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	07/19/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 5 residents (Resident #2) reviewed for advanced directives, in that: The facility failed to ensure Resident #2's Out-of-Hospital Do Not Resuscitate (OOH DNR) was honored. This failure could place residents at-risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. The findings included: Record review of Resident #2's face sheet, dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included hemiplegia following nontraumatic subarachnoid hemorrhage affecting the left non dominate side (partial or total paralysis on one side of the boday after a brain bleed), cerebrovascular disease, and seizures. The advanced directive was blank on the face sheet. Record review of Resident #2's admission MDS assessment, dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #2's baseline care plan, reviewed [DATE] revealed the resident was a full code. Record review of Resident #2's comprehensive care plan, reviewed [DATE] did not contain any advanced directive information. Record review of Resident #2's Order Summary Report, dated [DATE] revealed no code status order. Record review Resident #2's admission packet, dated [DATE], revealed it was signed and dated 5 days after the resident was admitted . The admission packet stated the resident was her own RP. The Resident or RP signature line contained the resident's own signature. Pages ,d+[DATE] of the admission packet contained information about an OOH DNR. The pages with DNR information were not signed. (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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:15 a.m. Resident #2's RP stated they did not complete any paperwork on admission and were not asked about Resident #2's code status. The RP stated Resident #2 was not in her right mind to make decisions on her own about her care. The RP stated she attempted to reach the social worker several time and stated when she finally spoke to the SW, she only went over her Medicaid coverage and therapy services. The RP stated they wished to have Resident #2's code status as a DNR. The RP stated Resident #2 was a DNR in the hospital. The RP stated no one asked them about code status for Resident #2 since admission on [DATE]. During an interview on [DATE] at 11:17 a.m. the CRC stated the SW would complete paperwork for advance directives or DNRs. The CRC stated in the past the advance directive acknowledgement paperwork was in the admission packet but the current electronic packet did not have advance directive information in it. The CRC stated it was now the responsibility of the SW to complete advance directive paperwork. During an interview on [DATE] at 12:41 p.m. the SW stated normally would run an advance directive report to look for any residents who needed orders for a code status. The SW stated she could not recall the last time she ran the report and had not done it the last time she worked. The SW stated they added an order for code status that day for full code. The SW stated she was not aware Resident #2 was supposed to be a DNR. The SW stated she had not spoken to Resident #2's RP. The SW stated she was busy at the facility and had many residents to see at the facility. The SW stated if a resident wanted a DNR and it was not honored they could receive CPR. During an interview on [DATE] at 12:11 p.m. the DON stated the SW was responsible for resident's code status. The DON stated if there was no advanced directive staff would perform CPR. The DON stated if the resident wanted a DNR and there was no discussion prior they would not be honoring their wishes. Record review of the facility policy titled Advanced Directives, dated ,d+[DATE], stated 1. An Acknowledgement Receipt for Advance Directives/Medical Treatment Decisions must be completed for each Patient upon admission and upon any change in the status of the Patient's Advance Directives. 2. The Advance Directives Decision Tree Protocol (see Protocol 13-A) must be used for each Patient at any time a question arises with respect to whether a Patient has Advance Directives, should have Advance Directives, or has requested to have Advance Directives .4. Upon completion of an Out-of-Hospital DR (OOH); a telephone order must be entered into the electronic medical record (EMR. 5. The Advanced Directive report must be reviewed daily for all Patients. The Social Worker or designee must verify the Advance Directive report for accuracy to ensure the clinical record reflects the current advanced directive status and use it to monitor the existence of a DR. 6. A Patient's Advance Directives choice must be care planned and updated as warranted with any changes in the Advance Directives .8. The Monthly Quality Assurance & Performance Improvement meeting (see PCMS 19) must include a review of the consistent, accurate and timely use of the Advance Directives Decision Tree, Acknowledgement of Receipt, an updated care plan, and the maintenance of an accurate and up-to-date Advanced Directive Report.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review, the facility failed to ensure an admission policy was implemented for 1 of 5 Resident (Resident #2), in that: The facility failed to ensure Resident #2's RP was provided admission documents on admission. This deficient practice could place residents at risk who are not being informed of the admission requirements, services, and processes. Findings Include: Record review of Resident #2's face sheet, dated 7/19/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included hemiplegia following nontraumatic subarachnoid hemorrhage affecting the left non dominate side (partial or total paralysis on one side of the boday after a brain bleed), cerebrovascular disease, and seizures. The advanced directive was blank on the face sheet. Record review of Resident #2's admission MDS assessment, dated 7/16/24 revealed the resident was severely cognitively impaired for daily decision-making skills. Record review Resident #2's admission packet, dated 7/12/24, revealed it was signed and dated 5 days after the resident was admitted . The admission packet stated the resident was her own RP. The Resident or RP signature line contained the resident's own signature. During an observation and interview on 7/19/24 at 10:42 a.m. Resident #2 was sitting in her bad. The resident was not able to answer any questions. During an interview on 7/19/24 at 10:15 a.m. Resident #2's RP stated they did not complete any paperwork on admission. The RP stated Resident #2 was not in her right mind to make decisions on her own about her care. The RP stated she was confused on what was going on with Resident #2's plan of care at the facility. The RP stated she felt there was a lack of communication from the facility. During an interview on 7/19/24 at 11:01 a.m. LVN B stated Resident #2 could speak but her responses were not appropriate. LVN B stated she would speak to the resident about her blood glucose and the resident would talk about outside. LVN B stated Resident #2 should not be her own RP. LVN B stated the office staff in the front handled admission paperwork documents. During an interview on 7/19/24 at 11:17 a.m. the CRC stated Resident #2 was her own RP and could make her own decisions. The CRC stated Resident #2 understood everything in the admission packet and was able to sign it on her own. The CRC stated the family refused to sign the admission packet because they did not want the financial responsibility. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 7/19/24 at 12:31 p.m. Resident #2's RP stated she was unsure if they had the resident sign her own admission paperwork, but the resident was very confused and not in her right mind to sign anything or understand what was going on. The RP stated she was never asked to sign admission paperwork and never refused to sign any admission paperwork. Record review of the facility policy titled Admission Agreement, dated 8/2018, stated Policy statement: All residents have a signed and dated admission agreement on file. Policy Interpretation and Implementation 1. At the time of admission, the resident (or his/her representative) must sign an admission agreement (contract) .4. A copy of the admission agreement is provided to the resident or his/her representative (sponsor), and a copy placed in the resident's permanent file .

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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** 41095 Based on interview and record review, the facility failed to incorporate the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning and transitions of care for 1 of 2 residents (Resident #1) reviewed for PASRR. The facility failed to submit NFSS forms timely to the TMHP Long Term Care Portal for Resident #1 to ensure payment for specialized services throught the PASRR program. This failure could place residents at risk for not receiving specialized services in a timely manner. Findings included: Record review of Resident #1's admission record, dated 07/19/24, revealed a [AGE] year-old male who admitted on [DATE] with diagnoses that included Down Syndrome (a genetic chromosome 21 disorder causing developmental and intellectual delays), hydrocephalus (a buildup of fluid in the cavities deep with the brain), contracture of muscle, left lower leg, muscle weakness, and mixed receptive-expressive language disorder (a communication disorder which results in difficulty understanding words and sentences). Record review of Resident #1's Annual MDS assessment, dated 07/02/24, reflected a BIMS score of 99 indicating resident was unable to complete the assessment requiring a Staff Assessment for Mental Status. The Staff Assessment revealed Resident #1 was severely impaired for cognitive skills for daily decision making. Record review of Resident #1's care plan, effective 02/17/23 to Present, revealed Resident #1 has been identified as PASRR positive status related to an ID/D with a diagnosis of Down Syndrome with interventions that included Resident #1 has been approved for a new CMWC related to increased weight, current CMWC right arm rest broke, seat is uncomfortable. Interview with the MDS Nurse on 07/18/24 at 2:06 pm revealed the IDT team had discussed getting Resident #1 an air mattress through PASRR but the vendor never came out. The facility decided to give him an overlay air mattress with bolsters rather than waiting for the PASRR vendor. The MDS Nurse also stated they had submitted paperwork for a custom wheelchair since the one he had no longer fit him due to weight gain and due to wear and tear. The vendor came out the previous month to measure him so the MDS Nurse felt the wheelchair would be delivered some time soon. The facility did not have an expected delivery date. The emails and phone calls from the PASRR office were discussed. The MDS Nurse stated she had received several emails through the TMHP portal and two phone calls from the PASRR office but did not submit required paperwork by the due date which was supposed to be within 20 days of the IDT care plan meeting. The MDS Nurse stated she checked the TMHP portal several times a day and was responsible for ensuring that the PASRR process was followed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the emails from the PASRR office at HHSC revealed the facility needed to submit a NFSS form for PASRR Specialized Services DME for Mattress by 09/21/23 and another revealed the facility needed to submit a NFSS request form for PASRR Specialized Services for CMWC (Customized Manual Wheelchair) by 01/25/24. Record review of policy for Assessments dated November 2017 documented: .8. Any specialized services or specialized rehabilitative serves the nursing facility will provide as a result of PASRR recommendations. If a facility disagrees with the findings of the PASRR, it must indicate its rationale in the Patient's/Resident's Medical Record. In addition, the facility must provide or obtain the required services from an outside resource from a Medicare and/or Medicaid provider to provide any rehabilitative services such as physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, required in the Patient's comprehensive plan of care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 1 newly admitted residents (Residents #2) reviewed for baseline care plan. The facility failed to ensure Resident #2's baseline care plan contained the correct code status. These deficient practices could place residents at-risk for decreased quality of life, improper care, and injury. The findings were: Record review of Resident #2's face sheet, dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included hemiplegia following nontraumatic subarachnoid hemorrhage affecting the left non dominate side, cerebrovascular disease, and seizures. The advanced directive was blank on the face sheet. Record review of Resident #2's admission MDS assessment, dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #2's baseline care plan, reviewed [DATE] revealed the resident was a full code. The baseline care plan contained a line for a resident or RP signature. The line contained a written X and no signature. Record review of Resident #2's comprehensive care plan, reviewed [DATE] did not contain any advanced directive information. Record review of Resident #2's Order Summary Report, dated [DATE] revealed no code status order. Record review of Resident #2's Order summary report, dated [DATE], revealed an order for full code was added and signed at 11:40 a.m. and stated, RP aware. Record review Resident #2's admission packet, dated [DATE], revealed it was signed and dated 5 days after the resident was admitted . The admission packet stated the resident was her own RP. The Resident or RP signature line contained the resident's own signature. Pages ,d+[DATE] of the admission packet contained information about an OOH DNR. The pages with DNR information were not signed. Record review of the MD's note for Resident #2, dated [DATE], stated code status full code was a DNR/DNI in hospital, will need OOH DNR if wishes. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:15 a.m. Resident #2's RP stated they did not complete any paperwork on admission and were not asked about Resident #2's code status. The RP stated Resident #2 was not in her right mind to make decisions on her own about her care. The RP stated she attempted to reach the social worker several time and stated when she finally spoke to the SW, she only went over her Medicaid coverage and therapy services. The RP stated they wished to have Resident #2's code status as a DNR. The RP stated Resident #2 was a DNR in the hospital. The RP stated no one asked them about code status for Resident #2 since admission on [DATE]. During an interview on [DATE] at 11:17 a.m. the CRC stated the SW would complete paperwork for advance directives or DNRs. The CRC stated in the past the advance directive acknowledgement paperwork was in the admission packet, but the current electronic packet did not have advance directive information in it. The CRC stated it was now the responsibility of the SW to complete advance directive paperwork. During a follow up interview on [DATE] at 12:31 p.m. Resident #2's RP stated she was unsure if they had the resident sign her own admission paperwork, but the resident was very confused and not in her right mind to sign anything or understand what was going on. The RP stated she was never asked to sign any paperwork and never refused to sign any paperwork. The RP stated she was confused on what was going on with Resident #2's plan of care at the facility. The RP stated she felt there was a lack of communication from the facility. During an interview on [DATE] at 12:41 p.m. the SW stated normally would run an advance directive report to look for any residents who needed orders for a code status. The SW stated she could not recall the last time she ran the report and had not done it the last time she worked. The SW stated they added an order for code status that day for full code. The SW stated she was not aware Resident #2 was supposed to be a DNR. The SW stated she had not spoken to Resident #2's RP. The SW stated she was busy at the facility and had many residents to see at the facility. The SW stated if a resident wanted a DNR and it was not honored they could receive CPR. During an interview on [DATE] at 12:11 p.m. the DON stated the SW was responsible for resident's code status. The DON stated if there was no advanced directive staff would perform CPR. The DON stated if the resident wanted a DNR and there was no discussion prior they would not be honoring their wishes. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Assessments, dated ,d+[DATE], stated 1. A Nursing Assessment must be completed within 24 hours of admission (including readmission) of a Patient/Resident .4. A Baseline, Person-centered Plan of Care for each patient that includes the instructions needed to provide effective and person-centered care of the patient that meet professional standards of quality care. The baseline care plan must be initiated within 48 hours of admission (including re-admission). The care plan must include Initial goals be based on admission orders, physician orders, dietary orders, therapy services, social services and PASRR recommendation if applicable. The Baseline Care Plan must be derived from the Nursing Assessment Form, Fall Assessment, Braden Assessment, Bowel/Bladder Assessment, Pain Assessment and Medication orders. If the comprehensive, Person-centered plan of care is developed within 48 hours of admission the baseline care plan is not required. 5. The facility must provide the patient and their representative with a summary of the baseline care plan that includes the initial goals of the patient, a summary of the patient's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and updated information based on the details of the comprehensive care plan as necessary .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interviews and record reviews, the facility failed to maintain medical records on each resident that are-accurately documented for 1 of 5 residents (Resident #2) reviewed for accurate medical records in that: The facility failed ensure Resident #2's emergency contacts were updated and accurate. The deficient practices place residents at risk of misinformation about professional care provided. The findings included: Record review of Resident #2's face sheet, dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included hemiplegia following nontraumatic subarachnoid hemorrhage affecting the left non dominate side (partial or total paralysis on one side of the boday after a brain bleed), cerebrovascular disease, and seizures. The emergency contacts listed were family member A and family member B. Record review of Resident #2's admission MDS assessment, dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills. During an observation and interview on [DATE] at 10:42 a.m. Resident #2 was sitting in her bad. The resident was inconsolable because she did not remember her family member had passed away a few years ago. The resident was not able to answer any questions. Resident #2's family was in the room and stated her family member had died a few years before. The family stated after her recent stroke her memory was bad and she would ask for her deceased family member and they would inform her they had passed a few years before. During an interview on [DATE] at 11:17 a.m. the CRC stated she used hospital paperwork to fill out emergency contact information. The CRC stated she spoke to Resident #2 for a while when they filled out the admission packet and the resident stated her family member had passed. The CRC stated in an emergency they would go down the list of emergency contacts and they would contact family member A before the deceased family member B. A policy for accuracy of medical records was requested and not provided.