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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the residents had a right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of convenience, and not required to treat the resident's medical symptoms and to use the least restrictive alternate for the least amount of time and document ongoing re-evaluation of the need for restraints for 1 of 9 residents (Resident #6) whose care was reviewed in that: CNA G restrained Resident #6 by tying trash bags around Resident #6's wheelchair wheels to reduce Resident #6's independent mobility in the facility. This deficit practice could potentially affect residents who required wheelchairs for mobility evidenced by restricting movement, a decline in ADL function and psychological distress. The findings were: Record Review of Resident #6's undated face sheet revealed Resident #6 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included a Nontraumatic Intracerebral Hemorrhage (bleeding into the substance of the brain/stroke), Hemiplegia (paralysis on one side of the body), Hemiparesis (muscle weakness of one side of the body), Schizophrenia (a chronic mental illness characterized by delusions, hallucinations and disorganized thinking) and Epilepsy (a brain disorder that causes seizures). Record review of Resident #6's admission MDS assessment, dated 05/14/2025, revealed a BIMS score of 03, indicating severe cognitive impairment. Section GG- Functional Abilities revealed Resident #6 had impairment on both sides of his upper and lower extremities that interfered with daily functions or placed the resident at risk of injury in the prior 7 days of the assessment date. Section GG also revealed Resident #6 required substantial assistance with dressing, showers and sit to stand. Section J- Health Conditions revealed Resident #6 had one fall without injury since admission to the facility. Record review of Resident #6's comprehensive care plan care plan revealed a care plan, dated 05/08/2025 and revised 05/18/2025, Resident #6 required 1 person assistance from staff for transfers to move between surfaces. Resident #6 had a care plan for falls related to generalized weakness, dated 06/11/2025 and revised 06/12/2025, and revealed resident had a fall on 05/12/2025, 05/18/2025, 05/22/2025, 05/25/2025, 06/06/2025, 06/07/2025 and 06/11/2025. An intervention included to keep the resident in common areas for maximum observation opportunities, date initiated 05/30/2025. (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
	676378	A. Building B. Wing	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's fall risk assessment, dated 06/10/2025, revealed Resident #6 was a high fall risk and had 3 or more falls in the past 3 months. The assessment revealed Resident #6 was chair bound. Record review of Resident #6's Occupational Therapy Treatment Encounter Note, dated 06/11/2025, revealed Resident #6 had poor standing balance and fair sitting balance. The note revealed complexities /barriers impacting the session included fall risk, reduced cognition, and LUE weakness. Record review of Resident #6's progress note, dated 06/17/2025 at 1:00 p.m. revealed Resident #6 was discharged to a rehabilitation center with all personal belongings and medications. Record review of a letter provided to the HHSC Investigator by a COTA, 06/18/2025 at 1:07 p.m., revealed On July 11, 2025, during 2 pm to 10 pm shift, this incident occurred at [facility] SNF in [city and state]. [CNA G] restrained [Resident #6 name] (patient) in one of the following ways: [CNA G name] tied patient arms to his hospital bed with trash bags. [CNA G name] tied patient arms to the wheelchair with trash bags. [CNA G] tied up patient w/c wheels so that patient could not move his w/c. [Resident #6 name] is cognitively impaired following a stroke and has hemiplegia. He is unable to recall information and events that have occurred. He can communicate basic wants and needs. [CNA G name] claims that [LVN G name] gave him permission to do so. Patient had been roaming the halls, opening med carts and taking items from the nurse's station. [LVN C name] witnessed [CNA G name] restraining patient and reported incident to Administrator. On another occasion, [CNA D name] overheard [CNA G name] tell the same patient that he was going to kill the patient. [CNA D name] reported this incident to [UM name]. [CNA G name] was suspended on July 12, 2025, pending investigation, however, he returned to work on July 15, 2025, during 2pm-10pm shift. During an interview with the COTA, 06/18/2025 at 1:10 p.m., the COTA stated the dates on her letter were for June 2025 and not July 2025 and stated she was informed by CNA D on 06/12/2025 that Resident #6 was restrained by CNA G on 06/11/2025. COTA stated LVN C witnessed the incident and reported it to the UM and CNA G was suspended but was allowed to return to work. The COTA stated she provided therapy services to Resident #6 on Friday 6/13/2025 and Resident #6 was not exhibiting any emotional distress. The COTA stated she did not witness the restraint but felt like it should have been reported to the state. The COTA stated she was not sure if any of the witnesses reported it, but she wanted to report it today. The COTA stated CNA D told her that CNA D witnessed CNA G tell Resident #6 that he was going to kill him and CNA D reported it to the UM. The COTA stated she should have reported it to the state when she became aware of the allegation so it could have been investigated at that time because the patients cannot advocate for themselves. The COTA stated she was not aware of any other residents being restrained or abused and stated she had been trained on abuse and neglect. (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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN C, 06/18/2025 at 2:56 p.m., LVN C stated she had suspected another employee of abusing a resident and stated she reported the incident to the UM and DON. LVN C stated on July 11, 2025, around 8 p.m., LVN C was walking by the café day room close to the nurse's station and observed Resident #6 sitting in his wheelchair with trash bags wrapped around the wheelchair tires. LVN C stated Resident #6 was unable to move and was observed trying to move his chair, appeared distressed and agitated and was leaning out of his chair reaching toward the coffee bar. LVN C stated the trash bags were looped throughout the wheels and tied to the center bar in the back of the chair and some bags were tied together from one wheel to the other. LVN C said there were so many trash bags used, and the bags were woven together like a spider web. LVN C stated the bags were so thick that she had to hack at the trash bags with her scissors to cut the bags off. LVN C stated CNA G came over to Resident #6 while LVN C was trying to cut the bags off, and CNA G was laughing and told LVN C not to cut the bags off and told LVN C that LVN E knew about it and to talk to LVN E about it. LVN C stated she was not talking to LVN E about it, briefly assessed Resident #6 to see that he did not have any markings on him and said Resident #6 regained his mobility and got himself a cup of coffee. LVN C stated she immediately reported the incident to the DON and UM and was told to send CNA G home. LVN C said she was under the impression an investigation would be conducted, and CNA G would be terminated but CNA G was allowed to return to work. During an interview with LVN C, 06/19/2025 at 11:43 a.m., LVN C stated CNA G stated he tied the trash bags to Resident #6's wheelchair because Resident #6 was going in and out of other resident rooms. LVN C stated Resident #6's primary mode of mobility was his wheelchair and Resident #6 was not ambulatory and was a fall risk. During an interview with CNA M, 06/19/2025 at 1:30 p.m., CMA M stated she arrived at work early on 06/11/2025 around 8 p.m. for her 10 p.m. - 6 a.m. shift. CNA M stated she was walking by the café day room and observed Resident #6 in the day room with his wheelchair wheels tied up with trash bags in all different directions in his wheels. CNA M stated Resident #6 was trying to move in the chair and could not move and appeared distressed. CNA M stated Resident #6 could not walk, and the trash bags were preventing Resident #6 from being about to move independently. CNA M stated she went to LVN E and told LVN E what she observed and LVN E said it was because he was going into other people's room and taking stuff. CNA M stated she told LVN E that was abuse and LVN E did not respond. CNA M stated another nurse was by Resident #6 and the nurse told CNA M that she reported the incident, so CNA M did not report it. CNA M stated she felt like the incident was a restraint and abuse and stated she should have reported the incident to the Administrator and DON. CNA M stated she had received training on reporting abuse and neglect prior to witnessing the incident and knew that abuse should be reported immediately to the Abuse Coordinator who was the Administrator. (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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the UM, 06/19/2025 at 2:00 p.m., the UM said the definition of a physical restraint was impeding a patient from being able to move freely and stated facility staff received training on abuse and neglect upon hire and anytime there was an investigation. The UM stated LVN C called the UM and DON on 06/11/2025 around 8 p.m. and reported observing CNA G place trash bags around Resident #6's wheelchair wheels and stated LVN C was instructed to send CNA G home. The UM stated he met with CNA G on 06/12/2025 and CNA G explained the situation to me and I suspended him and notified the DON of what he said. The UM stated CNA G said Resident #6 had increased behaviors during the shift and was going in other resident rooms and being disruptive so he attempted to slow him down from going into other rooms by getting some trash bags and wrapped them around the wheelchair wheels to slow him down from being able to move in the wheelchair. The UM stated the wheelchair was Resident #6's primarily mode for mobility and Resident #6 was not able to ambulate safely. The UM stated he was not sure if the Administrator was notified and stated the DON conducted the investigation, staff received in servicing on abuse and restraints and CNA G was placed on a final disciplinary warning. The UM stated CNA D did not report an allegation of CNA G being rough with Resident #6 or telling Resident #6 that CNA G would kill him. The UM stated if that was reported to him, he would have suspended CNA G and notified the DON and the Administrator. The UM stated he was not aware of any other restraints methods being used and stated a resident who was improperly restrained could fall, get a fracture, or skin tear while trying to get out of the restraint depending on the type of restraint used. During an interview with LVN E, 06/19/2025 at 2:56 p.m., LVN E stated Resident #6 had a witnessed fall in his room at the beginning of LVN E's shift on 06/11/2025 at 2 p.m. LVN E stated Resident #6 was brought out of his room and placed in the café day room so he could be observed. LVN E stated Resident #6 was observed throughout the shift going in and out of other resident rooms, turning water faucets on and off and LVN E observed Resident #6 propelling himself around the unit during the shift. LVN E stated she was not aware that Resident #6 had trash bags tied to his wheelchair wheels on the night of 6/11/2025 until this HHSC Investigator asked her about it. LVN E stated she did not observe anything tied to Resident #6's chair, no one called her and notified her that Resident #6 had trash bags tied to his chair and no one had contacted her and asked her to suspend CNA G. LVN E stated she observed CNA G leaving the facility around 9 pm and said CNA G told her he was leaving and LVN E assumed he was being sent home because census was low. LVN E stated she spoke to the UM and DON about Resident #6 having a fall on the shift but was not questioned or notified about the observation of trash bags being tied to Resident #6's wheelchair wheels. LVN E stated she was not asked to complete a head-to-toe assessment after the incident. LVN E stated she did not instruct CNA G to restrain Resident #6 and LVN E stated tying trash bags on the wheels of a resident wheelchair was a restraint and abuse and LVN E stated she would have notified the DON and abuse prevention coordinator. LVN E stated no other staff members had reported any allegations of abuse regarding CNA G and Resident #6 to her and she was not aware of any other restraint methods ever used in the facility. LVN E stated she had been trained on restraints, restraints were not allowed at the facility and a resident who was improperly restrained could cause bruising, fractures, or aggression when the resident tried to get out of the restraint or cause the resident to fall and get injured. (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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA G, 06/19/2025 at 4:22 p.m. CNA G stated Resident #6 was roaming around in different patient rooms on the evening of 06/11/2025 so CNA G redirected him to the café day room so we could keep a better eye on him. CNA G stated he put trash bags in the resident wheelchair wheels gently and stated he did it so we would be able to see him if he tried to leave again so we could see him and help him. CNA G said he placed the trash bags in the wheels to do something like slow the resident down. CNA G stated he had received training on restraints prior to this incident and stated the definition of a restraint was when a patient cannot move or get up or do anything on their own. CNA G stated he was not told to add the trash bags by anyone else and did not tell anyone else that he did it because he did not feel like it was a restriction. CNA G stated he had never tied Resident #6's arms to his bed or wheelchair, never placed trash bags in any other resident wheelchair wheels and had never restrained another resident. CNA G stated he was notified by LVN C that he restrained a resident and was being suspended. CNA G stated he met with the UM on 06/12/2025 and received training on abuse, neglect, and restraints. CNA G stated a resident who was improperly restrained could harm themselves mentally or physically. During an interview with the UM, 06/20/2025 at 3:11 p.m., UM stated he conducted a psychosocial wellbeing assessment for Resident #6 on 06/12/2025 as part of the investigation policy whenever there is an allegation or a concern. UM stated no one asked him to complete the assessment and stated it was usually completed by the Social Worker, but the Social Worker was not available. UM stated he completed patient safe survey questionnaires and employee abuse investigation questionnaires for a few employees on 06/12/2025 as part of the investigative protocols and turned the forms into the DON. UM stated Resident #6 did not recall the incident and was not exhibiting any emotional or psychosocial distress and no additional allegations were identified during the questionnaires. (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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON, 06/20/2025 at 9:33 a.m., the DON stated, staff received training on abuse/neglect, behavior management and restraints upon hire and throughout the year. The DON stated staff had received training on reporting abuse to the abuse coordinator and any allegations of abuse should have been reported immediately. The DON stated the facility was restraint free and described a physical restraint as any type of device used in contact with the body that limits the movement of the resident. The DON stated it would be considered a restraint if a resident's primary mode of mobility was his wheelchair and the resident was unable to move in the chair due to the wheelchair wheels being compromised by a staff member. The DON stated Resident #6 was a fall risk, had several falls at the facility, was able to propel himself in his wheelchair and was not able to ambulate safely. The DON stated LVN C sent the DON and UM a text on 06/11/2025 around 8:15 p.m. and said, someone needs to deal with [CNA G], he restrained a patient and he put trash bags on [Resident #6]'s wheelchair and it is not okay to tie him down and he cannot move. The DON said, I responded and said this is not acceptable behavior and please send him home and [UM] responded and said, yes send him home. The DON said LVN C informed her that she was not CNA G's nurse so the DON stated she called LVN E and asked LVN E to send him home and LVN E said she could see Resident #6 and he was moving around freely but I didn't think about the fact that LVN C had already cut the trash bags off so when I heard LVN E say he could move freely I thought it was with the trash bags on. The DON stated she did not notify the Administrator of the allegation and did not report the allegation to HHSC. The DON stated CNA G received a write up on 06/12/2025 by the UM and the DON met with CNA G when he returned to work on 6/16/25 after a 3-day suspension and in serviced him on customer service and what LVN C observed. The DON stated CNA G apologized and stated he was just trying to slow Resident #6 down. The DON said she did not instruct anyone to complete a head-to-toe assessment, psychosocial assessment after the incident but in servicing was started on 06/12/2025 on abuse and neglect and did not cover restraints. The DON said the Administrator became aware of the allegation after LVN C met with this HHSC investigator on 06/18/2025 and the DON stated they had CNA G come in and demonstrate how he placed the trash bags in the wheels and CNA G was suspended again on 06/18/2025. The DON stated the staff began receiving education on restraints after this HHSC investigator entered the facility. The DON stated [psychiatric company name] visited Resident #6 on 06/13/2025 on a routine visit and it was not related to the incident on 06/11/2025. The DON stated LVN E signed a head-to-toe assessment on 6/11/2025 that was completed by a CNA after a shower earlier in the day and the head-to-toe assessment in the investigation summary was not completed after the incident by LVN E. The DON stated an emergency QAPI was held on 6/19/2025 with the physician, behavior management education was initiated and [psychiatric company name] was conducting an in-service for the staff at 2:00 p.m. on 06/20/2025. The DON stated a question about restraints was added to the employee abuse questionnaire. The DON stated safe surveys were initiated for all interviewable patients on 06/19/2025 on 2 p.m.- 10 p.m. shift and non interviewable residents received head to toe assessments to ensure there were no further allegations. The DON said the allegation regarding the restraint was reported to HHSC on the evening of 06/19/2025. The DON stated she was never notified of any other allegation of abuse from any other employees and had not received any other reports of restraints. The DON stated physical injury or psychosocial injury could occur for residents who are improperly restrained. (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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator, 06/20/2025 at 12:23 p.m., the Administrator stated she is the Regional [NAME] President and became the acting Administrator on 5/23/2025 when the previous Administrator left the position and would remain in the position until the new Administrator started on 06/23/2025. The Administrator stated staff had received training on abuse and neglect, restraints and reporting abuse and neglect upon hire and throughout the year. The Administrator stated the expectation was for all allegations to be reported directly to the Administrator, who was the Abuse Prevention Coordinator and stated the facility was restraint free. The Administrator stated she was notified by the Regional Corporate Nurse on 06/18/2025 that a nurse had reported we had restrained a patient. The Administrator stated she spoke to the DON who told her a trash bag was used in a resident's wheelchair tires and the DON thought it was a customer service issue and did not report it. The Administrator stated, when I got here yesterday, my understanding is that they initiated an investigation and that there was a head to toe that night and that psych services saw him the next day to make sure there was no emotional distress. The Administrator stated she should have been notified on 06/11/2025 and she would have reported the incident to HHSC and completed an investigation. The Administrator stated she was not sure what harm could come to a resident who was improperly restrained because her understanding was that Resident #6 was able to propel himself in the wheelchair with the trash bags in place, but the investigation was ongoing. Record review of a facility incident report for Resident #6, dated 06/12/2025 at 2:00 p.m. and completed by the UM, categorized the incident as alleged abuse and described the incident as charge nurse reported that employee had wrapped trash bag around pt wheelchair wheel as a restraint to keep patient from moving in w/c. Immediate action taken revealed, employee was send home and suspended during investigation, head to toe assessment was performed on patient and patient was interviewed. The report revealed the physician and DON were notified on 06/13/2025 at 1:11 p.m. Record review of a facility document titled Employee Coaching and Counseling revealed CNA G placed a resident in small dining room then placed trash bags on wheelchair wheels to attempt to keep patient from going into other patient rooms. Action taken revealed employee was suspended x 3 days, in serviced regarding abuse and restraints and placed on final warning. The form was signed by the UM on 06/12/2025 and signed by CNA G, undated. Record review revealed CNA G signed a facility document titled, [Company name] Acknowledgement of Abuse Policy and Reporting Requirements, on 06/12/2025. Record review revealed CNA G completed a Restraint Quiz on 06/16/2025 that included the question, 2. It's okay to prevent a patient from roaming freely within the facility? A. true B. False. CNA G marked the question as B. False. Record review of an undated statement signed by CNA G revealed, on 6/11 [Resident #6] was having increased behaviors throughout the shift and going to other patient rooms and been inappropriate/disruptive, with guest and patients. [Resident #6] was redirected numerous times and taken out of patient's rooms and he kept going back to the rooms. In an attempt to help other patient and keep close watch on [Resident #6], I put him in café where he likes to drink coffee. I tried to slow him down by putting trash bags at the bottom of the wheelchair, but he was never restrained and could get up and move freely if he wanted to. (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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated statement signed by LVN E revealed, on 06/11/25 I was the nurse for [Resident #6 name] on the 2-10 shift. The patient had an unwitnessed fall at the beginning of the shift. After doing a thorough head to toe assessment on the resident, the aide and I place him in his w/c and placed him in the café next to the nurse's station so I could monitor him closely. The measure did not disable the patient's movement or restrict him from using his limbs. He was still doing things like turning the water on in the sink, getting up out of the wheelchair to fetch coffee, opening p the creams & sugars & pouring them on al the tables, and able to stand briefly. I witnessed this throughout the remainder for the shift. At no point was the resident's limbs compromised or he was confined to the café. I check on him frequently throughout the shift due to his fall risk until it was time for him to be put to bed. Record review of a statement dated 06/19/2025, and signed by LVN C revealed, On 06/11/2025 @ 8:00 pm I was walking down 700 hall to the Nurse's station when I passed the café and saw patient [Resident #6 last name] with 2 CNAs [CNA G and CNA H]. I hard [CNA G and CNA H] laughing in which case I came over and then had point [CNA G] point out to me that he had tied up the patient's wheelchairs together with trash bags. The trash bags were tied to each of the wheels and then tied to the center piece of the wheelchair limiting the patients ROM. Patient appeared aggravated while attempting to reach for the coffee cups and was seen attempting to scoot himself off his wheelchair in order to reach the coffee. I demanded that [CNA G] remove the trash bags, [CNA G] refused. I attempted to tear the trash bags with my hands and was unable to because of how many trash bags were used. I then proceeded to grab a pair of scissors, when [CNA G] attempted to stop me telling me 'ASK [LVN E first two letters of name]! ASK [LVN E first two letters of name]! ASK [LVN E first two letters of name]! BEFORE YOU CUT THEM OFF!' I told [CNA G] that I was not going to ask [LVN E first two letters of name] anything and if she did not want me to cut off the trash bags she can come over and discuss it with me. I then proceeded to cut off and remove the trash bags, and quickly looked over patient, no apparent injury was noted right after incident. I reported to DON and UM on 06/11/2025 at 8:15 p.m. Record review of a statement dated 06/12/2025 and signed by the UM revealed, This nurse conducted an interview with [Resident #6], patient stated that he is satisfied with all the services been provided by employees. Patient was asked if he feels safe as a patient here at the facility and he said yes, pt was asked if he ever has been mistreated, pt responded that it has never happened. [Resident #6] was asked if he has ever been restricted of kept from moving freely throughout the facility, and he responded no. that he can move around in his w/c at all times and that he transfers self from w/c to bed but has been told not to do that on his own because he can fall. Record review of a facility document titles, Psychosocial Well-Being, revealed the UM completed the assessment for Resident on 06/12/2025 and revealed Resident #6 had no change in his psychosocial well-being. Record review revealed 6 facility residents were administered a patient abuse questionnaire on 06/12/2025, completed by UM and included Resident #6. The questionnaires revealed no additional allegations. Record review of an employee abuse questionnaire revealed 39 employees completed the questionnaires dated 06/12/2025. (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	06/20/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an in-service roster, presented by the DON and dated 06/12/2025, revealed the topic was abuse and neglect, reporting abuse and neglect and the use of restraints and revealed 43 names. Record review of an in-service roster, presented by the DON on 6/12/25, revealed the topic was incident/accidents and revealed 27 names. Record review of facility document titled, Job Description Certified Nursing Assistant, revealed CNA G's signed the job description on 10/23/2024. The job description revealed the essential function of the role included promote and support the greatest possible degree of independence for patients and responsible for assuring patient/resident safety. Record review revealed CNA G completed a Restraint Competency Quiz on 10/15/2024. Record review revealed CNA G signed Senate [NAME] 9 of Nursing Home Policy on 10/14/2024 that included remember our policy that all patients/residents of this community are to be always treated with dignity and respect under all circumstances. Mistreatment or abuse of any nature will not be tolerated. Any employee guilty of abusing, neglecting or not disclosing such acts is subject to immediate discharge. Local authorities will be notified, and criminal charges may be filed. Record review of the facility's policy titled, [company name] Abuse Prohibition Protocol dated August 2024, revealed, The patient has the right to be free from abuse, neglect, mistreatment of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the Patient's symptoms. The protocol revealed, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. Instances of abuse of all patient/resident, irrespective of any physical or mental condition, cause physical harm, pain, or mental anguish. 'Willful' as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mistreatment means inappropriate treatment or exploitation of a patient. Record review of the facility's policy titled, [company name] Physical Restraints dated November 2016, revealed, 1. The facility promotes and adheres to restraint free care for the patient's overall well-being. 2. The patient must be free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the patient's medical symptoms .

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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the event, if the events result in serious bodily injury, or no later than 24 hours if the events and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with state law through established procedures for 1 of 9 residents (Residents #6) reviewed for abuse and neglect, in that: 1. CNA D observed CNA G yank Resident #6 out of bed and overheard CNA G tell Resident #6 he was going to kill him in Spanish. CNA D did not report the allegation timely and did not report to the Administrator. 2. CNA M observed Resident #6 with wheelchair wheels tied together with plastic bags, restricting Resident #6's mobility, and CNA M did not report the incident to the DON or Administrator. 3. The DON was notified by LVN C that Resident #6 was observed with his wheelchair wheels tied together, restricting Resident #6's mobility and the DON did not report the allegation to the Administrator. 4. The UM was notified by LVN C that Resident #6 was observed with his wheelchair wheels tied together, restricting Resident #6's mobility and the UM did not report the allegation to the Administrator. This failure/deficient practice could place residents at risk for not having allegations of abuse or neglect reported to the State Agency to ensure that allegations are fully investigated. The findings were: 1. Record Review of Resident #6's undated face sheet revealed Resident #6 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included a Nontraumatic Intracerebral Hemorrhage (bleeding into the substance of the brain/stroke), Hemiplegia (paralysis on one side of the body), Hemiparesis (muscle weakness of one side of the body), Schizophrenia (a chronic mental illness characterized by delusions, hallucinations and disorganized thinking) and Epilepsy (a brain disorder that causes seizures). (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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's admission MDS assessment, dated 05/14/2025, revealed a BIMS score of 03, indicating severe cognitive impairment. Section GG- Functional Abilities revealed Resident #6 had impairment on both sides of his upper and lower extremities that interfered with daily functions or placed the resident at risk of injury in the prior 7 days of the assessment date. Section GG also revealed Resident #6 required substantial assistance with dressing, showers and sit to stand. Section J- Health Conditions revealed Resident #6 had one fall without injury since admission to the facility. Record review of Resident #6's comprehensive care plan care plan revealed a care plan, dated 05/08/2025 and revised 05/18/2025, Resident #6 required 1 person assistance from staff for transfers to move between surfaces. Resident #6 had a care plan for falls related to generalized weakness, dated 06/11/2025 and revised 06/12/2025, and revealed resident had a fall on 05/12/2025, 05/18/2025, 05/22/2025, 05/25/2025, 06/06/2025, 06/07/2025 and 06/11/2025. An intervention included to keep the resident in common areas for maximum observation opportunities, date initiated 05/30/2025. Record review of Resident #6's fall risk assessment, dated 06/10/2025, revealed Resident #6 was a high fall risk and had 3 or more falls in the past 3 months. The assessment revealed Resident #6 was chair bound. Record review of Resident #6's Occupational Therapy Treatment Encounter Note, dated 06/11/2025, revealed Resident #6 had poor standing balance and fair sitting balance. The note revealed complexities /barriers impacting the session included fall risk, reduced cognition, and LUE weakness. Record review of Resident #6's progress note, dated 06/17/2025 at 1:00 p.m. revealed Resident #6 was discharged to a rehabilitation center with all personal belongings and medications. Record review of a letter provided to the HHSC Investigator by a COTA, 06/18/2025 at 1:07 p.m., revealed On July 11, 2025, during 2pm to 10 pm shift, this incident occurred at [facility name] SNF in [city and state name]. [CNA G name] restrained [Resident #6 name] (patient) in one of the following ways: [CNA G name] tied patient arms to his hospital bed with trash bags. [CNA G name] tied patient arms to the wheelchair with trash bags. [CNA G] tied up patient w/c wheels so that patient could not move his w/c. [Resident #6 name] is cognitively impaired following a stroke and has hemiplegia. He is unable to recall information and events that have occurred. He can communicate basic wants and needs. [CNA G name] claims that [LVN G name] gave him permission to do so. Patient had been roaming the halls, opening med carts and taking items from the nurse's station. [LVN C name] witnessed [CNA G name] restraining patient and reported incident to Administrator. On another occasion, [CNA D name] overheard [CNA G name] tell the same patient that he was going to kill the patient. [CNA D name] reported this incident to [UM name]. [CNA G name] was suspended on July 12, 2025, pending investigation, however, he returned to work on July 15, 2025, during 2pm-10pm shift. (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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the COTA, 06/18/2025 at 1:10 p.m., the COTA stated the dates on her letter were for June 2025 and not July 2025 and stated she was informed by CNA D on 06/12/2025 that Resident #6 was restrained by CNA G on 06/11/2025. COTA stated LVN C witnessed the incident and reported it to the UM and CNA G was suspended but was allowed to return to work. The COTA stated she provided therapy services to Resident #6 on Friday 6/13/2025 and Resident #6 was not exhibiting any emotional distress. The COTA stated she did not witness the restraint but felt like it should have been reported to the state. The COTA stated she was not sure if any of the witnesses reported it, but she wanted to report it to the HHSC investigator. The COTA stated CNA D told her that CNA D witnessed CNA G tell Resident #6 that he was going to kill him and CNA D reported it to the UM. The COTA stated she should have reported it to the state when she became aware of the allegation so it could have been investigated at that time because the patients cannot advocate for themselves. The COTA stated she was not aware of any other residents being restrained or abused and stated she had been trained on abuse and neglect prior to being told about the allegations by CNA D. During an interview with CNA D, 06/18/2025 at 2:07 p.m., CNA D stated she had suspected another employee of abusing a resident and stated she reported the incident to the UM and DON. CNA D stated a few weeks ago CNA D was with CNA G around 7 p.m. in Resident #6's room and observed CNA G yank Resident #6 up off of the bed so hard I thought [CNA G] was going to break his back. CNA D said CNA G also said I am going to kill you in Spanish to Resident #6. CNA D stated she reported the incident to LVN E at the time of the incident, 2 days later reported the incident to the UM and then reported the incident to the DON one week later. CNA D stated the UM said he would send CNA G home. CNA D stated when she notified the DON the following week, the DON told CNA D that CNA D should have reported it to the DON at the time of the incident so she could have properly handled it. CNA D stated she did not know if anyone took her report seriously and stated she should have reported it to the Administrator but did not know who that was at the time and said, I did not know anyone's name or who to call. CNA D stated it was important to report abuse because CNA G could of literally hurt him and I left the room, so who knows what even happened after that. During an interview with the UM, 06/19/2025 at 2:00pm, the UM stated he was not notified of CNA G being rough with Resident #6 or telling Resident #6 that CNA G would kill him. The UM stated it that was reported to him he would have suspended CNA G and notified the DON and the Administrator. During an interview with LVN E, 06/20/2025 at 2:56 p.m., LVN E stated she was not notified of CNA G being rough with Resident #6 or telling Resident #6 that CNA G would kill him. LVN E stated CNA D reported to her that CNA G was not a team player but did not make any allegations of abuse toward CNA G. LVN E stated she had not received any reports of abuse or concerns regarding CNA G as the Charge Nurse. LVN E said she would have reported the incident to the DON if she was notified of an allegation of abuse and stated it was important to report abuse and neglect because the patients are our number one priority and we have to protect them from harm. During an interview with the DON, 06/20/2025 at 9:33 a.m., the DON stated CNA D did not report any allegations against CNA G regarding Resident #6 and had not received any other allegations of abuse or resident concerns regarding CNA G. The DON stated if CNA D reported any allegations of abuse to her, she would have notified the Administrator and suspended the employee. The DON stated employees received training on abuse and neglect when hired and throughout the year and the expectation was for employees to report abuse immediately to the Administrator. The DON stated allegations of abuse that were not investigated could cause psychological and physical harm to facility residents. (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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility document titled, Job Description Certified Nursing Assistant, revealed CNA D's signed the job description on 04/15/2025. The job description revealed an essential function as, has reviewed [company name] clinical policies and procedures for abuse prevention and knows the employee's responsibility to enforce it and responsible for assuring patient/resident safety. Record review revealed CNA D signed Senate [NAME] 9 of Nursing Home Policy on 04/15/2025 that included remember our policy that all patients/residents of this community are to be always treated with dignity and respect under all circumstances. Mistreatment or abuse of any nature will not be tolerated. Any employee guilty of abusing, neglecting or not disclosing such acts is subject to immediate discharge. Local authorities will be notified, and criminal charges may be filed. Record review revealed CNA D signed the facility Abuse Prohibition Protocol on 04/15/2025. 2. During an interview with CNA M, 06/19/2025 at 1:30 p.m., CMA M stated she arrived at work early on 06/11/2025 around 8 p.m. for her 10 p.m. - 6 a.m. shift. CNA M stated she was walking by the café day room and observed Resident #6 in the day room with his wheelchair wheels tied up with trash bags in all different directions in his wheels. CNA M stated Resident #6 was trying to move in the chair and could not move and appeared distressed. CNA M stated Resident #6 could not walk, and the trash bags were preventing Resident #6 from being about to move independently. CNA M stated she went to LVN E and told LVN E what she observed and LVN E said it was because he was going into other people's room and taking stuff. CNA M stated she told LVN E what she witnessed was abuse and LVN E did not respond. CNA M stated another nurse by Resident #6 and the nurse told her that she reported the incident, so CNA M did not report it. CNA M stated she felt like the incident was a restraint and abuse and stated she should have reported the incident to the Administrator and DON. CNA M stated she had received training on reporting abuse and neglect prior to witnessing the incident and knew that abuse should be reported immediately to the Abuse Coordinator who was the Administrator. During an interview with LVN E, 06/19/2025 at 2:56 p.m., LVN E stated no one reported observing Resident #6 with trash bags tied around his wheelchair wheels and stated she would have notified the DON and abuse prevention coordinator. LVN E stated she had been trained on restraints, restraints were not allowed at the facility and a resident who was improperly restrained could cause bruising, fractures, or aggression when the resident tried to get out of the restraint or cause the resident to fall and get injured. During an interview with the DON, 06/20/2025 at 9:33 a.m., the DON stated after this HHSC investigator entered the facility, the DON interviewed other employees at the facility on the night of 06/11/2025 and said, no one else admitted seeing it to me anyway, I don't know if they were scared of what, CNA G admitted to putting the trash bags on the chair though. 3. (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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN C, 06/18/2025 at 2:56 p.m., LVN C stated she had suspected another employee of abusing a resident and stated she reported the incident to the UM and DON. LVN C stated on July 11, 2025, around 8 p.m., LVN C was walking by the café day room close to the nurse's station and observed Resident #6 sitting in his wheelchair with trash bags wrapped around the wheelchair tires. LVN C stated Resident #6 was unable to move and was observed trying to move his chair, appeared distressed and agitated and was leaning out of his chair reaching toward the coffee bar. LVN C stated the trash bags were looped throughout the wheels and tied to the center bar in the back of the chair and some bags were tied together from one wheel to the other. LVN C said there were so many trash bags used, and the bags were woven together like a spider web. LVN C stated the bags were so thick that she had to hack at the trash bags with her scissors to cut the bags off. LVN C stated CNA G came over to Resident #6 while LVN C was trying to cut the bags off, and CNA G was laughing and told LVN C not to cut the bags off and told LVN C that LVN E knew about it and to talk to LVN E about it. LVN C stated she was not talking to LVN E about it, briefly assessed Resident #6 to see that he did not have any markings on him and said Resident #6 regained his mobility and got himself a cup of coffee. LVN C stated she immediately reported the incident to the DON and UM and was told her to send CNA G home. LVN C said she was under the impression an investigation would be conducted and CNA G would be terminated but CNA G was allowed to return to work. During an interview with LVN E, 06/19/2025 at 2:56 p.m., LVN E stated Resident #6 had a witnessed fall in his room at the beginning of LVN E's shift on 06/11/2025 at 2 p.m. LVN E stated Resident #6 was brought out of his room and placed in the café day room so he could be observed. LVN E stated Resident #6 was observed throughout the shift going in and out of other resident rooms, turning water faucets on and off and LVN E observed Resident #6 propelling himself around the unit during the shift. LVN E stated she was not aware that Resident #6 had trash bags tied to his wheelchair wheels on the night of 6/11/2025 until this HHSC Investigator asked her about it. LVN E stated she did not observe anything tied to Resident #6's chair, no one called her and notified her that Resident #6 had trash bags tied to his chair and no one had contacted her and asked her to suspend CNA G. LVN E stated she observed CNA G leaving the facility around 9 pm and said CNA G told her he was leaving and LVN E assumed he was being sent home because census was low. LVN E stated she spoke to the UM and DON about Resident #6 having a fall on the shift but was not questioned or notified about the observation of trash bags being tied to Resident #6's wheelchair wheels. LVN E stated she was not asked to complete a head-to-toe assessment after the incident. LVN E stated she did not instruct CNA G to restrain Resident #6 and LVN E stated tying trash bags on the wheels of a resident wheelchair was a restraint and abuse and LVN E stated she would have notified the DON and abuse prevention coordinator. (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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA G, 06/19/2025 at 4:22 p.m. CNA G stated Resident #6 was roaming around in different patient rooms on the evening of 06/11/2025 so CNA G redirected him to the café day room so we could keep a better eye on him. CNA G stated he put trash bags in the resident wheelchair wheels gently and stated he did it so we would be able to see him if he tried to leave again so we could see him and help him. CNA G said he placed the trash bags in the wheels to do something like slow the resident down. CNA G stated he had received training on restraints prior to this incident and stated the definition of a restraint was when a patient cannot move or get up or do anything on their own. CNA G stated he was not told to add the trash bags by anyone else and did not tell anyone else that he did it because he did not feel like it was a restriction. CNA G stated he had never placed trash bags in any other resident wheelchair wheels and had never restrained another resident. CNA G stated he was notified by LVN C that he restrained a resident and was being suspended. CNA G stated he met with the UM on 06/12/2025 and received training on abuse, neglect, and restraints. CNA G stated a resident who was improperly restrained could harm themselves mentally or physically. CNA G stated he never threatened to kill Resident #6 and denied ever handling Resident #6 roughly during a transfer. CNA G stated he used a gait belt any time he transferred Resident #6. During an interview with the DON, 06/20/2025 at 9:33 a.m., the DON stated, staff received training on abuse/neglect, behavior management and restraints upon hire and throughout the year. The DON stated staff had received training on reporting abuse to the abuse coordinator and any allegations of abuse should have been reported immediately. The DON stated the facility was restraint free and described a physical restraint as any type of device used in contact with the body that limits the movement of the resident. The DON stated it would be considered a restraint if a resident's primary mode of mobility was his wheelchair and the resident was unable to move in the chair due to the wheelchair wheels being compromised by a staff member. The DON stated Resident #6 was a fall risk, had several falls at the facility, was able to propel himself in his wheelchair and was not able to ambulate safely. The DON stated LVN C sent the DON and UM a text on 06/11/2025 around 8:15 p.m. and said, someone needs to deal with [CNA G], he restrained a patient and he put trash bags on [Resident #6]'s wheelchair and it is not okay to tie him down and he cannot move. The DON said, I responded and said this is not acceptable behavior and please send him home and [UM] responded and said, yes send him home. The DON said LVN C informed her that she was not CNA G's nurse so the DON stated she called LVN E and asked LVN E to send him home and LVN E said she could see Resident #6 and he was moving around freely but I didn't think about the fact that LVN C had already cut the trash bags off so when I heard LVN E say he could move freely I thought it was with the trash bags on. The DON stated she did not notify the Administrator of the allegation and did not report the allegation to HHSC. The DON reviewed an in-service conducted by the Regional Nurse Manager regarding reporting abuse and neglect, dated 06/16/2025, and said, the in-service was because I did not report it and this was her telling me and [UM name] we should have reported this to the ED and said oh that must be a mistake because they didn't know about it until after you got here regarding the in service date. The DON stated In lieu of the concerns and the UM telling me the concerns of what happened we went ahead and reported it to HHS on 06/19/2025 regarding [CNA G] restraining the resident and I called the HHSC Liaison, and she said it definitely needed to be reported and should have been reported within the 2-hour window. She asked me if I thought I should have reported it and I said yes. The DON stated an emergency QAPI was held on 6/19/2025 with the physician, behavior management education was initiated and [psychiatric company name] was conducting an in service for the staff at 2:00 p.m. on 06/20/2025. 4. (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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the UM, 06/19/2025 at 2:00 p.m., the UM stated LVN C called the UM and DON on 06/11/2025 around 8 p.m. and reported observing CNA G place trash bags around Resident #6's wheelchair and stated LVN C was instructed to send CNA G home. The UM stated he met with CNA G on 06/12/2025 and CNA G explained the situation to me and I suspended him and notified the DON of what he said. The UM stated CNA G said Resident #6 had increased behaviors during the shift and was going in other resident rooms and being disruptive so he attempted to slow him down from going into other rooms by getting some trash bags and wrapped them around the wheelchair wheels to slow him down from being able to move in the wheelchair. The UM stated the wheelchair was Resident #6's primarily mode for mobility and Resident #6 was not able to ambulate safely. The UM stated he was not sure if the Administrator was notified and stated the DON conducted the investigation, staff received in servicing on abuse and restraints and CNA G was placed on a final disciplinary warning. The UM stated he did not notify the Administrator of the allegation of abuse and stated the Administrator was the Abuse Prevention Coordinator and all allegations should be reported to the Administrator immediately. The UM stated he was responsible for reporting abuse and neglect to the Administrator when I am notified and if the staff cannot get ahold of the Administrator. The UM stated, when allegations of abuse and neglect or restraints are not reported and investigated properly, the issues could continue to happen, and the employee could place other residents in danger. Record review of a facility incident report for Resident #6, dated 06/12/2025 at 2:00 p.m. and completed by the UM, categorized the incident as alleged abuse and described the incident as charge nurse reported that employee had wrapped trash bag around pt wheelchair wheel as a restraint to keep patient from moving in w/c. Immediate action taken revealed, employee was send home and suspended during investigation, head to toe assessment was performed on patient and patient was interviewed. The report revealed the physician and DON were notified on 06/13/2025 at 1:11 p.m. Record review of an undated statement signed by CNA G revealed, on 6/11 [Resident #6] was having increased behaviors throughout the shift and going to other patient rooms and been inappropriate/disruptive, with guest and patients. [Resident #6] was redirected numerous times and taken out of patient's rooms and he kept going back to the rooms. In an attempt to help other patient and keep close watch on [Resident #6], I put him in café where he likes to drink coffee. I tried to slow him down by putting trash bags at the bottom of the wheelchair, but he was never restrained and could get up and move freely if he wanted to. Record review of a statement dated 06/19/2025, and signed by LVN C revealed, On 06/11/2025 @ 8:00 pm I was walking down 700 hall to the Nurse's station when I passed the café and saw patient [Resident #6 last name] with 2 CNAs [CNA G and CNA H]. I heard [CNA G and CNA H] laughing in which case I came over and then had [CNA G] point out to me that he had tied up the patient's wheelchairs together with trash bags. The trash bags were tied to each of the wheels and then tied to the center piece of the wheelchair limiting the patients ROM. Patient appeared aggravated while attempting to reach for the coffee cups and was seen attempting to scoot himself off his wheelchair in order to reach the coffee. I demanded that [CNA G] remove the trash bags, [CNA G] refused. I attempted to tear the trash bags with my hands and was unable to because of how many trash bags were used. I then proceeded to grab a pair of scissors, when [CNA G] attempted to stop me telling me 'ASK [LVN E first two letters of name]! ASK [LVN E first two letters of name]! ASK [LVN E first two letters of name]! BEFORE YOU CUT THEM OFF!' I told [CNA G] that I was not going to ask [LVN E first two letters of name] anything and if she did not want me to cut off the trash bags she can come over and discuss it with me. I then proceeded to cut off and remove the trash bags, and quickly looked over patient, no apparent injury was noted right after incident. I reported to DON and UM on 06/11/2025 at 8:15 p.m. (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	06/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of in-service roster, presented by the Regional Corporate Nurse on 06/16/2025, revealed the topic was abuse and neglect reporting, incident and accidents, restraints and was signed by the DON and UM. Record review of a facility document titled, [facility name] Emergency QAPI Plan Reporting of Abuse and Neglect, dated 06/19/2025, revealed, Problem: Facility not reporting abuse/neglect allegations as required and are unsure of the policy and procedures associated. The document also revealed, Education: On 06/19/2025 the Director of Nursing and Unit Manager of in serviced by the Regional Director of Clinical services on the Abuse Prevention Protocol, Reporting of Abuse allegations, to include a questionnaire and statement ensuring understanding and knowing who the abuse coordinator is along with the contact information. Being on 6/19/25 - All staff were re-in serviced by the Director of Nursing Services and/or Nurse Manager on the following: *Abuse Prevention Protocol and reporting of abuse allegations to include a questionnaire and statement ensuring understanding and knowing who the abuse coordinator is along with their contact information. *Dealing with patients with behaviors to include a post test for understanding. The document was signed by 6 employees including the Medical Director, Director of Nursing, Regional [NAME] President, Regional Director of Clinical Services, Assistant Director of Nursing and Unit Manager. Record review of a facility document titled, [company name] Abuse Prohibition Protocol (Company Name Protocol 3-B August 2024), revealed, The patient has the right to be free from abuse, neglect, mistreatment of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the Patient's symptoms. The protocol revealed, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. Instances of abuse of all patient/resident, irrespective of any physical or mental condition, cause physical harm, pain, or mental anguish. 'Willful' as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mistreatment means inappropriate treatment or exploitation of a patient. Record review of a facility document, [Company name] Reportable Incident Protocol, revealed, External Reportable Incidents: In response to allegations of abuse, neglect, exploitation, or mistreatment the facility must: 1. Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of patient property, are reported immediately, but no later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility to other officials (including State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. 2. Have evidence that all alleged violations are thoroughly investigated. 3. Prevent further potential abuse, neglect, exploitation, or mistreatment while investigation is in progress. 4. Report the results of all investigations to the ED or his or her designee and to other officials in accordance with State law, including the State Survey Agency within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.