

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Sorrento		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34469</p> <p>Based on interview, and record review, the facility failed to ensure the resident's environment remained as free of accident hazards as was possible for two of six residents (Resident #s 2 and 3), reviewed for accidents and hazards:</p> <p>The facility failed to ensure Resident #2 did not have 15 disposable razors stored in his restroom drawer and a pair of scissors.</p> <p>The facility failed to ensure Resident #3 did not have 5 disposable razors stored in his restroom drawer.</p> <p>These failures placed residents at risk of injury.</p> <p>The findings:</p> <p>Resident #2</p> <p>Record review of Resident #2's electronic facesheet revealed Resident #2 was admitted to the facility on [DATE] and was [AGE] years of age. Further review revealed Resident #2's diagnoses included: vascular dementia with behavioral disturbance, anxiety disorder, cognitive communication disorder, and recurrent depression.</p> <p>Record review of Resident #2's MDS (Comprehensive), printed 6/14/2024, revealed Resident #2 had a BIMs Score of 9 which indicated moderate cognitive impairment. Further review revealed no history or ongoing concerns specific to suicidal ideation or a desire to harm others.</p> <p>Record review of Resident #2's Careplan, printed 6/14/2024, page 4 of 24, stated: (Resident #2) is currently taking psychotropic medication as evidenced by: Depression. Goals included, (Resident #2) will not experience adverse side effects over the next 90 days. Interventions included, Protect (Resident #2) from self harm or harm to others. Further review revealed no history or ongoing concerns specific to suicidal ideation or a desire to harm others.</p> <p>Observation and interview on 6/13/2024 at 10:08 AM of Resident #2's restroom revealed, 15 disposable razors in the top drawer located under Resident #2's sink. During an interview at this time, Resident #2 denied any thoughts of suicidal ideation or a desire to harm others.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation and interview on 6/14/2024 at 1:30 PM, ADON, LVN A, confirmed the presence of 15 disposable razors in the top drawer located under Resident #2's sink. LVN A confiscated the razors and confirmed Resident #2 should not have unsupervised access to the disposable razors or other sharp objects as they could result in harm to Resident #2 or others.</p> <p>During an interview on 6/28/2024 at 9:28 AM, the Social Worker was asked if staff was aware of Resident #2 had shaving razors in his room. The Social Worker asked if they were blue/disposable and said that if they were, they were issued by the facility and that staff would assist Resident #2 with shaving. When asked if Resident #2 had ever been a threat to self or others, the Social Worker said that he had not. When asked how this could be determined, the Social Worker stated Resident #2 was followed by psych services and would have been receiving therapy for suicidal ideation or aggression towards others if those interventions were needed. The Social Worker said there also would have been documentation indicating such a history when Resident #2 was admitted , which there was not. The Social Worker said Resident #2 had been thoroughly screened and was recently assessed to rule out the potential of him being a threat to himself or others at which time she said Resident #2 responded, I could never do that, I am catholic.</p> <p>Resident #3</p> <p>Record review of Resident #3's electronic facesheet revealed Resident #3 was admitted on [DATE] and was [AGE] years old. Resident #3's diagnoses included: Paranoid Schizophrenia, dementia, convulsions, depression, bipolar disorder, anxiety disorder, and manic episode - severe with psychotic symptoms.</p> <p>Record review of Resident #3's MDS (Comprehensive), printed 6/14/2024, revealed Resident #3 had a BIMs Score of 4 which indicated severe cognitive impairment. Further review revealed no history or ongoing concerns specific to suicidal ideation or a desire to harm others.</p> <p>Record review of Resident #3's Careplan, printed 6/14/2024, page 13 of 21 stated: (Resident #3) is currently taking psychotic medication as evidenced by depression, anxiety, schizophrenia/bipolar disorder. Goals included, (Resident #3) will not experience adverse side effects over the next 90 days. Interventions included, Protect (Resident #3) from self harm or harm to others. Further review revealed no history or ongoing concerns specific to suicidal ideation or a desire to harm others.</p> <p>Observation on 6/13/2024 at 10:40 AM of Resident #3's restroom revealed, 5 disposable razors in the top drawer located under Resident #3's sink. During an interview at this time, Resident #3 denied any thoughts of suicidal ideation or a desire to harm others.</p> <p>Observation and interview on 6/14/2024 at 1:34 PM, ADON, LVN A confirmed the presence of 5 disposable razors in the top drawer located under Resident #2's sink. LVN A confiscated the razors and confirmed Resident #3 should not have unsupervised access to the disposable razors as they could result in harm to Resident #3 or others.</p> <p>During an interview on 6/14/2024 at 2:00 PM, the DON was informed this investigator discovered disposable razors in Resident #2 and #3's restrooms and agreed they should not have been there given the diagnoses of both residents as they potentially injure themselves or others.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 6/28/2024 at 9:33 AM, the Social Worker said Resident #3 was being followed by psych services but not for suicidal ideation or aggression towards others. The Social Worker said Resident #3, had zero history of suicidal ideation, and informed this investigator Resident #3 was in law school when he first started experiencing his current diagnosis of schizophrenia. The Social Worker said Resident #3 was very friendly and would assist a blind female resident in his hall to the dining room and eat with her at the same table on a daily basis.</p> <p>During an interview on 6/28/2024 at 10:17 AM with the DON revealed Resident #s 2 and 3 were very self-sufficient. The DON said she would have no concerns with Resident #3 shaving his self as he was very high functioning and has never triggered as a threat to self or others. The DON described the shaving razors as bio-medical equipment and not cutlery. The DON was asked to define cutlery, as it was on a list of prohibited items in the facility's admission packet and responded that cutlery would include knives or silverware. The DON said it would be a different scenario had the shavers been the ones where the actual blade is accessible and large like the traditional old-fashioned razors. The DON further stated both Resident #s 2 and 3 both had a social and psychological assessment that was done each quarterly. Additionally, the DON said the facility utilized the PHQ9 assessment, which was done on admission, quarterly, and for a change of conditions. The DON indicated, since removing all resident shaving devices, a lot of tension had occurred, especially on the rehab/short-term side of the facility. The DON said however, that both Residents #2 and 3 understood and had acquiesced with this new intervention. The DON mentioned that both Resident #s 2 and 3 had been care-planned for shaving since this investigator's findings for the use of shaver razors and would implement once the plan of correction was received and hopefully approved by HHS. The DON further stated that all residents are monitored and spoken to on an hourly basis to include nursing rounds, CNA observations and care, and daily angel rounds.</p> <p>Record review of facility policy, Safety and Supervision of Residents, revised 7/2017, stated, Systems Approach to Safety . 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.</p>		