STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676378	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sorrento	2739 Babcock San Antonio, TX 78229

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview, and record review, the facility failed to ensure residents were permitted to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility and failed to ensure a resident was not transferred or discharged while the appeal was pending for 1 of 3 residents (Resident #3) reviewed for discharges, in that: The facility failed to wait to transfer Resident #3 to another facility until he was out of Medicaid pending status. These failures could result in residents being discharged without appropriate notice and while they were waiting for approval from Medicaid could place residents at risk being discharged against their wishes. The findings were: Record review of Resident #3's face sheet dated 4/04/2024 revealed an admitted [DATE] with diagnoses which included: heart failure, type 2 diabetes mellitus and generalized osteo-arthritis and a discharge date of [DATE]. Record review of Resident #3's comprehensive care plan dated 4/20/2024 revealed there was no plan of care. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS of 12 which indicated a moderate cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Nursing Home Transfer and Discharge Notice dated 3/08/2024 revealed the resident was given a notice to discharge to his home address by 4/07/2024 for an unpaid balance. The notice did not include the email or address of State Long-Term Care Ombudsman, or the phone number and email address of the office of Texas Health and Human Services in order to file the appeal and the notice did not include instructions or information or how to obtain an appeal form or information about assistance with completing and submitting the appeal form. The notice also did not include information that if the resident requested a hearing before the discharge date , the resident had the right to remain in the facility until the hearing officer made the final determination. Resident #3 stated the facility told him he could apply for Medicaid. He stated he filled out the application, gave the facility all the required documents including information about his home and bank information. He stated no one ever got back with him with the results of the application. He stated he was very frustrated. He stated he had wanted to stay at the facility but after months of not getting any information about his application he finally agreed to the transfer. During an interview on 4/05/2024 at 1:28 p.m., Resident #3 stated the nursing facility had transferred him to another nursing home in March 2024. He stated he originally went into the nursing facility after a fall at home, a hospital stay and wound which left him in need of therapy services. He stated he had completed therapy services; his wound had healed but he still did not have any strength and was wheelchair bound and could not clean or wipe himself. He stated his ultimate goal was to go home but right now he could not take care of himself. Resident #3 stated he was given a 30-day discharge and that said they wanted him out by 4/07/2024. He stated he spoke to the Ombudsman about the discharge notice who advised him not to worry about the notice and that the facility could not just kick him out. Resident #3 stated he was transferred to the new facility almost immediately after the conversation with the Ombudsman. He stated no one discussed anything about anything when asked if he understood his right to appeal. During an interview on 4/04/2024 at 4:29 p.m. the Financial Manager stated he had not reviewed the facility policy for discharges. He stated Resident #3 was Medicaid pending but according to the MDS Coordinator C did not meet medical necessity. He stated medical necessity was determined by the MDS Coordinator C. He stated because the MDS Coordinator C determined there was no medical necessity the applications for required to show medical necessity were never sent to Medicaid as required. The Finance Manager stated he didn't completely understand how medical necessity worked. He stated he thought medical necessity forms needed to be sent by the MDS Coordinator C. He stated he asked the MDS Coordinator C what was going on with the applications and she just said Residents #3 did not meet medical necessity. The Financial Manager stated he was the person responsible for the Medicaid applications. He stated he has not sent the financial portion into Medicaid because the MDS Coordinator C had not sent in the medical necessity portion. The Financial Manager stated Resident #3 was transferred to another facility before they determined he did not meet medical necessity but while he was Medicaid pending. He stated Resident #3 was transferred on 3/13/2024. During an interview on 4/04/2024 at 4:50 p.m., the Social Worker (SW) stated she started working at the facility on 1/08/2024. The SW stated she was aware a new discharge notice was issued to Resident #3 with a discharge date of [DATE]. The SW stated she had not spoken to Resident #3 about the discharge notices or right to appeal. The SW stated the MDS Coordinator C said Resident #3 did not meet medical necessity. The SW stated they sent Resident #3 to another facility where he received Medicaid. She stated, she wondered how the new facility was able to obtain medical necessity when they were not, but they new facility accepted him Medicaid pending. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/04/2024 at 5:37 p.m., the MDS Coordinator C stated she had worked at the facility since 2017 as the MDS coordinator C. She stated she had been a MDS Coordinator C for a long time at another facility. She stated she received her training from a DON at the other facility, whom she felt taught her very well. She stated, to determine medical necessity, she looked at the resident's diagnoses, their BIMS score, if they had any visual impairment, neuropathy, or if they were unable to draw up insulin in a syringe. She said then she will tell her boss if the resident meets medical necessity or not. The MDS Coordinator C stated her boss was the Administrator. She stated she knew from her experience what will be accepted and what will not. She stated she had to paint picture and send that picture of the resident (figuratively) online on why the resident needed to be at the facility. The MDS Coordinator C stated Resident #3 came to the facility as a skilled patient and had wounds when he was admitted . She stated he also had a BIMS of 12 which to her meant he had borderline cognitive impairment. She stated a BIMS of 11 or higher would not meet medical necessity. She stated she knew his medical necessity was iffy. The MDS Coordinator C stated if a resident had wounds and a low BIMS score, she could get medical necessity, but his wounds had resolved. The MDS Coordinator C stated Medicaid did not care if someone was completely bedbound, used a wheelchair or what level of care they required for activities of daily living. She stated they required necessity of a skilled nurse 24/7 (24 hours a day, 7 days a week). The MDS Coordinator C stated she will also look to see if the resident is PASRR positive or had a mental disability that put them in harm's way. She stated she would ask the nurses if the resident was able to identify their pills and if they knew what their pills do. The MDS Coordinator C stated she looked at all of this information and determined the residents did not meet medical necessity. She stated for Resident #3 it was because his wounds had healed. The MDS Coordinator C stated she informed her boss Resident #3 met medical necessity and they replied nonchalantly, ok. During an interview on 4/05/2024 at 12:54 p.m., the Ombudsman stated she was unable to talk about the discharges of Resident #3 at the time of the call. She stated she would return the call later in the day. No return call was received prior to exit. During an interview on 4/05/2024 at 1:18 p.m., with the MDS Coordinator B at the facility who received Resident #3 on 3/13/2024 stated their facility received Resident #3 as Medicaid pending and he received certification/approval for Medicaid on 3/28/2024. She stated Resident #3 had a fluctuating BIMS which at times could be as high as 15. She stated at their facility they work directly with the BOM to qualify someone for Medicaid. She stated the SW was also involved and they had financial meetings for anyone who wanted to stay in the facility long term. She stated for medical necessity she assessed the resident to see if they could open their own pill bottles and administer their own medications. She stated she also looked at hearing and visual impairments, reviewed their diagnoses, BIMS, and medications. She stated a high BIMS does not automatically disqualify a resident from meeting medical necessity. She stated Resident #3 took the medication coumadin and was not safe to recognize the dangers and make the adjustments, or monitor labs for his diagnoses. She stated bed-bound status will not qualify for medical necessity but if the resident was bed bound it was likely they would not be able to manage their medications. She stated it was not hard to meet medical necessity. She stated at their facility if they were not comfortable with being able to obtain medical necessity for the resident, they sent their application to Corporate for review. She stated they tried to do what was best to meet the needs of the resident. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/05/2024 at 2:09 p.m., the Administrator stated he was new to the facility as of 3/25/2024. He stated the facility did not have a policy for Medicaid applications, or application assistance or Medicaid pending residents and he had not reviewed the facility policy on discharges. Record review of a facility policy, titled Transfer or Discharge, Facility-Initiated dated October 2022 revealed: 1. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: e. the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility 1. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. 2. Transfer and discharges includes movement of a resident .b. discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or another location in the community, when return to the original facility is not expected. 2. In some cases residents are admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation program, they communicate that they are not ready to leave the facility. In these situations, if the facility proceeds with discharge, it is considered a facility-initiated discharge.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to ensure 30-day discharge notices included a statement of the resident's right to appeal which included the name, address (mailing and email), and telephone number of the entity which receives such requests: and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request and name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman for 3 of 3 residents (Resident's #1, #2, and #3) reviewed for discharge. The facility failed to include in 30-day discharge notices to Resident's #1, #2, and #3 the email or address for the State Long-Term Care Ombudsman or the email address and phone number of the agency in which to file an appeal or instructions or information on how to file the appeal. These failures could affect residents by placing them at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and the appeal processes. The findings included: 1. Record review of Resident #1's face sheet dated 4/04/2024 revealed an admitted [DATE] with diagnoses which included: type 2 diabetes mellitus with complications, end stage renal disease, hypotension of hemodialysis and dependance on renal dialysis. Record review of Resident #1's comprehensive care plan initialized on 2/19/2023 revealed there was no plan of care for the resident's discharge or goals for discharge. Record review of Resident #1's annual MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated a moderate cognitive impairment. Record review of Resident #1's Nursing Home Transfer and Discharge Notice dated 3/08/2024 revealed the resident was given a notice to discharge to her home address by 4/07/2024 for an unpaid balance. The notice did not include the email or address of State Long-Term Care Ombudsman, or the phone number and email address of the office of Texas health and Human Services in order to file the appeal and the notice did not include instructions or information or how to obtain an appeal form or information about assistance with completing and submitting the appeal form. The notice also did not include information that if the resident requested a hearing before the discharge date , the resident had the right to remain in the facility until the hearing officer made the final determination. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/04/2024 at 2:18 p.m., Resident #1 stated her goals were to remain in the facility long term as she had been placed in the facility by APS. She stated before coming to the facility she had fallen and could not get up. She stated she had advised the facility that she was not leaving because she was a renal patient that needed help with getting up in the morning and taking care of basic needs. She stated she had received a 30-day discharge letter previously (date unknown) and then one in March 2024 which told her she had to leave by April 2024. She stated she had spoken to the Ombudsman about the previous discharge because she wanted to appeal., but nothing had come from the encounter. She stated she did not appeal to the Ombudsman this time because nothing was done to help her. 2. Record Review of Resident #2's face sheet dated 4/04/2024 revealed an admitted [DATE] with diagnoses which included: obstructive and reflux uropathy, noninfective gastroenteritis and colitis, and chronic kidney disease. Record review of Resident #2's comprehensive care plan initiated on 8/29/2023 revealed there was no plan of care for the resident's discharge or goals for discharge. Record review of Resident #2's Nursing Home Transfer and Discharge Notice dated 3/08/2024 revealed the resident was given a notice to discharge to her home address by 4/07/2024 for an unpaid balance. The notice did not include the email or address of State Long-Term Care Ombudsman, or the phone number and email address of the office of Texas health and Human Services in order to file the appeal and the notice did not include instructions or information or how to obtain an appeal form or information about assistance with completing and submitting the appeal form. The notice also did not include information that if the resident requested a hearing before the discharge date , the resident had the right to remain in the facility until the hearing officer made the final determination. Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. During an interview on 4/04/2024 at 2:44 p.m., Resident #2 stated she came to the facility in August 2023 after a severe infection left her without the ability to walk. She stated she had not achieved her goal of walking and was bed bound. She stated she was being kicked out of the facility for nonpayment. Resident #2 stated the Ombudsman started helping her in December 2023 but later learned that if she applied for Medicaid she would lose her house, so she refused to apply for Medicaid. She stated she wanted to stay in the facility but acknowledged she was refusing to cooperate with the facility to find a payor source. She stated she had spoken to the Ombudsman who started helping her appeal the discharge in December. She stated no one else from the facility had spoken to her about her right to appeal or had offered assistance with the appeals. She stated she did not think she had appealed this time because she had to leave the facility by 4/07/2024. 3. Record review of Resident #3's face sheet dated 4/04/2024 revealed an admitted [DATE] with diagnoses which included: heart failure, type 2 diabetes mellitus and generalized osteo-arthritis and a discharge date of [DATE]. Record review of Resident #3's comprehensive care plan dated 4/20/2024 revealed there was no plan of care for Resident #1's plans for discharge or goals for discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS of 12 which indicated a moderate cognitive impairment. Record review of Resident #3's Nursing Home Transfer and Discharge Notice dated 3/08/2024 revealed the resident was given a notice to discharge to his home address by 4/07/2024 for an unpaid balance. The notice did not include the email or address of State Long-Term Care Ombudsman, or the phone number and email address of the office of Texas health and Human Services in order to file the appeal and the notice did not include instructions or information or how to obtain an appeal form or information about assistance with completing and submitting the appeal form. The notice also did not include information that if the resident requested a hearing before the discharge date , the resident had the right to remain in the facility until the hearing officer made the final determination. During an interview on 4/05/2024 at 1:28 p.m., Resident #3 stated the nursing facility had transferred him to another nursing home in March 2024. He stated he originally went into the nursing facility after a fall at home, a hospital stay and wound which left him in need of therapy services. He stated he had completed therapy services; his wound had healed but he still did not have any strength and was wheelchair bound. He stated his ultimate goal was to go home but right now he could not take care of himself. Resident #3 stated he was given a 30-day discharge and that said they wanted him out by 4/07/2024. He stated he spoke to the Ombudsman about the discharge notice who advised him not to worry about the notice and that the facility could not just kick him out. Resident #3 stated he was transferred to the new facility almost immediately after the conversation with the Ombudsman. He stated no one discussed anything about anything when asked if he understood his right to appeal. During an interview on 4/02/2024 at 1:11 p.m., the Ombudsman stated in December 2023 the facility issued multiple discharge notices. The Ombudsman stated she asked the former Social Worker to rescind the notices because they were not safe discharges. She stated all the discharges had been rescinded and the facility now had a new Social Worker who was working on providing safe discharges. The Ombudsman stated she had spoken to multiple residents about discharges but declined to give the name of the residents. During an interview on 4/04/2024 at 4:29 p.m. the Financial Manager stated he used a facility pre-written form to fill out the 30-day discharge notices for Residents #1, #2, and #3. He stated he knew the reason for discharge and the signatures from the Administrator and the resident needed to be included in the notice. He stated he relied on the form for the other information and was not entirely sure what was required to be in the notices. During an interview on 4/04/2024 at 4:50 p.m., the Social Worker (SW) stated she started working at the facility on 1/08/2024. She stated when she started working, she was made aware discharge notices had been issued to Resident #1, #2, and #3. The SW stated the Ombudsman came in and stated she had not received notices of the discharge. She stated the facility let the discharges go but did not officially rescind them. The SW stated she was aware new discharge notices were issued to Resident #1, #2, and #3 with a discharge date of [DATE]. The SW stated she did not know who drove the issuance of the 30-day discharges and did not have anything to do with issuing the discharge letters. The SW stated she had not spoken to any of the residents about the discharge notices or right to appeal. During an interview on 4/05/2024 at 12:54 p.m., the Ombudsman stated she was unable to talk about the discharges of Resident's #1, #2, and #3 at the time of the call. She stated she would return the call later in the day. No return call was received prior to exit. (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/05/2024 at 2:09 p.m., the Administrator stated he was new to the facility as of 3/25/2024. He stated the discharge notices for Residents #1, #2, and #3 were already in place. He stated he was told about the 30-day discharge notices issued by the previous Administrator. He stated he had reviewed the documents. The Administrator stated all 3 discharges were for nonpayment. He stated he contacted the Ombudsman who said to make sure it was a safe discharge. The Administrator stated he had not reviewed the facility discharge policy. After reviewing the discharge notices with the surveyor, the Administrator acknowledged the discharge notices were missing key information such as the address and email address of the State Long-Term Care Ombudsman and HHSC and information on how to obtain an appeal form and information on how to obtain assistance with filling out and submitting the appeal application. He stated the Administrator was responsible for signing discharge notices. Record review of a facility policy, titled Transfer or Discharge, Facility-Initiated dated October 2022 revealed: 2. The resident and representative are notified in writing of the following information: d. an explanation of the resident's rights to appeal the transfer or discharge to the state, including the name, address, email and telephone number of the entity which receives such appeal hearing requests 2. Information on how to obtain an appeal form 3. How to get assistance in completing and submitting the appeal hearing requests. F. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman .

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to develop and implement an effective person-centered discharge plan that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 3 of 3 residents (Resident's #1, #2 and #3) reviewed for comprehensive care plans in that: 1. The facility failed to ensure Resident #1's care plan included discharge planning and goals. 2. The facility failed to ensure Resident #2's care plan included discharge planning and goals. 3. The facility failed to ensure Resident #3's care plan included discharge planning and goals. These failures could affect residents and place them at risk of their discharge wishes not being honored and not receiving appropriate treatment and services on discharge: The findings included: 1. Record review of Resident #1's face sheet dated 4/04/2024 revealed an admitted [DATE] with diagnoses which included: type 2 diabetes mellitus with complications, end stage renal disease, hypotension of hemodialysis and dependance on renal dialysis. Record review of Resident #1's comprehensive care plan initialized on 2/19/2023 revealed there was no plan of care for the resident's discharge or goals for discharge. Record review of Resident #1's annual MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated a moderate cognitive impairment. Record review of Resident #1's Nursing Home Transfer and Discharge Notice dated 3/08/2024 revealed the resident was given a notice to discharge to her home address by 4/07/2024 for an unpaid balance. During an interview on 4/04/2024 at 2:18 p.m., Resident #1 stated her goals were to remain in the facility long term. She stated she had advised the facility that she was not leaving because she was a renal patient that needed help with getting up in the morning and taking care of basic needs. She stated she had received a 30-day discharge letter. She stated she had spoken to the Ombudsman about her discharge, but nothing had come from the encounter. She stated she knew she had an unpaid balance at the facility but felt like no one was doing anything to help her. She stated someone from the facility (unknown name) told her they found another facility for her to transfer to but she had declined stating it was in another city and too far from her family and friends (date unknown). She stated she had not spoken to anyone else about discharge plans. 2. Record Review of Resident #2's face sheet dated 4/04/2024 revealed an admitted [DATE] with diagnoses which included: obstructive and reflux uropathy, noninfective gastroenteritis and colitis, and chronic kidney disease. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's comprehensive care plan initiated on 8/29/2023 revealed there was no plan of care for the resident's discharge or goals for discharge. Record review of Resident #2's Nursing Home Transfer and Discharge Notice dated 3/08/2024 revealed the resident was given a notice to discharge to her home address by 4/07/2024 for an unpaid balance. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. During an interview on 4/04/2024 at 2:44 p.m., Resident #2 stated she came to the facility in August 2023 after a severe infection with left her without the ability to walk. She stated she had not achieved her goal of walking and was bed bound. She stated she was being kicked out of the facility for nonpayment. Resident #2 stated the Ombudsman started helping her in December 2023 but later learned that if she applied for Medicaid she would lose her house, so she refused. She stated she wanted to stay in the facility but acknowledged she was refusing to cooperate with the facility to find a payor source. She stated she had several options for discharge but did not know what she was going to do. She stated she could go to her home and her family member could come by to check on her, she could go to her other family members house but felt like it was not the best solution because another family member who also lived in the home. Resident #2 stated the facility had not been doing discharge planning with her. 3. Record review of Resident #3's face sheet dated 4/04/2024 revealed an admitted [DATE] with diagnoses which included: heart failure, type 2 diabetes mellitus and generalized osteo-arthritis and a discharge date of [DATE]. Record review of Resident #3's comprehensive care plan dated 4/20/2024 revealed there was no plan of care for Resident #1's plans for discharge or goals for discharge. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS of 12 which indicated a moderate cognitive impairment. Record review of Resident #3's Nursing Home Transfer and Discharge Notice dated 3/08/2024 revealed the resident was given a notice to discharge to his home address by 4/07/2024 for an unpaid balance. Record review of Resident #3's progress note dated 3/13/2024 revealed Resident #3 was transferred to another NF via ambulance transport service. During an interview on 4/05/2024 at 1:28 p.m., Resident #3 stated the nursing facility had transferred him to another nursing home in March 2024. He stated he originally went into the original nursing facility after a fall at home, a hospital stay and wound which left him in need or therapy services. He stated he had completed therapy services, his wound had healed but he still did not have any strength and was wheelchair bound. He stated his ultimate goal was to go home but right now he could not take care of himself. Resident #3 stated he was given a 30-day discharge and said they wanted him out by 4/07/2024. He stated he spoke to the Ombudsman about it and then was transferred to the new facility but did not know what the plans were until he was transferred. He stated the facility never discussed his application with Medicaid with him or the results. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676378	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sorrento	2739 Babcock San Antonio, TX 78229

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/04/2024 at 4:50 p.m., the SW stated she was aware of all three resident discharges (Resident #1, #2 and #3). She stated she was aware 30-day discharge notices had been given. The SW stated Resident #3 was sent to another NF. She stated Resident's #2 and #1 were complicated discharges. The SW stated it was the responsibility of either the MDS Coordinator or herself to document discharge planning in the residents care plans. She stated she had not been shown how to do care plans and had not documented discharge planning in any of the resident's care plans. She stated after reviewing the care plans online that the residents did not have a care plan for discharge documented. During an interview on 4/04/2024 at 5:37 p.m., the MDS Coordinator stated Resident #1, #2 and #3 did not have discharge planning or plans for discharge in their comprehensive care plans. She stated she does not document a resident's plan for long term care in their care plans because it was not on her radar. She stated she was not responsible for care plans. She stated the facility management was responsible for comprehensive care plans. The MDS Coordinator stated the SW might be responsible because the SW was the person who initialed discharges. The MDS Coordinator stated having a plan of care for discharges was important so they knew what the plans for the resident for were. During an interview on 4/05/2024 at 2:49 p.m., the DON stated the MDS Coordinator was not responsible for updating care plans in the facility. The DON stated the management team including herself was responsible. The DON stated she was aware discharge planning should be included in the comprehensive care plan and did not know why it was missed. The DON stated discharge planning in the comprehensive care plan was important because the care plan told them what to do and care was based on the care plan. Record review of a facility policy, titled Assessments dated November 2017 revealed: 6. A comprehensive, person-centered plan of care, consistent with the resident rights must be completed by the 21st day after admission (or, within 7 days of the CAA completion date) and must include discharge planning, as appropriate.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review the facility failed to ensure professional staff were licensed, certified, or registered in accordance with applicable State laws for 1 of 8 staff (LVN A reviewed for staff qualifications. The facility failed to ensure LVN A renewed his nursing license before the expiration date in order to practice nursing in the State of Texas. This failure could place residents at risk of not receiving care and services from staff who were properly licensed The findings included: Record review of LVN A personnel file revealed a Texas LVN nursing license which had expired on [DATE]. Record review of the Texas Board of Nursing website license verification portal on [DATE] at 12:16 p.m. revealed LVN A Texas nursing license was listed as delinquent with a license expiration date of [DATE]. During an observation/interview on [DATE] at 10:10 a.m., LVN A was observed in the nursing facility with a name badge on. LVN A stated he was currently on duty as an LVN. He stated his license was current and in good standing. During an interview on [DATE] at 12:31 p.m., LVN A stated he thought his LVN nursing license expired in 2025. He stated he was not aware that it had already expired as of [DATE]. LVN A stated he was currently working on the 600 hallway and his assignment included charge nurse for 14 skilled patients (residents). LVN A stated he had worked all week on day shift with an assignment. He stated no one in the facility reminded him to renew his license and no one told him his license was expired. During an interview on [DATE] at 12:38 p.m., the HR Coordinator stated she was not aware LVN A nursing license was expired. She stated she normally verifies all staff license on the Texas Board of Nursing website on a monthly and annual basis and upon hire. The HR Coordinator stated the nurse (LVN A) was responsible for renewing their license and she was responsible for verifying. After reviewing the Texas Board of Nursing website, the HR Coordinator stated, yes LVN A's license was currently delinquent and expired. She stated LVN A needed to be removed from the floor (working with residents). The HR Coordinator stated she did not notify LVN A that his license was due, about the expire because she did not know. She stated the nurses were usually really good about taking care of it. The HR Coordinator stated she does not send a license report to the DON or any other member of management. She stated she was the only person looking at licenses. The HR Director stated LVN A was hired prior to their computer system and required a manual license verification. She stated she did not catch it because the computer did not flag it. The HR Coordinator stated LVN A worked for 5 days at the facility with a delinquent license including: Monday [DATE], Tuesday [DATE], Wednesday [DATE], Thursday [DATE] and Friday [DATE] before surveyor intervention. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:02 p.m., the Administrator stated LVN A was sent home due to a delinquent license (after surveyor intervention). The Administrator stated he (Administrator) was new to the facility of a week and and was not familiar with facility policies. During an interview on [DATE] at 2:49 p.m., the DON stated LVN A was sent home immediately when she was notified (after surveyor intervention) of the expired license. The DON stated the HR Coordinator was responsible for verification of license. The DON stated the HR Coordinator does not give her a report or communicate with her when a nurse license needed to be renewed. The DON stated the nurse was responsible for updating their license and HR was responsible for verifying. The DON stated it was important to have a valid nursing license because it was required. Record review of LVN A's employee time card revealed hours worked since license became delinquent included: Monday, [DATE] 9.38 hours worked Tuesday, [DATE] 10.05 hours worked Wednesday, [DATE] 11.50 hours worked Thursday, [DATE] 9.95 hours worked Friday, [DATE] 6.27 hours worked Total hours 47.15 hours worked Record review of a facility policy, titled Recruitment Policy dated February 2016 revealed: The Recruiter or HR Coordinator is responsible for confirming all applicants are qualified with necessary license/certification upon hire and to monitor expirations on a monthly basis. HR Coordinator will need to maintain a log of all employee license/certification and reviewed on a monthly basis to ensure active renewal has been completed. This verification should be placed in the employee's personnel file.