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	05/21/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 4 residents reviewed for pharmacy services. 1. The facility failed to ensure Resident #1's medications administered to him were consumed and were not left in the resident's room. 2. The facility failed to ensure Resident #1 received acetaminophen-hydrocodone 10/325 tablets as prescribed by a physician. These failures could place residents at risk for medication error and drug diversion. The findings included: 1. Record review of Resident #1's face sheet dated 5/21/2025 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: metabolic encephalopathy (a condition where underlying health issues disrupts the brain's normal function), anxiety disorder and acute kidney failure. Record review of Resident #1's 5-day admission MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact with no symptoms of delirium. The assessment indicated Resident #1 had rejection of care behaviors 1 to 3 days a week. Record review of Resident #1's care plan dated 5/12/2025 revealed: hypertension with unrelated interventions and GERD with interventions to give medications as ordered. Record review of Resident #1's physician order summary dated 5/21/2025 revealed orders which included: -simethicone 80 mg chewable tablet, give one tablet by mouth every 8 hours as needed for gas with a start date of 5/06/2025. (continued on next page)

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-tamsulosin 0.4 mg, give one tablet orally two times a day for benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate with difficulty urinating) with a start date of 5/02/2025. -losartan 50 mg, give one tablet by mouth every 12 hours related to essential hypertension with a start date of 5/02/2025. -famotidine 20 mg, give one tablet orally every 12 hours for indigestion related to GERD (with a start date of 5/01/2025. -metoprolol 25 mg, give one tablet orally one time a day related to essential hypertension with a start date of 5/01/2025. -vitamin C (ascorbic acid) 500 mg, give one tablet by mouth one time a day for vitamin deficiency with a start date of 5/03/2025. -Zyrtec (cetirizine) 10 mg, give one tablet by mouth at bedtime related to allergy with start date 5/02/2025. -Lasix (furosemide 40 mg, give one tablet by mouth in the morning for edema related to essential hypertension with a start date of 5/03/2025. Hydrocodone-acetaminophen (Norco) 10/325, give two tablets orally every four hours as needed for pain with a start date of 5/02/2025. Record review of Resident #1's May 2025 MARS revealed: -simethicone 80 mg was documented as administered PRN with last dose documented on 5/19/2025 at 12:44 p.m. by LVN A. -tamsulosin 0.4 mg was documented as administered daily including last dose on 5/21/2025 at 7:00 a.m. by LVN B. -losartan 50 mg tablet was documented as administered daily including the last dose on 5/21/2025 at 7:00 a. m. by LVN B. -famotidine 20 mg was documented as administered daily including the last dose on 5/21/2025 at 7:00 a.m., by LVN B. -metoprolol 25 mg was documented as administered daily including the last dose on 5/21/2025 at 7:00 a.m. by LVN B. -vitamin C (ascorbic acid) 500 mg was documented as administered daily including last dose on 5/21/2025 at 7:00 a.m. by LVN B. -Zyrtec (cetirizine) 10 mg was documented as administered daily including the last dose at 7:00 p.m. on 5/20/2025 by LVN D (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lasix (furosemide) 40 mg was documented as administered daily including the last dose at 7:00 a.m. by LVN B. -hydrocodone-acetaminophen 10/325 mg was documented as administered PRN with last dose documented on 5/20/2025 at 8:00 p.m. by LVN D. During an observation and interview on 5/21/2025 at 10:21 a.m., Resident #1 was observed laying on his bed, awake and alert. There were two medication cups with pills to the right side of the resident's bed on the nightstand. One medication cup with two pills across the bed on the dresser under the TV, and several medication cups on the left nightstand with various pills (identified below). Two pills were noted on a piece of paper, not in a medication cup. One of those pills, a white oblong tablet stamped M365 and identified as hydrocodone-acetaminophen (narcotic for the treatment of pain) The other pill was a multi-colored capsule identified as tamsulosin . (relaxes muscles of prostate and bladder neck) Resident #1 acknowledged the pills but declined questions at this time. He stated he would take the pills in a little bit. Resident #1 then picked up one of the medication cups to the right side of his bed and brought it towards his mouth. This surveyor intervened and asked him not to consume any of the pills at the moment and wait until a nurse could confirm what the pills were for. Resident #1 agreed and stated he only knew the white capsule, marked M365 was Norco (hydrocodone-acetaminophen). During an observation and interview on 5/21/2025 at 10:27 a.m., the ADON stated he observed the pills in the room. He stated the multicolored pill was tamsulosin and stated the white oblong pill was a vitamin. Resident #1 corrected the ADON and stated it was Norco. The ADON asked the resident why he had Norco. Resident #1 stated the nurse gave him two pills and he only took one Norco. The ADON collected all the pills and medication cups and exited room. During an observation and interview on 5/21/2025 at 10:35 a.m., the ADON stated Resident #1 was not supposed to self-administer medication. The ADON sorted, separated the pills and the pills were matched with Resident #1's medication in the medication cart by color, size and markings. The 16 pills included: -four large white pills labeled 44-137, identified as simethicone 80 mg. -three multi-colored pink and brown capsules marked D53-3 identified as tamsulosin 0.4 mg -two white oval table 5-1, identified as losartan 50 mg -two small beige tablets marked 60/00 identified as famotidine 20 mg -one small pink tablet identified as metoprolol 25 mg -one white tablet identified as Vitamin C 500 mg -one white tablet marked D-4 identified as Zyrtec 10 mg -one white tablet marked 17, identified as Lasix 40 mg -one white oblong tablet marked M365 identified as hydrocodone-acetaminophen 5/325 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2025 at 10:47 a.m., LVN A stated the medication cart that he currently held the keys for was the one identified as containing Resident #1's medications. LVN A stated he had not administered any medication to Resident #1 today (5/21/2025). He stated LVN B had administered the medications. LVN A stated he had administered the medications in the two prior days. He stated Resident #1 does not always take his medications and tends to do that. He stated Resident #1 will say just leave them. LVN A stated he has not left any medication at the bedside. He stated he takes them with him and will bring them back when the resident wants them. LVN A stated if Resident #1 takes too long, he will document them as a refusal. During an interview on 5/21/2025 at 10:49 a.m., LVN B stated Resident #1 came to the nurse's station this morning for his medications. She stated she gave him his medications including two Norco tablets. She stated she also gave him a cup of water; he took a sip and then declined the water. She stated Resident #1 said he would drink his own water. LVN B stated she thought Resident #1 took his medication. She stated, I know I saw him take his morning meds. She stated she did not look in his mouth and was not aware of any pocketing behaviors. LVN B stated Resident #1 had a history of not taking his medication and refusing. She stated the Resident had requested two Norco's and she gave them to him for a pain level of 6 out of 10 for lower back and leg pain. LVN B stated she did see a medication cup on his dresser, and she asked him about the medications. She stated Resident #1 said he would get to it. She stated she did not see the other medication in the room. She stated she was sidetracked and on the phone with dialysis because Resident #1 had refused dialysis today. LVN B stated she was trained on the medication rights and to make sure Resident #1 took the medications. She stated she deviated from her training because she was sidetracked . During an interview on 5/21/2025 at 1:53 p.m., the ADON stated medication rights should be followed when administering medications regardless of whether it was a medication aide or a nurse. He stated the rights included: right patient, right route, right medication, right dose, right form and documentation. She stated they should make sure every medication given was verified. He stated if a medication was refused the nurse would discard the medication. He stated medications should not be signed off until consumed. He stated the staff were trained to watch the resident swallow the pills. He stated that was nursing 101. He stated the staff should not walk away from a resident without knowing if the medication was taken or not. He stated what went wrong in this situation was the nurse left the medications at bedside. He stated the nurse should have taken the medications if the resident was not ready and not leaving them in the room. The ADON stated Resident #1 was cognitively intact. He stated it was a frequent behavior by the resident. He stated the nurses were aware. The ADON stated the risk of leaving the medication at bedside was too much medication at one time or the wrong patient could get a hold of the medications. During an interview on 5/21/2025 at 2:33 p.m., LVN C stated Resident #1 would approach him for medications. He stated when he administered medication, he would stay in the room just to talk even after the medications were taken. He stated he never saw Resident #1 putting any medications to the side or sorting the medications before taking. He stated he would just throw them back. He stated he did not look under a resident tongue for medications. He stated he was trained to make sure all medications were taken. He said it was important for the therapeutic range of the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2025 at 2:26 p.m. LVN D stated she administered Norco to Resident #1 on 5/20/2025 and a couple of days prior along with other medications. She stated she watched the resident swallow his pills but did not check his mouth to ensure they were swallowed. She stated Resident #1 sorts out his medication and only took certain medication but did not see the resident set any medications aside. She stated he did not refuse any of the medications. She stated she sat and watched him as she was trained and was under the assumption the medications were all swallowed. During an interview on 5/21/2025 at 3:11 p.m., LVN E stated he was trained to watch residents swallow their pills when administered. He stated he does not leave medications at bedside for any resident. He denied knowing who Resident #1 was. During an interview on 5/21/2025 at 3:26 p.m., the DON stated leaving medications at bedside was not best practice and should be stored on the medication cart. She stated she expected the nurses to take (remove) the medications and discharge. She stated when the resident was ready, the nurse should re-dispense and administer. She said this applied even to cognitively intact residents. She said it was not safe to leave meds at the bedside. 2. Record review of Resident #1's care plan dated 4/15/2025 revealed: pain management acute/chronic with interventions which included: Resident will participate actively in making choices/decision for care regarding pain management. Record review of Resident #1's physician order summary dated 5/21/2025 revealed orders which included: Hydrocodone-acetaminophen (Norco) 10/325, give two tablets orally every four hours as needed for pain with a start date of 5/02/2025. Record review of Resident #1's Controlled Drug Record revealed a pharmacy label for hydrocodone-acetaminophen 5/325, take 1-2 tablets every four hours as needed by mouth and was documented as administered on 10 occasions between 5/16/2025 and 5/20/2025 by unknown staff due to illegible signatures. Record review of Resident #1's May 2025 MAR revealed hydrocodone-acetaminophen 5/325 mg was documented as a administered by LVN D and LVN A between 5/16/2025 and 5/21/2025 for a total of 3 occasions. During an observation and interview on 5/21/2025 at 10:21 a.m., Resident #1 was observed laying on his bed, awake and alert. A white oblong tablet was noted on a piece of paper on the bedside table. The pill was stamped M365 and identified a 5/325 mg of hydrocodone-acetaminophen. He stated the pill was Norco that he intended to take in a little bit. He stated the nurse gave him two pills and he only took one. He declined to answer any other questions at this time. During an observation and interview on 5/21/2025 at 10:27 a.m., the ADON stated observed the pills in the room. Resident #1 stated to the ADON that the pill was Norco. The ADON asked the resident why he had Norco. Resident #1 stated the nurse gave him two pills and he only took one Norco. The ADON collected the pill and exited room. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/21/2025 at 10:35 a.m., the ADON stated Resident #1 was not supposed to self-administer medication. The matched with Resident #1's medication in the medication cart by color, size and markings and stated the M365 pill was 5/325 of hydrocodone-acetaminophen. The original blister pack in the medication cart was labeled 5/325 and dated 5/16/2025. An amount of Norco in the blister packet matched the number of Norco of the narcotic record indicating a correct count. The ADON identified the nurse signatures on the narcotic record as belonging to LVN A, LVN B, LVN C, LVN D and LVN E. During an interview on 5/21/2025 at 10:49 a.m., LVN B stated administered two hydrocodone-acetaminophen tablets 5/325 mg with Resident #1's morning medications. She stated she did not realize the physician order was for hydrocodone-acetaminophen 10/325 mg. She stated she assumed the medication in the med cart was the accurate dose and did not double check. She stated she was trained on the medication rights and knew she was supposed to check the dosage against the physician's order. During an interview on 5/21/2025 at 12:34 p.m., the ADON stated the resident's physician order was for hydrocodone-acetaminophen 10/325 mg and not 5/325 mg. He stated confirmation that the medication on hand and signed out by several nursing staff was for 5/325 mg. The ADON stated the pharmacy sent over to the facility the 10/325 mg on 4/21/2025. He stated the resident exhausted the supply of medication on 5/15/2025 and a new prescription was requested by the provider. He stated the new blister packet was received on 5/16/2025 for 5/325 instead of 10/325 and that was what the staff had been using (5/325). The ADON stated the order in the medical record for 10/325 mg did not match what was on hand. He stated when the new blister packet was received by the pharmacy, the receiving nurse, who was unknown, should have double checked the medication delivered against the physician order. He stated this was important to ensure the resident was receiving the right dosage for pain management. During an interview on 5/21/2025 at 12:40 p.m., a pharmacy tech stated hydrocodone-acetaminophen was delivered to the facility for Resident #1 on 5/16/2025. She stated just because the resident had an order at the facility for 10/325 mg did not mean that was what would get filled at the pharmacy. She stated what got filled was the physical prescription that was sent to the pharmacy by the physician. She stated each refill required a new written prescription because hydrocodone-acetaminophen was a narcotic and a controlled substance. She stated she tells the nurses that even if they have an order for one thing, the pharmacy might not fill it, depending on the script. She stated Resident #1 had no pending prescriptions. She stated the pharmacy received a script for 5/325 mg and not 10/325 for the refill on 5/16/2025. During an interview on 5/21/2025 at 12:55 p.m., Resident #1 stated his pain was absolutely controlled. He stated Norco (acetaminophen-hydrocodone) was essential for him. He stated he did not know what dosage he was on. He stated he tried to take the medication only when needed and to be cautious with it. During an interview on 5/21/2025 at 1:53 p.m., the ADON stated when staff administers medication, they should very the right dose, the right medication and right resident. He stated they have to make sure every medication given is verified as ordered vs. what is on hand. He stated if the facility did not have on hand what was written in the electronic medical record by the physician, the nurse should notify the physician for clarification. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2025 at 2:33 p.m., LVN C stated he had administered hydrocodone-acetaminophen 5/325 mg to Resident #1, date unknown for pain. He stated he had assumed the medication had already been check and was the right dose by the nurse who received it. LVN C stated it was an honest mistake. He stated he got too comfortable knowing with Resident #1's medications. LVN C stated Resident #1's pain had been controlled on the 5/325 mg dosage. He stated Resident #1 was very vocal when about pain. LVN C stated he was trained to verify the order and the medication including the dosage to make sure he was administering the right one. He stated it was important for patient safety and so their pain was controlled correctly. During an interview on 5/21/2025 at 2:26 p.m., LVN D stated she administered pain medication to Resident #1 yesterday (5/20/2025) and on a Saturday (date unknown). She stated each time she administered two 5/325 mg of hydrocodone -acetaminophen when apparently the order was for 10/325 mg. She stated she was trained to compare the medication on hand to the order in the computer and she did not do that. She stated it was a very hectic day and she guess she was just careless. She stated she was made at herself and learned from her mistakes. She stated she was trained to do it the correctly. During an interview on 5/21/2025 at 2:36 p.m. LVN A stated he administered Norco 5/325 mg when the order was for 10/325 mg. LVN A stated Resident #1 was seen by on pain management and seen by a pain management physician. He stated the nurses notify the physician when the medication was running low for a new script. LVN A verified the order stated 10 mg hydrocodone and the medication was for 5 mg of hydrocodone. He stated he was not certain when the mix up or change of dosage occurred. LVN A stated he did not check the medication to the order for dosage. He stated he had Resident #1 all week. He stated he did not realize there were two different dosages. He stated he was trained on medication rights. He stated it was really easy to miss and he admitted he missed it. LVN A stated Resident #1 had never complained about pain. He stated the resident did go to dialysis and that was when he would request pain meds. During an interview on 5/21/2025 at 3:11 p.m., LVN E stated he had just been made aware of the medication error by the facility. He stated he was not aware prior to today. He stated he was trained to check the order, date of birth, check the patient, the room number, look for correct route, time, side effects and correct dose. He stated he does not know why the correct dose was missed. LVN E stated he could assume he did not look at the blister pack. During an interview on 5/21/2025 at 3:26 p.m., the DON stated it was her expectation for a resident to get the right dosage of their medication, period. She stated the staff should verify if a discrepancy is noted between the electronic medication administration record and the medication on hand. She stated the nurse should not give the medication until the discrepancy was clarified. The DON stated she did not know why so many of the nurses missed the correct dose. She stated it was important for the resident to receive the right dosage of medication because adverse things could happen. Record review of a facility policy, titled Medication Administration (undated) revealed: 2. The 7 Rights of Medication Administration: 3. Right Dose. Verify the label and the MAR match 3. Oral Administration: e. ensure the resident swallows medications before walking away and drinks all of the liquid medication/supplement due.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38511 Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 5 residents reviewed for medical records. The facility failed to ensure LVN A documented Resident #1's acetaminophen-hydrocodone in the electronic medical record. This failure placed resident at risk for delayed or inaccurate medication administration which could result in decline in health and well-being. The findings included: Record review of Resident #1's face sheet dated 5/21/2025 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: metabolic encephalopathy (a condition where underlying health issues disrupts the brain's normal function), anxiety disorder and acute kidney failure. Record review of Resident #1's 5-day admission MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact with no symptoms of delirium. The assessment indicated Resident #1 had rejection of care behaviors 1 to 3 days a week. Record review of Resident #1's care plan dated 4/15/2025 revealed: pain management acute/chronic with interventions which included: Resident will participate actively in making choices/decision for care regarding pain management. Record review of Resident #1's physician order summary dated 5/21/2025 revealed orders which included: Hydrocodone-acetaminophen (Norco) 10/325, give two tablets orally every four hours as needed for pain with a start date of 5/02/2025. Record review of Resident #1's Controlled Drug Record revealed a pharmacy label for hydrocodone-acetaminophen 5/325, take 1-2 tablets every four hours as needed by mouth and was documented as administered on: -5/16/2025 at 5:00 p.m. by an unknown nurse due to illegible signature -5/18/2025 at 8:20 a.m. and 9:30 p.m by an unknown nurse due to illegible signature -5/21/2025 at 8:50 a.m. by LVN B. Record review of Resident #1's May 2025 MAR revealed hydrocodone-acetaminophen 5/325 mg was missing documentation for administration on 5/16/2025, 5/18/2025 and 5/21/2025. During an interview on 5/21/2025 at 10:35 a.m., the ADON identified the nurse signatures on the narcotic record as belonging to LVN A, LVN B, LVN C. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2025 at 10:49 a.m., LVN B stated administered two hydrocodone-acetaminophen tablets 5/325 mg with Resident #1's morning medications on 5/21/2025 with his morning medication. She stated she forgot to document in the electronic medical record after administering the medication. She stated she was trained to sign out the medication on the narcotic record and then come back and sign the electronic medical record after the resident swallowed the medication. During an interview on 5/21/2025 at 12:55 p.m., Resident #1 stated his pain was absolutely controlled. He stated Norco (acetaminophen-hydrocodone) was essential for him. He stated he did not know what dosage he was on. He stated he tried to take the medication only when needed and to be cautious with it. During an interview on 5/21/2025 at 1:53 p.m., the ADON stated when staff administers medication, they should document in the electronic medical record. He stated he did not know why the hydrocodone-acetaminophen was not documented in the medical record for Resident #1, but it should be documented once the resident swallows the medication. During an interview on 5/21/2025 at 2:33 p.m., LVN C stated he had administered hydrocodone-acetaminophen 5/325 mg to Resident #1. He stated he could not remember what date. He stated he was trained to ensure the resident took the medication and then document. During an interview on 5/21/2025 at 2:36 p.m., LVN A stated he administered Norco 5/325 mg to Resident #1 because he had him all week. He stated he was trained to utilize the medication rights, including documentation. During an interview on 5/21/2025 at 3:26 p.m., the DON stated it was her expectation for staff to sign off medications in the electronic medical record after the medication was given. Record review of a facility policy titled Medication Administration (undated) revealed: 2. The 7 Rights of Medication Administration: 7. Right Documentation. Once you have prepared each medication/dose document the MAR and after med is taken complete MAR documentation.