage 4. Record review of the quarterly MDS submitted 3/25/2025 revealed a BIMS score of 11, indicating moderate cognitive impairment. This MDS also reported the presence of one stage 4 pressure ulcer (question M0300). Review of Resident #7's EMR contained a physician's order dated 3/14/2025 indicating staff may utilize EBP for high contact resident care. The resident's comprehensive care plan revealed a focus area dated 5/6/2025 indicating Resident #7 required EBP during contact care r/t chronic wound. On 5/7/2025 at 10:14 AM, simultaneous to the previous observation, no signage was observed present on the exterior of Resident #7's room to indicate EBP precautions. A cart containing PPE was also not observed to be present in the exterior area or inside of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included sacral spina bifida with hydrocephalus (a congenital disorder causing malformation of the brain, spine, and/or spinal cord with resulting increased pressure on the brain leading to potential cognitive impairment); and pressure ulcer of contiguous site of back, buttock and hip, stage 4; and colostomy status. Record review of the admission MDS submitted on 4/1/2025 revealed a BIMS score of 15, indicating intact cognition. This MDS also reported the presence of one stage 4 pressure (question M0300) as well the presence of an ostomy (question H0100). Review of Resident #9's EMR contained a physician's order dated 4/8/2024 indicating staff may utilize EBP for high contact resident care. Also present were physician's orders for colostomy care and urostomy (surgically created opening in the abdomen for the output of urine) The resident's comprehensive care plan revealed focus areas for the urostomy (dated 4/10/2025) and colostomy (dated 4/10/2025) but did not reveal a focus area or interventions associated with any focus area indicating the need for EBP. On 5/7/2025 at 10:15 AM, no signage indicating EBP was observed on the exterior of Resident #9's room. Record review of Resident #10's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included gastrostomy status (a surgically created opening in the abdomen for the intake of food, medications, etc.) and multiple myeloma (a type of cancer) in relapse. No MDS was available for review as the resident was newly admitted and the MDS was not yet required for submission on the survey dates. Review of Resident #10's EMR contained a physician's order dated 5/7/2025 indicating enhanced barrier precautions with high-contact resident care activities. The resident's baseline care plan revealed a focus area dated 5/6/2025 indicating [Resident #10] requires EBP (enhanced barrier precautions during contact care r/t PEG tube. On 5/7/2025 at 10:16 AM, no signage indicating EBP was observed on the exterior of Resident #10's room. A cart containing PPE was also not observed to be present in the exterior area or inside of the resident's room. LVN B was interviewed on 5/7/2025 at 10:18 AM, immediately following the observations of Residents #6, #7, #9, and #10. LVN B confirmed the need for EBP for these residents and their associated diagnoses. LVN B also verified the previously listed observations of missing signage and/or PPE carts. She stated residents on EBP should have both a sign indicating the EBP as well as a PPE cart. LVN B reported the potential harm to residents of the missing signage/PPE carts was infection. The DON was interviewed on 5/7/2025 at 10:20 AM and notified of the observations of missing signage and PPE carts for the residents. The DON stated PPE was available for staff to access in a cart located at the end of the hallway containing Resident #10's room. The DON reported being unaware that EBP required a PPE cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's face sheet reflected an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included dementia; non-pressure chronic ulcer of skin; neuromuscular dysfunction of bladder, unspecified; and benign prostatic hyperplasia with lower urinary tract symptoms (a condition in which the size and/or position of the prostate gland create difficulties with the urinary system, typically difficulty urinating). Record review of the quarterly MDS submitted 2/24/2025 revealed a BIMS score of 4, indicating severe cognitive impairment. This MDS did not indicate the presence of a catheter. Review of Resident #8's EMR contained a physician's order dated 4/21/2025 for an indwelling catheter. An order was not present for EBP. The resident's comprehensive care plan revealed a focus area dated 2/27/2025 indicating Resident #8 required EBP during 'high contact care r/t wounds, indwelling catheter. On 5/6/2025 at 11:10 AM, no signage indicating EBP was observed on the exterior of Resident #8's room. A cart containing PPE was observed near the resident's bed. Record review of Resident #11's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included acquired absence of the right leg above knee and colostomy status. Record review of the quarterly MDS submitted on 3/25/2025 revealed a BIMS score of 3, indicating severe cognitive impairment. This MDS also reported the presence of an ostomy (question H0100). Review of Resident #11's EMR did not reveal a physician's order for EBP. The resident's comprehensive care plan revealed a focus area dated 4/04/2024 indicating [Resident #11] requires EBP (enhanced barrier precautions) during high contact care r/t colostomy status. On 5/8/2025 at 8:40 AM signage indicating EBP was observed on the exterior of Resident #11's room. A cart containing PPE was not observed to be present in the exterior area or inside of the resident's room. CNA A was interviewed on 5/8/2025 at 8:57 AM. She verified Resident #11 required EBP. She was unsure why there was no PPE cart in the room, and she stated she would obtain PPE from the central supply area before providing resident care, if a PPE cart was not present. CNA A reported potential harm to residents of not using indicated PPE was contamination or illness to residents. The IP was interviewed on 5/7/2025 at 11:30 AM. She stated the facility expectation is to post signage of TBP and obtain PPE carts as soon as possible for any resident requiring isolation precautions. The IP was notified the survey team's observation, and she reported potential harm to residents from staff not implementing isolation precautions appropriately was the spread of organisms that are contagious. The IP reported frequent in-services to staff regarding infection prevention and PPE, and the most recent one she could recall was in April 2025. A record review of the facility police titled Infection Control- Precautions dated 12/2017 and revised 3/2024, revealed the following, under subheading Resident Transport: c. Signs- signs will be used to alert staff of the implementation of precautions, while protecting the privacy of the resident. d. A sign instructing visitors to report to the nurses' station before entering should be placed at the doorway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, under subheading Considerations the policy reflected: 2. Ensure PPE and alcohol-based handrub are readily accessible to all staff. 2. Record review of Resident #12's face reflected a [AGE] year-old male, admitted to the facility on [DATE]. Relevant diagnoses included dementia, osteomyelitis (an infection of bone tissue) of vertebra sacral (base of the spine) and sacrococcygeal (tailbone) region, and pressure ulcer of sacral region stage 4. Record review of the quarterly MDS submitted on 3/25/2025 revealed in question C0100 that the resident is rarely/never understood, thus making a BIMS score not able to be assessed. Question M0300 of the MDS reflected one stage 4 pressure ulcer. Review of Resident #12's EMR revealed a physician's order dated 11/4/2024 indicating staff may utilize EBP for high contact resident care. The comprehensive care plan contained a focus area dated 4/17/2025 directing staff to utilize EBP during high contact care. The listed interventions for the focus area directed staff to provide/utilize appropriate PPE along with standard precautions while providing care (i.e.: ADLs . incontinent care/toileting, wound care, care to enteral tubes, IV sites, catheters, tracheostomy). On 5/7/2025 at 8:13 AM, Resident #12 was heard yelling. Resident #12's room was open and the curtain was drawn around the bed making the resident not visible from the hallway. Three staff members, including the ADON were observed exiting the curtained area of the room. None of the staff members were wearing PPE at the time they exited the curtained area. The three staff members were observed removing gloves prior to exiting the room and using hand sanitizer from the dispenser located in the hallway. Signage was present on the resident's door indicating EBP. The ADON was interviewed at this time, and she reported Resident #12 was undergoing insertion of a peripheral IV into his arm for a medication infusion. She stated the other two staff members were registered nurses from a third-party vendor company who provided the infusion service, including the initiation of the IV. The ADON stated this procedure did not require the use of PPE. In a subsequent interview with the ADON on 5/7/2025 at 10:00 AM, she reported for resident's with EBP, PPE is indicated when changing residents' clothes, transfering, or accessing indwelling catheters. She also stated she did not feel an IV catheter initiation procedure met the requirements for PPE because it was not listed on the rules of the EBP sign and the staff were not accessing his wounds. Resident #12's care plan was reviewed with ADON, including the intervention that explicitly listed IV sites as cause for PPE utilization. The ADON responded we don't normally use PPE for starting an IV. She reported potential harm of not utilizing PPE for residents with EBP as the spread of bacteria. A record review of the facility police titled Infection Control- Precautions dated 12/2017 and revised 3/2024, in section titled Enhanced Barrier Precaution Guidance, subheading Considerations: 1. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: . wound care: any skin opening requiring a dressing.