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 07/26/2024

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 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 27520

Based on record review and interview, the facility failed to complete an assessment which accurately reflected the resident's status for 2 of 8 residents (Residents #52 and #138) reviewed for assessments.

1. The facility failed to indicate Resident #138 had an indwelling catheter on their MDS.

2. The facility failed to indicate Resident #52 was receiving Dialysis and oxygen services on her MDS.

These failures could result in inadequate care due to an incomplete assessment of the residents' physical status.

The findings included:

1. Record review of Resident #138's face sheet dated 7/23/2024, revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included, pressure ulcer of sacral region stage 4, unspecified hydronephrosis, acute kidney injury, and acute cystitis with hematuria.

Record review of Resident #138's care plan, revised 07/16/2024, revealed the resident was at risk for impaired skin integrity related to bowel incontinence with interventions to check the resident every two hours and assist with toileting as needed and provide peri care after each incontinent episode. The presence of a catheter was not documented in the care plan.

Record review of Resident #138's significant change MDS, dated [DATE], revealed his cognition was severely impaired for daily decision making. Under section H for bladder and bowel no appliances were checked off and showed none of the above. It showed he was always incontinent of bowel and bladder.

During an observation on 7/25/24 at 2:14 p.m. staff provided care to Resident #138's catheter.

During an interview on 7/25/24 at 11:39 a.m. the MDS Regional Consultant stated they had been through a few MDS nurses recently, so she was training and helping with MDS nurse responsibilities. The MDS Regional Consultant stated they should have care planned Resident #138's catheter and it should be indicated on the MDS so staff can care for it.

(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: 455713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Sunrise Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	2. Review of Resident #52's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses including Acute systolic (congestive) heart failure and End stage renal disease. Review of Resident #52's quarterly MDS, dated [DATE], revealed her BIMS was 14 reflective she was cognitively intact. Further review did not reveal Resident #52 was receiving Dialysis and oxygen therapy while at the facility. Review of Resident #52's Care Plan, dated 2/4/24, revealed she required oxygen therapy related to respiratory failure. One of the approaches was to Short Term Goal Target Date: 09/11/2024 administer oxygen at 2-4 LPM via nasal cannula. Further review revealed the Care Plan reflected Resident #52 required Dialysis related to renal insufficiency. One of the approaches was that staff encourage Resident #52 to attend her scheduled appointments three times a week. Review of Resident #52's consolidated physician orders for July 2024 revealed she received Dialysis on M-W-F PICK-UP TIME: 1300 (1:00 p.m.) CHAIR TIME: 1400 (2:00 p.m.) with start date of 02/06/2024. Further review revealed Resident #52 received O2 2-4 L continuous NC Every Shift; Day, Night with start date 2/9/24. Observation and interview on 07/21/24 at 10:58 AM Resident #54 was lying in bed with 02 infusing via NC @2 L. Resident #54 stated used 02 for shortness of breath. She stated she had been at the facility for 6 months. She stated she was also going for Dialysis on MWF; chair time was at 1 PM. Resident #54 stated she breakfast/lunch at the facility and staff would save her dinner tray and warmed it up when ready to eat after returning from Dialysis. Interview on 07/23/24 at 04:11 PM with LVN MDS Regional Consultant revealed Resident #54's quarterly MDS did not accurately reflect her care needs. She stated it did not include she was receiving Dialysis and O2 therapy. She stated it was important for the MDS to be accurate so that staff would know what care and services Resident #54 received. She stated the care areas, care and services were also transferred over to the Care Plan which staff was to use as a tool to learn about the Resident needs. MDS Regional Consultant stated any negative outcomes would reflect in staff not understanding/knowing the Resident's needs. She further stated the facility used the CMS RAI manual for meeting regulatory requirements. When asked for a policy on MDS, the Administrator stated the facility used the CMS RAI manual. 45857

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for 2 of 8 residents reviewed for PASRR (Resident #8 and Resident #35). 1. The facility failed to ensure Resident #8 had an accurate PASRR Level 1 Screening indicating diagnoses of mental illness and refer the residents to the state local authority for an evaluation. 2. The facility failed to ensure Resident #35 had an accurate PASRR Level 1 Screening indicating diagnoses of mental illness and refer the resident to the state local authority for an evaluation. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: 1. Record Review of Resident #8's Admission record, dated 7/23/24, revealed a [AGE] year-old female initially admitted [DATE] and with diagnoses including dementia, recurrent depressive disorder, psychotic disorder with hallucinations due to known physiological condition and paranoid schizophrenia. Record Review of Resident #8's quarterly MDS assessment, dated 5/10/24, reflected Resident #8 had had severely impaired cognition for daily decision making and had anxiety and schizophrenia. Record review of Resident #8's a physician's order for dates 6/25/24-7/25/24 indicated Resident #8 took the following medications: buspirone for anxiety, risperidone for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, mirtazapine for recurrent depressive disorders, lorazepam for anxiety, and paroxetine for recurrent depressive disorder. Record review of Resident #8's PASRR Level 1 Screening completed on 8/28/23 indicated in section C0100 there was no evidence of this individual having mental illness or dementia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/24 at 3:13 p.m. the regional consultant stated Resident #8 should have had an additional document completed because she had a diagnosis of dementia. The regional consultant stated she would complete the extra paperwork as soon as possible. 2. Review of Resident #35's face sheet, dated 7/25/24, revealed he was admitted to the facility on [DATE] with diagnoses including unspecified Dementia and Psychotic disorder with delusions due to known physiological condition. Review of Resident #35's quarterly MDS, dated [DATE], revealed he had Non-Alzheimer's Dementia, Psychotic Disorder and he received antipsychotic medications. Review of Resident #35's Care Plan, dated 03/05/2024 revealed he was at risk for adverse consequences related to receiving antipsychotic medication for treatment of psychotic disorder. Goal Target Date: 9/29/2024. Resident will not exhibit signs of drug related side effects or adverse drug reaction. Approach Start Date: 03/05/2024. Approach End Date: 09/29/2024. Assess if the resident's behavioral symptoms present a danger to the resident and/or others. Intervene as needed. Review of Resident #35's PASRR Level 1 Screening, dated 10/01/2017 revealed there was no evidence or indication he had a mental illness. Review of Resident #35's consolidated physician orders dated July 2024 revealed an order with start date of 8/23/23, Zyprexa (olanzapine) tablet; 10 mg; amt: 1 tab; oral Special Instructions: 1 tab PO at HS, [DX: Psychotic disorder with delusions due to known physiological condition] At Bedtime; 20:00. (8:00 p.m.) Interview on 07/25/24 at 02:42 PM the MDS Regional Consultant she did not update Resident #35's PASRR Level I Screening after being diagnosed with Psychosis. She stated he would probably would not meet the criteria for mental illness but they were still required to update the Level I screening and contact LIDDA so they would complete an evaluation. This would determine whether or not they would receive services through LIDDA. The MDS Regional Consultant stated Resident #35 would miss out on services if he happened to meet the criteria for mental illness and that's why it was important to update his Level I Screening PASRR. 45857

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 45857 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 8 residents (Resident #50, Resident #74 and Resident #138) reviewed for comprehensive care plans in that: 1. The facility failed to ensure Resident #50 had an order for bed rails and was care planned for the rails on her bed. 2. The facility failed to ensure Resident #74 care plan reflected he had a catheter. 3. The facility failed to ensure Resident #138 care plan reflected he had a catheter. This deficient practice could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings included: 1. Record Review of Resident #50's Admission record, dated 7/23/24, revealed a [AGE] year-old female initially admitted [DATE] and with diagnoses including dementia severe with other behavioral disturbances, weakness, psychotic disorder with delusions due to known physiological condition, and muscle wasting and atrophy, not elsewhere classified, multiple sites. Record Review of Resident #50's quarterly MDS assessment, dated 5/24/24, reflected Resident #20 cognition was fully intact for daily decision making. Section P restraints and alarms reflected bed rails were not used. Record review of Resident #50's care plan did not reflect she had rails on her bed. Record review of Resident #50's physician order summary dated 7/23/24 revealed no orders for side rails. During an observation on 7/22/24 at 3:29 p.m. Resident #50 was laying in bed. Resident #50 did not respond when her name was called. Resident #50 had a 1/8 rail on either side of her bed. During an interview on 7/25/24 at 9:36 a.m. the DON stated they do not have bed side rails in the facility they only have grab bars. The DON stated Resident #50's family requested the mobility bar because the resident was blind. The DON stated she would need to check if the resident needed orders for the mobility bar and they planned to perform an audit of residents to add the bars to the care plans. The DON stated they did not have a care plan for bed rails because they did not consider the mobility bar a bed side rail. The DON stated bed rails were not allowed at the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record Review of Resident #74's Admission record, dated 7/26/24, revealed a [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy, pressure ulcer of the sacral region, urinary tract infection, need for assistance with personal care, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Record Review of Resident #74's discharge MDS assessment, dated 6/30/24, reflected Resident #74 cognition was severely impaired for daily decision making. Under section H for bladder and bowel no appliances were checked off and showed none of the above. It showed he was always incontinent of bowel and bladder. Record review of Resident #74's care plan, revised 07/25/2024, revealed the resident was incontinent and exhibited functional bowel/bladder incontinence and to provide peri care. The resident catheter was not mentioned in the care plan. During an observation on 7/21/24 at 10:39 a.m. Resident #74 was lying in bed. Resident #74 had a catheter hanging from the side of his bed. The bed was low and the catheter was touching the floor. The urine was clear yellow and was not in a dignity bag. The resident was not able to be interviewed. 3. Record review of Resident #138's face sheet dated 7/23/2024, revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included, metabolic encephalopathy, pressure ulcer of sacral region stage 4, unspecified hydronephrosis, acute kidney injury, acute cystitis with hematuria, and cognitive communication deficit (a difficulty with communication that is caused by a problem with thinking). Record review of Resident #138's significant change MDS, dated [DATE], revealed his cognition was severely impaired for daily decision making. Under section H for bladder and bowel no appliances were checked off and showed none of the above. It showed he was always incontinent of bowel and bladder. Section P restraints and alarms reflected bed rails were not used. Record review of Resident #138's care plan, revised 07/16/2024, revealed the resident was at risk for impaired skin integrity related to bowel incontinence with interventions to check the resident every two hours and assist with toileting as needed and Provide peri care after each incontinent episode. The presence of a catheter was not documented in the care plan. Record review of Resident #138's physician order summary dated 7/23/24 revealed no orders for a catheter. During an observation on 7/25/24 at 2:14 p.m. staff provided care to Resident #138's catheter. During an interview on 7/25/24 at 11:39 a.m. the MDS Regional Consultant stated they should have care planned Resident #138's catheter and it should be indicated on the MDS so staff can care for it. During an interview on 7/25/24 at 3:39 p.m. The DON stated she thought hospice had ordered the catheter for Resident #138. The DON stated they had to get in touch with hospice because they did not have the orders or the plan of care for Resident #138. The DON was unsure of when or how long the resident had the catheter. The DON stated it was not in their orders or care plan because hospice ordered the catheter. (continued on next page)

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	07/26/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/26/24 at 10:13 a.m. the DON stated Resident #138 had the foley catheter placed during a hospital stay and returned on 5/2/24 with the catheter in place. The DON stated the nursing staff at the facility should have entered orders for the catheter at that time. The DON stated while the orders should have been there staff was still providing daily catheter care but was not able to document the care because there was no order. Record review of the facility's policy titled Care Plan - Resident, dated 12/2017, stated Policy, It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident .4. Concerns and Problems . 1. The specific problem as well as the underlying cause should be listed. 2. If the home is using nursing diagnoses for problem statements, the underlying condition must be identified. This may be done by following the nursing diagnoses with a statement beginning Due to . or Related to . b. Sources are, but are not limited to: 1. Problems relating to diagnoses. 2. Problems relating to physician's orders. (Remember, all orders for care should correspond to a diagnosis.) 6. Approach / Plan a. List care to be provided for the problem listed. The care must be NECESSARY AND APPROPRIATE to accomplish the goal stated b. Coordinate care to be provided to the resident for the most effective, efficient utilization of resources. c. Individualize care to ensure the care plan is person centered for the unique needs of the resident. d. Communicate vital information to staff providing direct resident care. e. List infection control measures. f. List safety measures. g. Each discipline should list approaches for the care it will provide. Coordinating care by all disciplines, working toward a common or similar goal, will improve efficiency . 12. Resident Care Plan Documentation and Use of The Plan a. The resident care plan is used to plan and assign care for all disciplines. b. The resident care plan must be started the day the resident is admitted and completed within seven days after the comprehensive assessment is completed c. The resident care plan must be kept current at all times. d. All residents receiving either Hospice or Dialysis are to have care plans developed in conjunction with these organizations. Both the home and the outside organization will be responsible to communicate resident needs at least weekly as well as an on needed basis.

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	455713	A. Building B. Wing	07/26/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to review and revise Resident Care Plans after each assessment for 2 of 8 Residents (Resident #68 and Resident #71) whose records were reviewed. 1. Resident #68's Care Plan was not updated after his significant change MDS reflected he was dependent on staff for ADL care. 2. Resident #71's Care Plan was not updated after he experienced a change of condition and developed a venous ulcer to his left shin. These deficient practice could affect any resident and contribute to Residents not receiving the care and services they needed. The findings were: 1. Review of Resident #68's face sheet, dated 7/25/24, revealed he was admitted to the facility on [DATE] with diagnoses including Cerebral infarction (Stroke), unspecified and Local infection of the skin and subcutaneous tissue, unspecified, Review of Resident #68's significant change MDS assessment, dated 5/14/24, revealed Resident #68 was dependent on staff for all ADL care. Review of Resident #68's Care Plan, dated 7/17/24, revealed there was no indication Resident #68 was dependent on 1 or 2 staff for ADL care. Interview on 07/25/24 at 02:22 PM with MDS Regional Consultant revealed Resident #68's Care Plan, dated 7/17/24, did not reflect Resident #68 was dependent on staff for ADL care. 2. Review of Resident #71's face sheet, undated, revealed he was admitted to the facility on [DATE] with diagnoses including Essential hypertension (high blood pressure), Cellulite of left lower limb, Chronic venous hypertension (idiopathic) with ulcer of left lower extremity, Unsteadiness on feet, Other abnormalities of gait and mobility, Other lack of coordination and Muscle weakness (generalized). Review of Resident #71's admission MDS assessment, dated 4/18/24, revealed Resident #71 did not have any pressure ulcers. Review of Resident #71's physician orders for July 2024 revealed Resident #71 was receiving wound treatment for venous ulcer on left shin, Cleanse venous wound to left shin with NS, pat dry, apply Santyl to wound bed, cover with ca alginate, secure with silicone dressing daily, Once A Day at 08:00 - 18:00, start date 6/25/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 07/21/24 at 01:56 PM revealed Resident #71 sitting on the edge of the bed. He stated he transferred in from another nursing facility. Further observation revealed Resident #71 had a dressing around lower left leg. Resident #71 stated it was related to lack of circulation in his legs. Interview on 07/22/24 PM at with LVN/MDS Regional Consultant revealed Resident #71 did not acquire the venous ulcer until after the admission MDS was completed. However, they should update the Care Plan with any significant changes and they did not update Resident #71's Care Plan to reflect the change of his venous wound status. She stated an outside organization was providing wound care and diagnosed Resident #71 with a venous pressure ulcer to his on left shin. MDS Regional Consultant stated it was important the Care Plan reflect an accurate picture of each Resident's physical and medical condition so nursing staff would have an understanding of the care they were to provide the Resident. She stated they used the MDS RAI to ensure they met regulatory requirements.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure each resident received assistance devices to prevent accidents for 1 of 8 Residents (Resident #69) whose records were reviewed for falls. CNA E and CNA F failed to use a gait belt properly by applying a gait belt over Resident #69's breast instead of around her waistline during a bed to wheelchair transfer. LVN G failed to use a gait belt while transferring Resident #69 from the wheelchair to the bed. These deficient practices could affect any residents who required assistance with transfers and could contribute to an avoidable fall/injury. The findings were: Review of Resident 69's face sheet, dated 7/25/24 revealed she was admitted to the facility on [DATE] with diagnoses including Vascular Dementia with other behavior disturbance, Chronic Kidney Disease, and Congestive Heart Failure. Review of Resident #69's quarterly MDS, dated [DATE] revealed Resident #69 was unable to complete the BIMS assessment; was dependent on staff for sit to stand, chair to bed, to chair transfers and she used a manual wheelchair for mobility. Review of Resident #69's Care Plan, dated 6/14/24 revealed Resident had History of falling related to debility, and altered mental status. Long Term Goal Target Date: 09/26/2024. Resident will remain free from serious injury related to fall/s. If occur resident will be assessed/treated promptly/ appropriately to decrease risk of adverse outcome by the review date. Approach Start Date: 7/13/2024. Call light in reach, cue/reorient resident to call light use. Nursing. Approach Start Date: 06/14/2024. Approach End Date: 09/26/2024. Resident bed moved to wall per family request to decrease resident rolling out of bed to right side. Review of incident/accident reports from [DATE] to July 2024 revealed Resident #69 had the following incidents: 1. 2/15/24: CNA found the Resident on the floor sustained a bump on the back of her head. No other injuries. 2. 3/10/24: Nurse heard Resident crying and found her lying face down on the floor. Resident complained of pain to arm (chronic pain). No other injuries noted. 3. 3/25/24: Resident heard crying out. CNA walked into room and saw Resident with feet over side of bed. CNA walked towards Resident and she rolled out of bed onto her left side. No injuries noted. (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

4. 3/29/24: LVN walked in room and saw Resident lying face down on floor with blood on side of head. Resident sustained 3 inch laceration on forehead over left eye. Resident only remembered rolling out of bed. She was provided with first aid in house and then sent out to the hospital.

5. 7/13/24: Housekeeper heard Resident's roommate comment, you are going to fall and then heard a thump. Nurse walked into the room and saw Resident in front of her wheelchair with her legs to the side. Resident stated she hit her head. Upon assessment found a bump on the top of her head and on left temple with small scratch. Skull series showed negative findings for any injuries.

Observation and interview on 07/23/24 at 10:15 AM revealed Resident #69 lying in bed, in low position, and call light draped over her linens. She kept asking for help to get up and to take her booties off. CNA E positioned Resident #69 on the edge of bed to transfer into wheelchair. Further observation revealed 2 fall mats wedged between the head of the bed and the wall. CNA E stated she was about to transfer the resident. Further observation revealed CNA E did not have a gait belt. CNA E stated she would have to get one. Interview with Resident #69 revealed she had fallen three times. CNA E came back in the room and put gait belt around the Resident #69's chest. She instructed Resident #69 to stand as she tried to lift the Resident. The Resident was not baring weight and unsteady. CNA E stopped and asked the Resident if she was going to stand. CNA E decided to get help. CNA E and CNA F returned to the room and sat Resident #69 back up on the edge of the bed, put gait belt around the Resident's chest. CNA F instructed Resident #69 to stand up. Resident #69 stood as CNA E and CNA F pulled up on the gait belt. Resident #69 swayed back a little, but the CNA's stabilized her and helped to turn her as the Resident pivoted around and sat in the wheelchair.

Interview on 07/23/24 at 10:30 AM with CNA E and CNA F stated they usually put the gait belt along a resident's waist but could not secure it on Resident #69's waist because of her breast so they wrapped it around her chest. CNA E and CNA F stated the purpose of using a gait belt was to help with stabilizing the Resident if unsteady during the transfer. CNA F stated they would be less likely to stabilize the Resident with the gait belt around the chest if the Resident was more than a little unsteady. CNA F further stated the belt could slide up over the Resident's head if they pulled on it suddenly and with force.

Observation and interview at 07/24/24 at 01:50 PM revealed LVN G transferring Resident #69 from the wheelchair to the bed without using a gait belt. The bed was in the low position and there were 2 fall mats on the floor on the outside of the bed. Further observation revealed Resident #69 back was arched and was not bearing weight; her feet were not placed on the floor. LVN G was able to carry Resident #69, turned towards the bed and placed her down on the bed; hard ending at the end of the transfer. LVN G then helped Resident #69 back to a sitting position. LVN G stated he should have used a gait belt while transferring Resident #69 to ensure a stable and safe transfer. He stated he did not have a gait belt. LVN G stated Resident #69 bared weight but did not seem steady on her feet. LVN G stated he thought Resident #69 was dizzy and that way why he sat her back up and would sit with her for a minute. LVN G pressed the call light and stated he was going to have an aide sit with Resident #69.

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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	07/26/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/26/24 at 10:40 AM with the DON and ADON revealed a gait belt should always be placed around the waistline and not on the chest. They stated it would be difficult to stabilize a Resident if the gait belt was around the chest and it could also lead to a fall. The ADON and DON stated Resident #69 was a high risk for falling and had a history of falling. Resident #69 had poor gait and balance. The interventions in place included call light within reach, low bed, 2 fall mats on the outside of the bed and frequent rounding by staff. Interview on 07/25/24 at 11:38 AM with the DON revealed LVN G told her about transferring Resident #69 without a gait belt. She stated staff should use a gait belt anytime doing a one person transfer. It helped to stabilize the Resident to keep them from falling; the gait belt was used for safety purposes. Review of a facility policy, dated 12/2017, read It is the policy of this home that when a gait belt is used with a resident, the correct procedure will be followed to promote for the safety of the resident and employee. 4. Apply the Gait Belt: Always use the gait belt when the resident requires {hands on} assistance to ambulate or transfer. Always place belt around the waist in soft tissue and never over ribs-never loosely. 8. Chair to Bed Transfer: Move to unaffected side. Apply gait belt. Move resident to edge of chair. Assist Resident to standing position. Have resident or pivot or turn toward bed. Assist resident to sitting position at edge of bed (guide with belt and body mechanics). Remove belt. Assist the resident to a safe and comfortable position in bed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 2 resident (Resident #74's and #138) reviewed for indwelling urinary catheter. 1. The facility failed to ensure Resident #74's catheter was off the floor and protect from potential contaminants on the floor and from staff stepping on the catheter bag and tubing. 2. The facility failed to ensure Resident #138 had physician orders to care for his catheter and daily care was performed and documented. This deficient practice could place residents with in dwelling urinary catheters at-risk for urinary tract infections and/or pain. The findings were: 1. Record Review of Resident #74's Admission record, dated 7/26/24, revealed a [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy, pressure ulcer of the sacral region, urinary tract infection, need for assistance with personal care, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Record Review of Resident #74's discharge MDS assessment, dated 6/30/24, reflected Resident #74 cognition was severely impaired for daily decision making. Under section H for bladder and bowel no appliances were checked off and showed none of the above. It showed he was always incontinent of bowel and bladder. Record review of Resident #74's care plan, revised 07/25/2024, revealed the resident was incontinent and exhibited functional bowel/bladder incontinence and to provide peri care. The resident catheter was not mentioned in the care plan. Record review of Resident #74's physician order summary dated 7/25/24 revealed orders for: - 16Fr Catheter with 10 cc balloon. Every Shift; Day, Night with a start date of 7/7/24 and no end date. - Ensure leg anchor in place Q shift. Every Shift; Day, Night with a start date of 7/7/24 and no end date. - Ensure privacy bag in place Q shift Every Shift; Day, Night with a start date of 7/7/24 and no end date. - Foley Catheter Care q shift and PRN Every Shift; Day, Night with a start date of 7/7/24 and no end date. (continued on next page)

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an observation on 7/21/24 at 10:39 a.m. Resident #74 was lying in bed. Resident #74 had a catheter hanging from the side of his bed. The bed was low and the catheter was touching the floor. The urine was clear yellow and was not in a dignity bag. The resident was not able to be interviewed. LVN E came into the room and reached over Resident 74's bed. LVN E stepped on the catheter bag and tubing.

During an interview on 7/21/24 10:39 a.m. LVN E stated the catheter bag should not be touching the floor.

During an interview on 7/26/24 at 10:18 a.m. the DON stated catheter bags should not be touching the floor because of infection control.

2. Record review of Resident #138's face sheet dated 7/23/2024, revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included, metabolic encephalopathy, pressure ulcer of sacral region stage 4, unspecified hydronephrosis, acute kidney injury, acute cystitis with hematuria, and cognitive communication deficit (a difficulty with communication that is caused by a problem with thinking).

Record review of Resident #138's care plan, revised 07/16/2024, revealed the resident was at risk for impaired skin integrity related to bowel incontinence with interventions to check the resident every two hours and assist with toileting as needed and Provide peri care after each incontinent episode. The presence of a catheter was not documented in the care plan.

Record review of Resident #138's significant change, dated 7/7/24, revealed his cognition was severely impaired for daily decision making. Under section H for bladder and bowel no appliances were checked off and showed none of the above. It showed he was always incontinent of bowel and bladder.

Record review of Resident #138's physician order summary dated 7/23/24 revealed no orders for catheter care.

During an observation on 7/21/24 at 10:59 a.m. Resident #138 was laying in bed. The Resident was not able to be interviewed. The resident had a catheter bag hanging from the side of the bed in a dignity bag.

During an interview on 7/25/24 at 3:39 p.m. The DON stated she thought hospice had ordered the catheter for Resident #138. The DON stated they had to get in touch with hospice because they did not have the orders or the plan of care for Resident #138. The DON was unsure of when or how long the resident had the catheter. The DON stated it was not in their orders or care plan because hospice ordered the catheter.

During an interview on 7/26/24 at 10:13 a.m. the DON stated Resident #138 had the foley catheter placed during a hospital stay and returned on 5/2/24 with the catheter in place. The DON stated the nursing staff at the facility should have entered orders for the catheter at that time. The DON stated while the orders should have been in the EMR staff was still providing daily catheter care but was not able to document the care because there was no order.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Incontinent Care/ Perineal Care with or without a Catheter, dated 12/2017, stated Policy, it is the policy of this home to provide incontinent care to residents in a manner which provides privacy promotes dignity and ensures no cross contamination.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews and record reviews, the facility failed to ensure correct installation, use, and maintenance of bed rails for 3 residents of 8 residents (Resident #16, Resident #50, and Resident #138) reviewed for use of side or bed rails in that: The facility did not ensure Resident #16, #50, and #138 were assessed for risk of entrapment from bed rails before they were installed and did not have a signed informed consent from his responsible party for the bed rails. This failure could affect residents who use bed or side rails as enablers and could result in entrapment. The findings included: 1. Record Review of Resident #16's Admission record, dated 7/25/24, revealed a [AGE] year-old female initially admitted [DATE] and with diagnoses including myocardial infarction, dislocation of internal left hip prosthesis, major depressive disorder recurrent severe without psychotic features, seizures, and need for assistance with personal care. Record Review of Resident #16's quarterly MDS assessment, dated 7/25/24, reflected Resident #16 cognition was fully intact for daily decision making. Section P restraints and alarms reflected bed rails were not used. Record review of Resident #16's care plan did was updated on 7/25/24 to include Resident utilizes turn assist devices on bed to enable resident to assist with turning/repositioning to their abilities. Record review of Resident #16's electronic medical record from his admitted [DATE] to 7/25/24 revealed there was no bed rail assessment or consent. During an observation on 7/21/24 at 11:12 a.m. Resident #16 was asleep in bed. Resident had side rails on either said of her bed. 2. Record Review of Resident #50's Admission record, dated 7/23/24, revealed a [AGE] year-old female initially admitted [DATE] and with diagnoses including dementia severe with other behavioral disturbances, weakness, psychotic disorder with delusions due to known physiological condition, and muscle wasting and atrophy, not elsewhere classified, multiple sites. Record Review of Resident #50's quarterly MDS assessment, dated 5/24/24, reflected Resident #20 cognition was fully intact for daily decision making. Section P restraints and alarms reflected bed rails were not used. Record review of Resident #50's care plan did not reflect she had rails on her bed. (continued on next page)

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F 0700

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record review of Resident #50's electronic medical record from his admitted [DATE] to 7/25/24 revealed there was no bed rail assessment or consent.

During an observation and attempted interview on 7/22/24 at 3:29 p.m. Resident #50 was laying in bed. Resident #50 did not respond when her name was called. Resident #50 had a 1/8 rail on either side of her bed.

3. Record review of Resident #138's face sheet dated 7/23/2024, revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included, metabolic encephalopathy, pressure ulcer of sacral region stage 4, unspecified hydronephrosis, acute kidney injury, acute cystitis with hematuria, and cognitive communication deficit (a difficulty with communication that is caused by a problem with thinking).

Record review of Resident #138's significant change MDS, dated [DATE], revealed his cognition was severely impaired for daily decision making. Section P restraints and alarms reflected bed rails were not used.

Record review of Resident #138's electronic medical record from his admitted [DATE] to 7/25/24 revealed there was no bed rail assessment or consent.

Record review of Resident #138's care plan, revised 07/16/2024, revealed the bed rails were not care planned.

During an observation and attempted interview on 7/21/24 at 10:59 a.m. Resident #138 was laying in bed. The Resident was not able to be interviewed. The resident had quarter rails on either side of his bed.

During an interview on 7/26/24 at 1:29 p.m. the maintenance supervisor stated he would refer to the DON for what side rails he could place on a residents' bed. The maintenance supervisor stated he would only install rails that were compliant, he would check for gaps between the mattress and rail, replace the mattress if needed and did not keep track of what residents had bed rails. The maintenance supervisor stated hospice beds came with the quarter rails and he was not allowed to touch them.

During an interview on 7/25/24 at 9:36 a.m. the DON stated they do not have bed side rails in the facility they only have grab bars. The DON stated she would need to check if the residents' needed orders for the mobility bars and they planned to perform an audit of residents to add the bars to the care plans. The DON stated they did not have a care plan for bed rails because they did not consider the mobility bar a bed side rail. The DON stated bed rails were not allowed at the facility.

During an interview on 7/25/24 at 11:30 a.m. the MDS Regional Consultant stated they added orders and care plans to each resident that they identified during an audit they conducted that day. The MDS Regional Consultant stated the rails were not big enough to be considered a restraint, so they were not reflected on the MDS.

During an interview on 7/25/24 at 11:36 a.m. the Administrator stated this had never been an issue before and they did not have a policy for bed rails because they did not consider the assistive devices bed rails.

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NAME OF PROVIDER OR SUPPLIER: Sunrise Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 62.96%, based on 17 errors out of 27 opportunities which involved 3 of 8 residents (Resident #16, Resident #63 and Resident #79) reviewed for medication administration and medication errors. 1. The facility failed to ensure Resident #16 received her medications on time. 2. The facility failed to ensure Resident #63 received her medications on time and received her bumetanide (used to reduce extra fluid in the body (edema) caused by conditions such as heart failure, liver disease, and kidney disease) as ordered. 3. The facility failed to ensure Resident #79 received his medications on time. These deficient practices could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: 1. Record Review of Resident #16's Admission record, dated 7/25/24, revealed a [AGE] year-old female initially admitted [DATE] and with diagnoses including myocardial infarction (is a type of heart attack that usually happens when your heart's need for oxygen can't be met. This condition gets its name because it doesn't have an easily identifiable electrical pattern (ST elevation) like the other main types of heart attacks.), dislocation of internal left hip prosthesis, major depressive disorder recurrent severe without psychotic features, seizures, and need for assistance with personal care. Record Review of Resident #16's quarterly MDS assessment, dated 7/25/24, reflected Resident #16 cognition was fully intact for daily decision making. Record review of Resident #16's care plan did was updated on 7/25/24 to include Resident had coronary artery disease and atrial fibrillation (an irregular and often very rapid heart rhythm) with history of NSTEMI with interventions to Give all cardiac meds as ordered by the physician. Monitor and document side effects. Give meds for hypertension and document response to medication and any side effects. Report Adverse reactions to MD PRN. Record review of Resident #16's physician's orders, dated 7/25/24, revealed the following: - lactobacillus acidophilus (probiotic) 1 capsule by mouth for prophylactic measures twice A Day; 8:00 a.m. and 8:00 pm with a start date of 7/15/24 and no end date. -aspirin 1 tablet 325 mg by mouth at 9:00 a.m. for atherosclerotic heart disease of native coronary artery without angina pectoris with a start date of 7/10/24, and no end date. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- carbidopa-levodopa 1 tablet 25-100 mg by mouth three times a day 8:00 a.m., 2:00 p.m., and 8:00 p.m. for Parkinson's disease without dyskinesia, without mention of fluctuations with a start date of 7/10/24 and no end date. -cetirizine 10mg tablet by mouth daily at 9:00 a.m. for allergy with a start date of 7/10/24 and no end date. -divalproex 500 mg tablet by mouth daily at 9:00 a.m. for seizures with a start date of 7/10/24 and no end date. -apixaban 5 mg tablet by mouth twice a day at 8:00 a.m. and 8:00 p.m. for atrial fibrillation with a start date of 7/19/24 and no end date. -metoclopramide hcl 5mg tablet by mouth twice at day at 8:00 a.m. and 8:00 p.m. for gastro-esophageal reflux disease without esophagitis with a start date of 7/19/24 and no end date. -mirabegron 50 mg tablet by mouth daily at 9:00 a.m. for overactive bladder. During an observation on 7/23/24 at 10:51 a.m. Resident #16 was administered lactobacillus acidophilus, aspirin, carbidopa-levodopa, cetirizine, divalproex, metoclopramide, and mirabegron by LVN F. 2. Record Review of Resident #63's Admission record, dated 7/25/24, revealed a [AGE] year-old female initially admitted [DATE] and with diagnoses including atrial fibrillation, localized edema (observable swelling from fluid accumulation in body tissues), lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system. It most commonly affects the arms or legs, but can also occur in the chest wall, abdomen, neck and genitals.), and morbid obesity. Record Review of Resident #63's quarterly MDS assessment, dated 7/25/24, reflected Resident #63 cognition was fully intact for daily decision making. Record review of Resident #63's care plan did was updated on 6/25/24 to include Resident was on diuretic therapy for lymphedema with intervention to administer medication as ordered and monitor Dose. May require modification to achieve desired effects while minimizing adverse consequences, especially when multiple antihypertensives are prescribed simultaneously. When discontinuing, gradual tapering may be required to avoid adverse consequences caused by abrupt cessation. Record review of Resident #63's physician orders, dated 7/25/24, revealed the following: - ascorbate calcium (vitamin c) 500 mg tablet by mouth for pressure ulcer of right buttock, stage 2 once a day at 9:00 a.m. with a start date of 3/1/24 and no end date. -clopidogrel 75 mg 1 tablet by mouth daily at 9:00 a.m., with a start date of 9/28/24 and no end date. - cyanocobalamin 1,000 mcg tablet by mouth at 9:00 a.m. for anemia with a start date of 2/28/24, and no end date. (continued on next page)

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 07/26/2024
NAME OF PROVIDER OR SUPPLIER Sunrise Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- daily multi-vitamin tablet by mouth once daily for pressure ulcer of right buttock, stage 2 at 9:00 a.m. with a start date of 3/1/24 and no end date. -gabapentin 300mg tablet by mouth three time a day at 9:00 a.m., 2:00 p.m., and 8:00 p.m. for other idiopathic peripheral autonomic neuropathy with a start date of 7/10/24 and no end date. -iron 325 mg tablet by mouth daily at 9:00 a.m. for anemia with a start date of 7/19/24 and no end date. -sucralfate 1 gram tablet by mouth four time a day at 8:00 a.m., 12:0 p.m. , 4:00 p.m., and 8:00 p.m. for gastro-esophageal reflux disease without esophagitis with a start date of 7/10/24 and no end date. -bumetanide 1 mg 2 tablets by mouth daily at 9:00 a.m. for lymphedema. Hold is systolic blood pressure is less than 90. A start date of 4/17/24 and no end date. During an observation on 7/23/24 at 10:37 a.m. LVN F took Resident #63 blood pressure and it read as 108/58 and pulse of 68. LVN F then administered Resident #63's ascorbate calcium, cyanocobalamin, daily multivitamin, gabapentin, iron, and bumetanide. 2 hours and 37 minutes after the order time a.m. ordered times and 1 hour and 37 minutes after the 9 a.m. order times. LVN F did not administer Resident #63's bumetanide. 3. Record Review of Resident #79's Admission record, dated 7/25/24, revealed a [AGE] year-old male admitted on [DATE] with diagnoses including depression, hypertension, cerebral infarction, and need for assistance with personal care. Record Review of Resident #79's quarterly MDS assessment, dated 6/24/24, reflected Resident #79's cognition was intact for daily decision making. Record review of Resident #79's care plan did was reviewed last on 6/27/24 did not reflect the resident had depression. Record review of Resident #79's physician order, dated 7/25/24, revealed the following: -sertraline 50 mg tablet by mouth daily at 9:00 a.m. for major depressive disorder single episode, with a start date of 7/17/24 and no end date. During an observation on 7/24/24 at 9:26 a.m. MA G administered 10 mg of sertraline to Resident #79. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/24 at 4:13 p.m. LVN F stated the facility policy was to administer medications one hour before and one hour after the scheduled time on the order. LVN F stated if there was a nurse available, he could have asked them for help, but he did not because everyone was busy. LVN F stated he normally worked the night shift but was asked to come in and help administer medications. LVN F stated he held Resident #63's blood pressure medication because he misread the order. LVN F stated he thought the parameters were for the resident pulse to be above 90 bpm and not the systolic blood pressure to be below 90 mmhg, so he held the medication. LVN F stated if residents received their medications late, they were at risk for example if it was anxiety medication, they would have increased anxiety. LVN F stated holding resident #63's bumetanide could have increased her blood pressure and could lead to a heart attack. During an interview on 7/26/24 at 10:09 a.m. the DON stated staff to administer medications one hour before and one hour after the scheduled time. The DON stated the LVN should have passed the hardest hall medications first then gone to the easy hall. The DON stated LVN F does not normally pass medications on day shift. The DON did not provide a statement for Resident #63's medication that was held. The DON stated other staff is not usually behind on medication pass and it was not an issue the facility normally had. Record review of the facility's policy titled Medication - Administration, dated 12/2017, stated POLICY It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations. PROCEDURE . 8. Medications are administered within 60 minutes of scheduled time, unless otherwise specified by the physician.

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 07/26/2024

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41095 Based on interviews and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required. The Dietary Manager (DM) did not have the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services. This deficient practice could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition. The findings included: Record review of the DM's personnel file revealed the hire date for the DM was 10/02/23. Further review of this personnel file, which included the DM's resume, did not reveal the DM was: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Had similar national certification for food service management and safety from a national certifying body; or (D) Had an associate's or higher degree in food service management or in hospitality; or (E) had completed a course of study in food safety management that included topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving. The resume did indicate he had worked as an assistant DM in 4 other nursing facilities beginning in 2014. Record review of the DM's certification documentation provided by the facility revealed the DM successfully completed the Texas Food Safety Manager Certification Examination, effective 10/08/23, expiration date 5 years from the effective date. Record review of the facility employee files revealed the facility's RD was contracted and not a full-time employee of the facility. Interview with DM on 07/25/24 at 11:40 am revealed he had taken a short 4 hour course prior to taking the Texas Food Manager Exam. The DM stated he had not had any other dietary manager courses and was not aware he needed to be nationally certified. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 1-201.10.10(B) Accredited Program. (1) Accredited program means a food protection manager certification program that has been evaluated and listed by an accrediting agency as conforming to national standards for organizations that certify individuals. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2-102.12.

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F 0805

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41095

Based on observations, interviews and record reviews, the facility failed to ensure provided food was prepared in the proper form to meet residents needs for 1 of 6 residents reviewed, (Resident #1), reviewed for food form.

On 7/21/24 the facility failed to ensure Resident #1 was given the correct physician-ordered diet texture of a meal which led to choking.

An IJ was identified on 07/22/24. The IJ template was provided to the facility on [DATE] at 7:07 pm. While the IJ was removed on 07/26/24 the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.

This failure could place residents at risk of choking, decline in health and death.

Findings include:

Record review of Resident #1's Admission Record documented a [AGE] year-old female first admitted to facility on 09/26/06 with latest admission on 08/17/14. Resident #1's diagnoses included Alzheimer's Disease, aphasia following cerebral infarction, dysphagia following cerebral infarction, contracture of muscle, right lower leg, and Type 2 diabetes mellitus without complications.

Record review of Resident #1's Physician's Orders dated 06/25/24 - 07/25/24 revealed she had an order for a regular diet with puree texture and nectar thickened liquids with meals. The orders also included snacks BID (pudding, yogurt, applesauce, or other pureed snack).

Record review of Progress Note dated 07/21/24 revealed that Resident #1 was served a regular mech soft diet instead of pureed/nectar liquids, spoon fed by CNA 100%. Resident started vomiting, face flushed. Nurse on unit performed Heimlich maneuver, called ADON, DON, on call PA, and family member. PA ordered stat chest x-ray, monitor O2 frequently during night. X-ray ordered. Vital signs indicated that oxygen was 93% during the event and 98% about an hour later.

Record review of Progress Note dated 07/22/24 at 4:48 pm revealed Resident awake and alert. Spoon fed pureed diet as ordered. No s/s of SOB, cough or congestion. X-ray results were negative for aspiration, no Cardio Pulmonary abnormalities. MD made aware.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/22/4 at 1:02 pm with CNA A, it was revealed that CNA B, an agency aide, was assigned to work Hall 300 after having been originally oriented to Halls 100 and 200 earlier in the day. CNA A went to the dining room to assist with the supper meal. When it was discovered that Resident #1 was not in the dining room, CNA A brought Resident #1's tray to the resident's room to give to CNA B. CNA B told CNA A that she had already fed Resident #1. CNA A then realized that CNA B had given Resident #1's roommate's tray to her which was mechanical soft. CNA A then noticed that Resident #1 had bubbles coming out of her mouth. CNA A told charge nurse LVN C who was in the dining room that Resident #1 was having trouble and LVN C told CNA A to get LVN D who was also on the hall as a Med Nurse. LVN D then went to the room and found Resident #1 to be red and choking and did the Heimlich maneuver. CNA A stated she went to get the crash cart and brought it to the room but it was not needed. CNA A stated that Resident #1's tray should have been on the hall tray cart since she normally eats in the dining room for breakfast and lunch and then goes back to bed. Resident #1's roommate, Resident #48, ate either in the dining room or in her room depending on whether or not her family was visiting. On this date, the family was in the dining room with Resident #48. Since her tray had gone to the hall, the dietary department just made her another plate. CNA A stated they try to tell the kitchen whether the residents will eat in the dining room or in their rooms so the trays can be placed on the correct cart. During an interview with LVN D on 07/22/24 at 1:40 pm, it was revealed that she was serving as a Medication Aide on 300 and 400 Halls. LVN D stated that CNA A came and told her that she was needed in Resident #1's room since it appeared she may be choking. LVN D stated, I saw that she was red so I did the Heimlich maneuver and did a finger sweep in her mouth and got some broccoli out. LVN D stated she then relieved LVN C so LVN C could call the doctor, get an order for an x-ray and call the family. LVN D stated that her color came back to normal and her vital signs were good. LVN D stated she was coughing a little. LVN D stated that Resident #1 sometimes eats in the dining room but if she has been up all day she will be put back to bed and eat in her room. LVN D stated that Resident #48 usually sleeps until 1:00 pm and then she usually eats in the dining room or may eat in her room if her family comes and wants to feed her there. LVN D stated that Resident #1 needed total assistance to eat since she was contracted on her right side. LVN D stated she had never seen the agency CNA B in the facility before. LVN D stated that CNAs usually do a walk around to orient agency aides. She said that CNA B left right after this incident since it was at the end of the shift. During a telephone interview with CNA B on 07/22/24 at 2:00 pm, she stated that the nurse checked the trays and told her that they were all correct and to hand them out. She said she did not get any orientation on the residents on that hall since she had originally been placed on the other side of the facility. CNA B also stated she had never worked in the facility before so did not know any of the residents. CNA B stated she just looked at the room number and did not know which was the A bed or B bed. Since Resident #1 was in the room, she fed her the tray with that room number on it. CNA B also said she fed most of the tray which consisted of noodles and some other things but no vegetables. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During the interview with LVN C on 07/24/24 at 3:20 pm, she explained the sequence of events for the incident with Resident #1. LVN C stated the hall trays came to the unit and I checked all the trays. The agency CNA B came out of a room and I told her I was going to the dining room. In the dining room, I saw that Resident #48's tray didn't come out on the dining room cart so I asked CNA A to go get her tray from the cart on the hall. Resident #48's family brought her to the dining room. LVN C then stated that she didn't know if Resident #48's family was going to feed her in the dining room or in her room prior to her going to the dining room. Resident #1's tray was on the dining room cart. LVN C stated that when CNA A returned to the dining room CNA A told her about the mixed-up trays so they ordered another tray for Resident #48. LVN C stated that is also when CNA A told her about Resident #1 getting the wrong tray and having issues. LVN C told CNA A to go get LVN D to either assist Resident #1 or come to the dining room so she could go and assist Resident #1. LVN C stated that LVN D took care of the situation with Resident #1 and when she was finished in the dining room she called the doctor and the family. LVN C stated she took Resident #1's vital signs and the oxygen came back up to 95% and by the time she left around 7:00 pm the oxygen level was at 98% and resident was back to normal. A review of the menu on 7/21/24 revealed turkey tetrazzini, broccoli florets, breadstick and mandarin oranges. Interview on 7/22/24 at 4:17 pm with the DON revealed an agency CNA passed the trays. CNA B got the A bed and B bed mixed up. Resident #1 did not get the correct diet and started choking. LVN D performed the Heimlich maneuver. The DON stated, When possible, the agency aides will not pass hall trays; they should be assigned to the dining room since facility nurses are always in the dining room. The DON stated, We are inservicing staff on this now. The DON further stated that after the incident with Resident #1, her oxygen level was 93% and that should have been fine. The DON also stated that Resident #1's x-ray was clear. Facility's policy titled Meal Service-Nursing Responsibilities, dated 12/2017, stated .Nursing Services associates will follow these guidelines regarding meal service: 1. Distribute food trays to residents in resident rooms, dining rooms, and ancillary dining rooms. 2. Trays will be passed in a timely manner. Food must remain covered while being distributed through the hallways and tray cards should remain with trays throughout meal service .14. A licensed member of the nursing staff must check meals trays for accuracy, and be present in the dining room during the entire meal service. The Administrator was notified of the IJ situation on 07/22/24 at 7:07 pm due to the above failures and a template was given. On 07/23/24 at 1:43 pm the POR was accepted. It was documented as follows: 7/22/2024 [Facility] Plan of Removal - F 805 Immediate Action Taken (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident Specific Resident # 1 will receive the appropriate physician ordered diet for all meals going forward. Resident # 1 has had a chest x ray. The results reveal no negative outcome to her lungs. Resident # 1's physician who is also the medical director has been notified both of the incident and the IJ status at the facility. System Changes Starting on 7/22/2024 at 11:20 am a facility audit took place to ensure that all residents requiring modified texture diets for meals will receive their meals in the appropriate texture. Starting on 7/22/2024 at 1:00 pm DON and the dietary consultant audited all residents who require their diet to be served in an altered texture for meals to ensure that their meal tickets reflect the residents individual needs regarding texture with food in accordance with physician's diet orders. * Starting on 7/22/2024 and ongoing there will be a 3 part system to ensure that all diets are served with the correct texture to include the following: * The dietary department designee will check all meals coming from dietary to compare the ticket with what is actually being served on the tray/plate. * The nurse in the dining room will check all meals coming from dietary to compare the ticket with what is actually being served on the tray/plate. * The nurse on the hall will check all meals coming from dietary to compare the ticket with what is actually being served on the tray/plate. Starting on 7/22/2024 and ongoing the DON will monitor two meals daily x 5 days a week to ensure staff compliance with ensuring that all meals/trays have the appropriate texture that matches the meal ticket and the physician ordered diet. Starting on 7/22/2024 and ongoing residents meal texture statuses will be audited upon admission, change of condition, appropriate mds cycles and or anytime necessary. Starting on 7/22/2024 at 11:00 am the facility's mechanism for ensuring correct diet texture for the residents is that all trays will be compared to the actual plated meal for the resident by a licensed staff member prior to being served to the resident. The printed meal ticket will be compared to the tray/plate for accuracy. Education (continued on next page)

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F 0805

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

Starting on 7/22/2024 at 12:30 pm the Assistant Director of Nursing provided education to all staff regarding residents requiring specially textured meals to ensure those residents will receive the appropriately textured meal at all times. Staff on future shifts will be educated prior to taking the floor. This will be accomplished by having a designated staff member in the building for that purpose and with that specific assignment. Licensed staff will be assigned by the DON to ensure that all trays/plates are correct prior to being served to the residents. Diet orders will match correctly to what is being served to the residents. This assigned licensed staff member will ensure specifically that the texture of all resident meals matches the physician ordered diet.

Starting on 7/22/2024 at 12:00 pm the Regional Clinical Consultant provided education to Administrator and Director of Nursing regarding residents requiring specially textured diets for meals.

Starting on 7/22/2024 at 12:00 pm the regional clinical consultant will be responsible for ensuring that staff receive the inservice/training regarding residents requiring specially textured food for meals.

Starting on 7/22/2024 the residents dietary food texture status will be communicated to facility staff directly by the DON and ADON. This process will be accomplished through photo copy and or written communication.

Starting on 7/22/2024 the DON or their designee will be responsible for ensuring that the residents who require specially textured diets receive their food with the appropriate texture according to the physician's ordered diet.

Starting on 7/23/2024 at 9:00 am during the daily stand up process all recommendations and orders will be audited by the clinical team in consultation with the dietary supervisor to ensure compliance and follow up for all residents with orders and recommendations. The clinical consultant will review orders and recommendations daily x 4 weeks as a tool for oversight to ensure compliance.

Starting on 7/22/24 at 11:00 am staff have bee re educated to identify the resident's diet by room number and bed designation of A or B.

100% Staff education compliance for those who may serve food to a resident will be completed by 3:00 pm 7/23/24.

On 7/26/24 the surveyor confirmed the facility implemented their plan of removal (POR) sufficiently to remove the IJ by:

During the interview on 07/24/24 at 3:20 pm, LVN C stated she was called for the inservice following the IJ. LVN C stated they are going to put A and B on the doors beside the residents' names and we are not going to let agency CNAs pass trays on the halls. Agency CNAs will only pass trays in the dining room. LVN C stated when she was in the dining room she would check each tray and give it to the aide to pass to the resident. LVN C also stated she helped feed residents in the dining room.

Record review of the facility staff list indicated there were a total of 71 staff members and 5 contracted therapists who work full time in the facility.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review in-service documentation dated 7/22/24 indicated 71 staff members and 5 contracted therapists had been inserviced either in person or by phone on the new procedures which included adding the letters A and B beside each resident name on the doors to indicate bed position in the room whereby the A bed was closest to the door and the B bed was closest to the window. The procedure also includes having only full time staff pass trays in the halls. Agency staff will pass trays in the dining room along with a full time nurse. No agency staff will pass trays without assistance from full time staff members. The charge nurse will check all trays to ensure the meal ticket matches the meal texture, specialized utensils, and liquid texture on the plate prior to its distribution to the resident. Record review of documentation dated 7/23/24 showing the DON had contacted the staffing agencies used by facility and had them place a copy of the inservice on their paperwork for agency staff who may come to work in the facility. Interviews beginning at 4:13 pm on 07/24/24 through 6:00 pm on 07/25/24 with 20 staff members and 1 contract therapist revealed their understanding of the new procedures which included adding the letters A and B beside each resident name on the doors to indicate bed position in the room whereby the A bed was closest to the door and the B bed was closest to the window. The procedure also included having only full time staff pass trays in the halls. Agency staff will only pass trays in the dining room along with a full time nurse. No agency staff will pass trays without assistance from full time staff members. The charge nurse will check all trays to ensure the meal ticket matches the meal texture, specialized utensils, and liquid texture on the plate prior to its distribution to the resident. Interviews with 3 dietary staff and 1 DM on 07/25/24 at 11:30 am, revealed their understanding of the above procedure. Additionally, the dietary staff had highlighted residents who had pureed diets on the meal ticket and had written the word Pureed in yellow highlighter. Observation of Resident #1 on 07/25/24 at 11:45 am revealed the resident was being fed a pureed diet with nectar thickened liquids according to meal ticket and physician orders. Record review of Resident #1's chest x-ray indicated no abnormalities. Record review review of documentation that medical director who was the attending physician for Resident #1 had been notified of the incident and IJ status. Record review and interview with DON and ADON on 07/25/24 at 2:00 pm, provided meal audit forms and identified room/bed changes. Interview with DON revealed she and the Dietary Consultant had audited residents who required altered texture for meals by comparing the facility EHR system with the dietary electronic system to ensure that all diet textures matched on 07/22/24 at 1:00 pm. Record review of dietary audits provided. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation of meal tickets and interview with dietary staff on 07/25/24 at 11:30 am revealed that room numbers with A or B and pureed textures had been highlighted for all residents requiring specialized texture with the highlighted word Pureed on the ticket. Meal tickets also contained the resident's room number with bed designation of A or B. The Dietary Manager (DM) revealed they are doing this on all meal tickets going forward. Observed nurse in dining room on 07/25/24 at 12:10 pm checking meals coming from dietary to compare ticket with what is being served on plate. Observed nurse on hall checking trays and tickets on hall carts on 07/25/24 at 11:45 pm. Interview with DON on 07/25/24 at 10:00 am revealed she was monitoring the nurses for breakfast and lunch to ensure they are checking trays and ADON is monitoring nurses for supper meal. On weekends the charge nurse will monitor. Record review of audit sheets completed. Interview with DON on 07/25/24 at 10:00 am revealed the DON will monitor meals 2 meals per day 5 times per week. The DON reported that she will continue to monitor meals and once compliance was achieved over a 30 day period, they will do random checks twice a week. Observed the DON in dining room during lunch beginning at 12:15 pm on 07/22/24, 07/24/24, and 07/25/ 24. Interview with the DON on 07/25/24 at 10:00 am stated during their facility Clinical Meeting, dietary textures will be audited and monitored. Interview with the ADON on 07/25/24 at 10:00 am stated during the Care Plan meetings diet changes will be discussed and monitored. Interview with DON on 07/25/24 at 10:00 am, the DON stated mechanism to ensure correct diet texture was included in staff education. Observation of resident room doors on 07/25/24 at 9:00 am revealed A and B had been added to the end of each resident name to indicate their designated bed assignment. While the IJ was removed on 07/26/24 the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview, and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 6 residents (Resident #2 and Resident #138) reviewed for hospice services, in that: 1. The facility failed to ensure Resident #2's most recent Physician Certification of Terminal Illness and Hospice election form were completed and part of the hospice documents. 2. The facility failed to ensure Resident #138's Physician Certification of Terminal Illness was completed, the most recent plan of care was available at the facility, and hospice physician orders were available and at the facility. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. The findings were: 1. Record review of Resident #2's quarterly MDS, dated [DATE], revealed a [AGE] year-old female was readmitted to the facility on [DATE] and initially admitted on [DATE] with diagnosis of dementia, depression, and atrial fibrillation. The MDS indicated the resident's cognition was severely impaired for daily decision making and received hospice services. Record review of form 3071 titled Individual Election/Cancellation/Update, dated 02/2023, showed the form was completed on 3/21/24 for Resident #2. Numbers 1, 2, 3, 4, 5, 6, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24, indicated the date range, the Medicaid number, Social Security number, all terminal diagnoses, the Hospice name, the attending physician name, the license number, and the date of order were blank. Record review of the 3074 Physician certification and recertification of the terminal illness form was not found for Resident #2. During an interview on 7/23/24 4:30 p.m. the Regional Consultant stated the 3071 form for Resident #2 was not completely filled out and needed to be. The Regional Consultant stated the form 3074 for the physician certification of terminal illness was not fill out and was not necessary to be completed. The Regional Consultant stated the 3074 form was only needed 6 months after the initial 3071 hospice election form was completed to recertify the terminal illness. (continued on next page)

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	07/26/2024

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #138's face sheet dated 7/23/2024, revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included, metabolic encephalopathy, pressure ulcer of sacral region stage 4, unspecified hydronephrosis, acute kidney injury, acute cystitis with hematuria, and cognitive communication deficit (a difficulty with communication that is caused by a problem with thinking). Record review of Resident #138's care plan, revised 07/16/2024, revealed the resident required hospice as evidenced by terminal illness of: senile degeneration of the brain with interventions to assist with ADL's and provide comfort measures as indicated, communicate with Hospice when any changes are indicated in residents plan of care, and ensure facility and hospice agency are aware of the others responsibilities. Another problem area Resident #138 was at risk for unavoidable significant decline and is on Hospice with interventions to Collaborate with Hospice regarding Resident #138's care. Discuss the options of Hospice with Resident #138 and RP. Notify Hospice and physician for changes in condition if noted report to nurse, and to Hospice. Resident #138/RP has elected Hospice. Record review of Resident #138's significant change, dated 7/7/24, revealed his cognition was severely impaired for daily decision making and received hospice services. Record review of Resident #138's physician order summary dated 7/23/24 revealed orders to admit to hospice with a start date of 5/5/24 and no end date. During an interview on 7/25/24 at 3:39 p.m. The DON stated they had to get in touch with hospice because they did not have the orders or the plan of care for Resident #138. During an interview on 7/23/24 4:27 p.m. the Regional Consultant stated Resident #138's form 3074 for the physicians certification of terminal illness was missing and she needed to get in touch with the hospice company to get one filled out. Interview on 7/25/24 at 5:22 p.m. the facility was asked for the hospice policy. The policy was not provided prior to exit.

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 07/26/2024
NAME OF PROVIDER OR SUPPLIER: Sunrise Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections for 2 of 8 residents care (Resident #74 and Resident #81) reviewed for infection control, in that: 1. The facility failed to ensure Resident #74's fall mat was clean. 2. The facility failed to ensure LVN E performed hand hygiene between glove changes while administering Resident #81's bolus tube feeding. These deficient practices could place residents at-risk for infections. The findings included: 1. Record Review of Resident #74's Admission record, dated 7/26/24, revealed a [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy, pressure ulcer of the sacral region, urinary tract infection, need for assistance with personal care, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Record Review of Resident #74's discharge MDS assessment, dated 6/30/24, reflected Resident #74 cognition was severely impaired for daily decision making. Record review of Resident #74's care plan, revised 07/25/2024, revealed a problem area stated Resident #74 liked to climb out of his bed onto his floor mats with interventions to encourage resident to use the call light for assistance and frequent rounding when Resident #74 was in bed. During an observation on 7/21/24 at 10:39 a.m. Resident #74 was lying in bed. The fall mat next to the bed had multiple visible stains and spots, the stains were dispersed across the surface of the mat. The fall mat was light gray, and the spot and stains were dark brown or black. The resident was not able to be interviewed. During an interview and observation on 7/26/24 the Administrator stated she could not be certain if the spots on the mat were dirty because staff could have tried to clean it but it was stained. The Administrator went to observe the mat in the resident's room and stated the mat was cleaned on one side now and stated maybe the mat was flipped over. The Administrator turned the mat over and one large stain was observed. The Administrator stated she did not think the mat was dirty. The Administrator stated the mat could have been placed against the wall and had something spilled on it then. 2. During an observation on 7/25/24 at 2:55 p.m. LVN E set up a bolus feeding for Resident #81 through a gastric tube. LVN E removed her gloves twice and put on new gloves twice during the feeding. LVN E did not sanitize her hands after removing her gloves. (continued on next page)

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 07/26/2024
NAME OF PROVIDER OR SUPPLIER Sunrise Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Briggs St San Antonio, TX 78224	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 3:04 p.m. LVN E stated she was pulled from her assigned hallway to provide the tube feeding to the resident. LVN E stated she did not have her normal supplies since it was not her assigned hallway and forgot to get hand sanitizer. LVN E stated she was supposed to perform hand hygiene between glove changes to kill germs she came in contact with and prevent infection to the resident. Record review of the facility's policy titled Infection control precautions categories and notices, dated 12/2017, stated policy, it is the policy of this home to assure that appropriate precautions will be established ensure that necessary isolation techniques are implemented. c. Gloves and hand washing, during the course of caring for a resident, change gloves after having contact with infected material and may contain high concentrations of microorganisms . remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or a wireless antiseptic agent, after glove removal and hand washing ensure that hands do not touch potentially contaminated environmental surfaces .f. resident care equipment, when possible, dedicate the use of potential non critical patient care equipment items such as a stethoscope, . use of common items is unavoidable, then adequately clean and disinfect them before use for another resident . 2. Ensure PPE and alcohol based hand rub are readily accessible to staff. Record review of the facility's policy titled Enteral and Parenteral feeding- Documentation orders and Nutrition, dated 12/2017, stated it is the policy of this home that intro or parental nutrition will not be utilized unless clinically unavoidable. The resident, who utilizes enteral or parental nutrition will be free, to the extent possible, from complications related to enteral and parental nutrition .12. Standard precautions, clean techniques, applicable nursing policies, and manufacturers recommendation are followed by nursing personnel when dealing with nutritional support residents.

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 07/26/2024

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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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for one of one laundry room reviewed for environment. The facility failed to properly dispose and maintain the lint accumulation in the facility dryers in a timely manner. This failure could put residents at risk for an unsafe and unsanitary environment. Findings included: Observation on 7/25/24 at 10:50 AM of facility's laundry room revealed there were three (3) dryers that were in use at that time. Observation of the lint collector area beneath two (2) dryers revealed a layer of thick lint about 1 inch thick accumulated on the top of lint trap and some lint at the bottom of the dryers. Interview on 7/25/24 at 11:50 AM with the laundry aide stated there was no laundry log for tracking cleaning the laundry lint traps. The [NAME] aide stated she last cleaned the lint traps at 6:00 a.m. that morning. The Laundry aide stated she is supposed to clean them after every two loads, at the start of her shift, and at the end of her shift. The [NAME] aide stated she had a headache from the laundry room being so hot since she had to keep the doors closed. The Laundry aide stated it had been about 4-5 loads since she last cleaned the lint raps because she was busy delivering clothes all morning. The laundry aide stated she had been drying blankets in the last dryer and it caused more lint build up. The laundry aide stated there was a risk of fire if they were not cleaned regularly. Interview on 7/25/24 at 12:07 PM with the Laundry/Housekeeping Supervisor revealed the lint trap should be cleaned every 2-3 loads and at the end of the night. The supervisor stated there was a risk of fire if they were not cleaned. The supervisor stated the facility did not have a log to track when the lint trap was cleaned for each dryer. Interview on 7/25/24 at 5:45 PM with the Administrator stated she personally went to the laundry room to inspect the lint traps and they were clean. The Administrator stated the laundry aide had kept them clean. The Administrator stated staff was expected to clean the lint trap every 2 hours or after 2 loads. The Administrator stated the laundry aide had only done 2 loads and had clean the dryer lint traps prior. The Administrator stated the facility did not have a log or written policy for cleaning the dryer lint traps. A laundry policy was requested and not provided.