

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Sunrise Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure all necessary information, including a resident's discharge summary or a 30-day written discharge notice was completed to ensure a safe and effective transition of care for 1 (Resident #1) of 4 residents reviewed for safe transfer or discharge.</p> <ol style="list-style-type: none"> The facility failed to provide a notification of transfer notice in written form and in a manner that Resident #1 and Resident #1's RP/POA could understand prior to Resident discharge on [DATE]. The facility failed to record the reasons for the transfer in Resident #1's medical record when discharged on 05/16/2025. The facility failed to provide a 30-day written notice of transfer to Resident #1 and to the facility's ombudsman prior to Resident #1's discharged from the facility on 05/16/2025. <p>This failure could result in residents experiencing psychosocial harm (feelings of anger and sadness) due to inappropriate discharges and placed residents at risk of being discharged without alternate placement and not having access to available advocacy services, discharge/transfer options, and denying them their rights in the appeal process.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 05/29/25, reflected a [AGE] year-old female was admitted [DATE] and discharged [DATE]. It further reflected Resident #1 had diagnoses to include moderate intellectual disabilities, developmental disorder of speech and language, need for assistance with personal care, lack of coordination, and cognitive communication deficit. It further reflected Resident #1 had a responsible party that was also her POA.</p> <p>Record review of Resident #1's admission Minimum Data Set (MDS) assessment, dated 02/21/25, reflected a BIMS assessment was inappropriate for resident in that her had short- and long-term memory problems.</p> <p>Record review of Resident #1's Discharge summary, dated [DATE], did not indicate a reason for transfer.</p> <p>Record review of Resident #1's progress notes, accessed 05/29/25 did not reflect a reason for transfer.</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Electronic Medical Record, accessed 05/29/25, did not reveal a 30-day discharge notice.</p> <p>Interview on 05/29/25 at 10:34 AM, Resident #1's RP/POA revealed they did not receive a notification for transfer for Resident #1. They revealed they wanted the opportunity to search for other facilities before Resident #1 was transferred. They revealed since the facility chose the next facility Resident #1 would be placed, they wanted to see the place before Resident #1 was transferred. Resident #1's RP/POA gave permission to speak with complainant for a complaint received by HHSC.</p> <p>Interview on 05/29/25 at 12:22PM, the Complainant revealed Resident #1 was at the facility for about 3 months. The complainant revealed the facility discussed transferring Resident #1 to another facility the week before Resident #1 was transferred to another facility. The complainant revealed they needed until the end of June 2025 so they could look for place. They revealed the Marketing Director sent the complainant a text the same week that they (the facility) found a place to transfer Resident #1 to. The Complainant revealed they wanted time to tour the new facility before Resident #1 was placed there, and never got to tour this new facility.</p> <p>Interview on 05/29/25 at 1:59 PM, the Social Worker revealed the BOM gave discharge notices. She revealed doctors gave discharge orders. She further revealed 30-day discharge notices were only given for non-payment, but she was not fully aware. The SW revealed the Marketing Director and her spoke with Resident #1's family about transferring the week before Resident #1 was transferred to another facility.</p> <p>Interview on 05/29/25 at 2:31 PM, the Marketing Director revealed they would help residents find other facilities to be transferred to, if they needed help, like Resident #1. He revealed he spoke with family that this facility could possibly not meet the needs of Resident #1 as they were wanting more one-on-one care. He further revealed the family was in agreement to transferring Resident #1 to another facility.</p> <p>Interview on 05/29/25 at 2:55 PM, the Ombudsman revealed if residents were at the facility for over 30 days and got transferred to another facility, she expected a 30-day discharge notice. She revealed there had been no 30-day notices from this facility for transfers in the past 3 months. She revealed giving out 30-day discharge notices allowed the residents to appeal and work with the ombudsman for any questions or help.</p> <p>Interview on 05/29/25 at 3:08 PM, the ADM revealed the facility only gave 30-day discharge notices for non-payment and not if families requested help being placed in another facility. She revealed they always met residents' needs so they never had to deal with transferring residents due to not meeting their needs. The ADM revealed Resident #1 was not a facility-initiated transfer.</p> <p>Interview on 05/29/25 at 4:15PM, the BOM revealed she oversaw completing the 30-day discharge notices. She revealed most of these were for non-payment. She revealed they do not do these discharge notices for transfers to another facility. She revealed 30-day discharge notices were important because it gave the resident a chance to stay at the facility if they wanted to. She revealed she did not inform the ombudsman of all discharges, just the 30-day discharge notices for non-payment.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Email communication on 5/29/25 at 04:36 PM, the ADM revealed they did not provide monthly reports of discharges to ombudsman, if not requested. The ADM further revealed the ombudsman information was on the 30-day notice, so they did not need to notify the ombudsman.</p> <p>Interview on 05/29/25 at 5:41 PM with the ADON, the SW, and the ADM revealed they did not have to document who initiated discharges in the residents' electronic medical record. They revealed Resident #1's RP/POA agreed with the transfer to another facility, and they did not provide written notice to Resident #1's RP/POA in the Spanish language, which was the language they spoke. They revealed the Resident #1's RP/POA initiated this transfer and the SW helped with this transfer. The ADM revealed they had no policy for resident-initiated and facility-initiated transfers. The ADM revealed if there was an involuntary transfer, then they would provide a 30-day discharge notice, but Resident #1 voluntarily discharged . The ADON searched through Resident #1's electronic medical record and confirmed the basis for Resident #1's discharge was not documented anywhere. The ADM could not provide documentation if Resident #1's transfer was a resident initiated or facility-initiated transfer.</p> <p>Record review of facility's policy Discharge-Transfer of the Resident, dated 12/2017, reflected 7. Document in the clinical software, date, time, type of transportation and individual accompanying resident, Include whether resident took medication and validation that resident/family understand instruction .8. Document, in clinical software, resident and/or responsible party understand discharge plan of care and if, resident discharging to another home or a lower level of care they receive a copy of discharge plan of care.</p>		