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	07/05/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36232 Based on interview and record review, the facility failed to notify the resident and the resident's representative/s of the discharge and the reasons for the move in writing and in a language and manner they understand, failed to update the recipients of the notice as soon as practicable once the updated information became available, and failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 5 residents (Residents #1) reviewed for discharge. The facility failed to notify Resident #1's RP in writing and did not notify the State Long-Term Care Ombudsman by phone or in writing of Resident #1's discharge due to safety concerns. This deficient practice could place residents at risk of being discharged and not allowed to return to the facility, causing a disruption in their care and services and potential decline in health. Findings included: Closed record review of Resident #1's undated face sheet revealed the resident was a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included spondylosis of the lumbar region (age-related degeneration of the vertebrae and disks of the lower back), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain) and borderline personality disorder (a mental health condition that affects the way people feel about themselves and others with symptoms including a strong fear of abandonment, mood swings and impulsiveness). Resident #1 discharged to a hospital on 06/09/2024 and from there to another long-term care. Further review of this face sheet revealed the resident's primary payer source was Medicaid. Closed record review of Resident #1's care plan, undated, revealed focus areas that included Resident #1's dependence on staff for ADL care, a history of falls and pain management. There were no focus areas indicating behaviors towards self, other residents or staff prior to the incident leading to her admission to the hospital on 06/09/2024. Closed record review of Resident #1's quarterly MDS dated [DATE] revealed the resident had a BIMS of 15, indicating she was cognitively intact. Further review of this MDS revealed the resident had no symptoms of delirium, no behaviors documented, no documented rejection of care and a mood score of 00. (continued on next page)

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

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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 - Few	Closed record review of Resident #1's EHR revealed a physician's note dated 5/21/2024 indicated the resident had intact judgment and insight; AO x 2 with a cordial affect, and no depression. Closed record review of a progress note in Resident #1's EHR dated 06/09/2024 by LVN A revealed Resident #1 was observed lying on the bathroom floor in prone position next to a wheelchair. Resident #1 was hollering, crying, and when assisted back to the wheelchair, Resident #1 stated, I drank bleach. There was an odor of bleach in the room. Vitals: 163/66, 94, 97.8, 98%, 20, Code Status: DNR, neurological assessment WNL, no respiratory distress noted, skin assessment clear, no abnormalities noted. EMS initiated and Resident #1 was transported to the hospital in stable condition. The resident's RP, MD, Administrator and DON were notified of the resident's clinical situation and transfer to the hospital. Closed record review of Resident #1's EHR revealed there was no documentation of written notification to the resident's RP or the LTC Ombudsman of the resident's discharge from the facility. Record review of hospital records revealed Resident #1 was admitted and treated for psychiatric illness after an alleged suicide attempt where she informed facility, EMS and hospital staff she ingested bleach because she was frustrated with the alleged lack of care at the facility. She reported severe nausea and vomiting but there was no evidence Resident #1 actually consumed bleach. The resident did not have trouble with breathing or swallowing and there was no damage to her esophagus. Testing revealed no issues. She consumed a regular diet without difficulty. The hospital tried to admit her to the psychiatric unit for extended evaluation but Resident #1 lost the ability to ambulate or stand and had a past history of stroke, and further evaluation by psychiatry services revealed she did not require a sitter or inpatient psychiatric care. Due to the sudden inability to stand and history of stroke she was not eligible to be admitted to psychiatric unit. She was initially on 1:1 supervision due to threat of harm. Once at the hospital Resident #1 stated she no longer wanted to harm herself. Record review clinical note by MD B in Resident #1's hospital records dated 6/13/2024 11:51 AM: Resident #1 was ready for discharge from the hospital on 06/13/2024. The resident wanted to return to the facility and her RP wanted her to return to the facility. Record review of clinical note by MD B in Resident #1's hospital record dated 06/14/2024 revealed, Medically ready for discharge but her NH will not take her back. Record review of progress note in Resident #1's EHR dated 06/14/2024 at 10:25 AM from the facility's SW revealed the SW witnessed the DON call Resident #1's RP and tell her the facility would not be able to readmit her mother due to the RP's disclosure of the resident's suicidal ideation and attempts. The resident's RP stated her understanding and asked that her belongings be left in the room until her friend could come and pack things up. The DON agreed that her room would be left as is for up to a week. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 07/02/2024 at 12:25 PM with Resident #1's RP, she stated Resident #1 was unhappy at the facility and did not feel she was getting adequate care. She'd had diarrhea for an extended period of time, had another accident a nurse came to her room she refused to let enter and she had to wait for another nurse. Out of exasperation she told the facility she drank bleach and texted her she drank bleach and did not want to live. She had a history of threatening harm as a cry for help but has never followed through. She went to the hospital on 06/09/2024. On 06/12/2024 the SW and DON called her and told her they were not going to take Resident #1 back and stated they were denied admission by a lot of other facilities who all refused to take her. A resident care advocate got involved. She was placed in one facility for 24-hours, and was then moved to another one, where she remains and was happy there. During an interview on 07/02/2024 at 1:42 PM with the Ombudsman, she stated the facility was required to send her discharge notices and had no residents with specific concerns about admission/transfer/discharge. She had not been informed of Resident #1's discharge. During an interview on 07/05/2024 at 1:45 PM, the Administrator stated Resident #1 and her RP had a contentious relationship. The RP had sent the resident the bleach, laundry soap and a knife. Resident #1 did not have a history of psychiatric issues or care, behaviors or suicidal ideation; in fact, when she was on and wanted to be fancy, she would dress up with makeup and wigs and was even featured in the facility's promotional materials. She was in the hospital over a week. The Administrator stated, We did not want her back. We did not give her a 30-day notice. During an interview on 07/05/2024 at 2:37 PM, the SW stated the DON had asked her to witness the call she placed to Resident #1's RP during which she told the RP that the facility would not be able to readmit the resident because the RP had disclosed her history of past suicidal ideation and attempts. The DON also asked the SW to document the conversation, and this was the only documentation of Resident #1's transfer to the hospital. It was possible Resident #1 requested her RP send her the bleach and laundry detergent so she could wash her own clothes due to her repeated bouts of diarrhea. Sometimes women have incontinent episodes and don't want anyone to know so they will wash their own clothes. If the resident required 1:1 care post admission, it was he facility's responsibility to provide that care. To her knowledge, no other residents had been transferred to the hospital under emergency conditions and refused readmission to the facility. During an interview on 07/05/2024 at 3:17 PM, the DON stated she requested the SW witness and document in Resident #1's EHR on 07/14/2024 the call she placed to the resident's RP informing her the facility would not take the resident back due to the facility learning she had a history of suicidal ideation and attempts. During an interview on 07/05/2024 at 3:35 PM, LVN C stated after Resident #1 was sent to the hospital, he checked with the DON and was told the resident could be readmitted after she was seen by psychiatric services at the hospital and was cleared by them. He was told on 06/14/2024 by the DON that the facility would not be readmitting Resident #1 after speaking with the Resident's RP and learning the Resident had a history of suicidal ideation they were not aware of until recently. He informed the case manager at the hospital the facility would not be taking the resident back. Record review of facility policy Transfer or Discharge, Facility-Initiated, dated October 2022, revealed: (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 - Few	Notice of Transfer or Discharge (Emergent or Therapeutic Leave) I. When residents who are sent emergently to an acute care setting, these scenarios are considered facility initiated transfers, NOT discharges, because the resident's return is generally expected. 2. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility. 3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; c. An immediate transfer or discharge is required by the resident's urgent medical needs; 4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements). 5 Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer. 6. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. 7. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge. Notice of Discharge after Transfer 1. If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care). 2. If the facility does not permit a resident's return to the facility (i.e., initiates a discharge) based on inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. 3. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. 4. Notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. If a resident chooses to appeal a discharge, the facility will not discharge residents while the appeal is pending. 6. If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to establish and follow written policy on permitting residents to return to the facility after they were hospitalized for one (Resident #1) of five residents reviewed for transfer/discharge. The facility failed to readmit Resident #1 to the facility after she was sent to the hospital on 06/09/2024. This deficient practice could place residents at risk of being discharged and not allowed to return to the facility, causing a disruption in their care and services and potential decline in health. Findings included: Closed record review of Resident #1's undated face sheet revealed the resident was a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included spondylosis of the lumbar region (age-related degeneration of the vertebrae and disks of the lower back), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain) and borderline personality disorder (a mental health condition that affects the way people feel about themselves and others with symptoms including a strong fear of abandonment, mood swings and impulsiveness). Resident #1 discharged to a hospital on 06/09/2024 and from there to another long-term care. Further review of this face sheet revealed the resident's primary payer source was Medicaid. Closed record review of Resident #1's care plan, undated, revealed focus areas that included Resident #1's dependence on staff for ADL care, a history of falls and pain management. There were no focus areas indicating behaviors towards self, other residents or staff prior to the incident leading to her admission to the hospital on 06/09/2024. Closed record review of Resident #1's quarterly MDS dated [DATE] revealed the resident had a BIMS of 15, indicating she was cognitively intact. Further review of this MDS revealed the resident had no symptoms of delirium, no behaviors documented, no documented rejection of care and a mood score of 00. Closed record review of Resident #1's EHR revealed a physician's note dated 5/21/2024 indicated the resident had intact judgment and insight; AO x 2 with a cordial affect, and no depression. Closed record review of a progress note in Resident #1's EHR dated 06/09/2024 by LVN A revealed Resident #1 was observed lying on the bathroom floor in prone position next to a wheelchair. Resident #1 was hollering, crying, and when assisted back to the wheelchair, Resident #1 stated, I drank bleach. There was an odor of bleach in the room. Vitals: 163/66, 94, 97.8, 98%, 20, Code Status: DNR, neurological assessment WNL, no respiratory distress noted, skin assessment clear, no abnormalities noted. EMS initiated and Resident #1 was transported to the hospital in stable condition. The resident's RP, MD, Administrator and DON were notified of the resident's clinical situation and transfer to the hospital. (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Closed record review of Resident #1's EHR revealed there was no documentation of written notification to the resident's RP or the LTC Ombudsman of the resident's discharge from the facility. Record review of hospital records revealed Resident #1 was admitted and treated for psychiatric illness after an alleged suicide attempt where she informed facility, EMS and hospital staff she ingested bleach because she was frustrated with the alleged lack of care at the facility. She reported severe nausea and vomiting but there was no evidence Resident #1 actually consumed bleach. The resident did not have trouble with breathing or swallowing and there was no damage to her esophagus. Testing revealed no issues. She consumed a regular diet without difficulty. The hospital tried to admit her to the psychiatric unit for extended evaluation but Resident #1 lost the ability to ambulate or stand and had a past history of stroke, and further evaluation by psychiatry services revealed she did not require a sitter or inpatient psychiatric care. Due to the sudden inability to stand and history of stroke she was not eligible to be admitted to psychiatric unit. She was initially on 1:1 supervision due to threat of harm. Once at the hospital Resident #1 stated she no longer wanted to harm herself. Record review clinical note by MD B in Resident #1's hospital records dated 6/13/2024 11:51 AM: Resident #1 was ready for discharge from the hospital on 06/13/2024. The resident wanted to return to the facility and her RP wanted her to return to the facility. Record review of clinical note by MD B in Resident #1's hospital record dated 06/14/2024 revealed, Medically ready for discharge but her NH will not take her back. Record review of progress note in Resident #1's EHR dated 06/14/2024 at 10:25 AM from the facility's SW revealed the SW witnessed the DON call Resident #1's RP and tell her the facility would not be able to readmit her mother due to the RP's disclosure of the resident's suicidal ideation and attempts. The resident's RP stated her understanding and asked that her belongings be left in the room until her friend could come and pack things up. The DON agreed that her room would be left as is for up to a week. During a telephone interview on 07/02/2024 at 12:25 PM, Resident #1's RP stated Resident #1 was unhappy at the facility and did not feel she was getting adequate care. She'd had diarrhea for an extended period of time, had another accident a nurse came to her room she refused to let enter and she had to wait for another nurse. Out of exasperation she told the facility she drank bleach and texted her she drank bleach and did not want to live. She had a history of threatening harm as a cry for help but has never followed through. She went to the hospital on 06/09/2024. On 06/12/2024 the SW and DON called her and told her they were not going to take Resident #1 back and stated they were denied admission by a lot of other facilities who all refused to take her. A resident care advocate got involved. She was placed in one facility for 24-hours, and was then moved to another one, where she remains and was happy there. During an interview on 07/05/2024 at 1:45 PM, the Administrator stated Resident #1 and her RP had a contentious relationship. The RP had sent the resident the bleach, laundry soap and a knife. Resident #1 did not have a history of psychiatric issues or care, behaviors or suicidal ideation; in fact, when she was on and wanted to be fancy, she would dress up with makeup and wigs and was even featured in the facility's promotional materials. She was in the hospital over a week. The Administrator stated, We did not want her back. We did not give her a 30-day notice. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/05/2024 at 2:37 PM, the SW, stated the DON had asked her to witness the call she placed to Resident #1's RP during which she told the RP that the facility would not be able to readmit the resident because the RP had disclosed her history of past suicidal ideation and attempts. The DON also asked the SW to document the conversation, and this was the only documentation of Resident #1's transfer to the hospital. It was possible Resident #1 requested her RP send her the bleach and laundry detergent so she could wash her own clothes due to her repeated bouts of diarrhea. Sometimes women have incontinent episodes and don't want anyone to know so they will wash their own clothes. If the resident required 1:1 care post admission, it was he facility's responsibility to provide that care. To her knowledge, no other residents had been transferred to the hospital under emergency conditions and refused readmission to the facility. During an interview on 07/05/2024 at 3:17 PM, the DON stated she requested the SW witness and document in Resident #1's EHR on 07/14/2024 the call she placed to the resident's RP informing her the facility would not take the resident back due to the facility learning she had a history of suicidal ideation and attempts. During an interview on 07/05/2024 at 3:35 PM, LVN C stated after Resident #1 was sent to the hospital, he checked with the DON and was told the resident could be readmitted after she was seen by psychiatric services at the hospital and was cleared by them. He was told on 06/14/2024 by the DON that the facility would not be readmitting Resident #1 after speaking with the Resident's RP and learning the Resident had a history of suicidal ideation they were not aware of until recently. He informed the case manager at the hospital the facility would not be taking the resident back. Record review of facility policy Transfer or Discharge, Facility-Initiated, dated October 2022, revealed: Notice of Transfer or Discharge (Emergent or Therapeutic Leave) I. When residents who are sent emergently to an acute care setting, these scenarios are considered facility initiated transfers, NOT discharges, because the resident's return is generally expected. 2. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility. 3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; c. An immediate transfer or discharge is required by the resident's urgent medical needs; 4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements). (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5 Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer. 6. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. 7. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge. Notice of Discharge after Transfer 1. If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care). 2. If the facility does not permit a resident's return to the facility (i.e., initiates a discharge) based on inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. 3. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. 4. Notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative. 5. If a resident chooses to appeal a discharge, the facility will not discharge residents while the appeal is pending. 6. If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.