STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676378	A. Building B. Wing	07/17/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #6) reviewed for care plans 1. The facility failed to ensure CNA D and CNA E implemented Resident #6's care plan when they used a gait belt instead of a mechanical lift to transfer the resident. 2. The facility failed to ensure Resident #6 had her oxygen tubing on as care planned. These failures could place residents at risk of a decrease in independence and injury. The findings include Record review of Resident #6's admission Record, dated 07/15/2025, she was [AGE] year documented a female resident who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #6 had diagnoses which included acute respiratory failure with hypoxia (a condition where the body, or a region of the body, is deprived of adequate oxygen supply.), history of pneumonia, cognitive communication deficit, limitation of activates due to disability, dementia (a general term for a decline in mental ability severe enough to interfere with daily life), shortness of breath, muscle weakness, dependence on other enabling machines and devices.Record review of Resident #6's consolidated orders for July 2025 was documented Oxygen at 2-4 liters per nasal cannula, every shift related to acute respiratory failure with hypoxia, shortness of breath. Record review of Resident #6's Quarterly MDS dated [DATE], was documented she had a BIMS of 6/15 (severely cognitively impaired), she required a wheelchair to mobilize, he required partial/moderate assistance (does less than half the effort, helper lifts or holds trunk or limbs and provided more than half the effort) for chair/bed to chair transfer and was on oxygen therapy. Record review of Resident #6's care plan dated 5/26/2025 has altered acute respiratory status/difficulty breathing related to hypoxia also had obstructive sleep apnea-Interventions provide oxygen as ordered per MD orders. Resident [NAME] had an ADL self-care performance deficit related to decrease in mobility-Intervention was Transfer, the resident required a mechanical lift with 2 person staff assistance for transfers.A.Observation on 7/15/2025 at 12:21 PM with Resident #6, sitting on bed, CNA D and CNA E and observed a mechanical lift in the room. CNA D came back into Resident #6's room with CAN E and had a gait belt with him. Observation of a 2 person transfer with gait belt from Resident #6's bed to her wheelchair. No observations of harm during transfer. Interview on 7/16/2025 at 10:22 AM with CNA D stated he could not find a mechanical lift sling for Resident #6, so he was going use the gait belt. CAN D stated they did not have a lot of mechanical slings, and he had looked in the linen closet. CAN D stated Resident #6 usually is transferred with a mechanical lift. He had to leave because he was busy with resident. CNA D stated Resident #6 is stronger today and was able to pivot. Interview on 7/16/2025 at 10:42 AM with CNA E stated she did assist CNA D with Resident #6's transfer from bed to wheelchair. CNA E stated Resident #6 needs a mechanical lift transfer with a sling. CNA E stated she did report to her charge nurse. B. Observation on 7/15/25 at 1:17 PM in Resident #6's room revealed the oxygen concentrator was at 2 LPM (liters per minute) and the oxygen tubing was not on the resident nasal area. The oxygen was laying across her bed. Observation on 7/15/2025 at 1:35 PM with Resident #6 was sitting in her wheelchair, eating lunch and she was not wearing her oxygen tubing on her nasal area. Interview on 7/15/2025 at 1:36 PM with Resident #6 stated she wears her oxygen tubing on at night. Interview on 7/15/25 at 1:38 PM with ADON stated Resident #6 confirmed resident did not have the oxygen tubing in place as ordered with no response to risk. Interview on 7/16/2025 at 5:17 PM with ADM/DON stated they updated the care plan for Resident #6 and the risk would be resident could fall, and staff could fall with her. Interview with DON did not respond to risk of resident transfers. Interview with ADM/DON did not provide a policy for care plans. Interview with ADM stated the long-term care plan staff was not working any longer, as of last Friday. Record review of policy, Protocol for Oxygen Administration dated March 2019 was documented was documented, Patients with oxygen therapy will have their plan of care updated to reflect their oxygen use. When not in use, oxygen cannulas. will be stored in plastic bags attached to oxygen concentrator tank.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 2 (#6) residents in the 500 hall in that: Resident #6 was not transferred with Mechanical lift (Hoyer) during a transfer as care planned. This could affect all residents with Hoyer transfers and could result in accidents/injury. The Failures included: Record review of Resident #6's admission Record, dated 07/15/2025, she was [AGE] year documented a female resident who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #6 had diagnoses which included acute respiratory failure with hypoxia (a condition where the body, or a region of the body, is deprived of adequate oxygen supply.), history of pneumonia, cognitive communication deficit, limitation of activates due to disability, dementia (a general term for a decline in mental ability severe enough to interfere with daily life), shortness of breath, muscle weakness, dependence on other enabling machines and devices. Record review of Resident #6's Quarterly MDS, dated [DATE] documented she had a BIMS of 6/15, which indicated the resident was severely cognitively impaired. Resident #6 required a wheelchair to mobilize, she required partial/moderate assistance (does less than half the effort, helper lifts or holds trunk or limbs and provided more than half the effort) for chair/bed to chair transfer and was on oxygen therapy. Record review of Resident #6's care plan, dated 5/26/2025. Documented the resident #6 had an ADL self-care performance deficit related to decrease in mobility-Intervention was Transfer, the resident required a mechanical lift with 2 person staff assistance for transfers. Observation on 7/15/2025 at 12:21 PM of Resident #6 revealed the resident was sitting on her bed, CNA D and CNA E observed a mechanical lift in the room. CNA D came back into Resident #6's room with CNA E and had a gait belt with him. Observation of a 2 person transfer with gait belt from Resident #6's bed to her wheelchair. No observations of harm during transfer. Interview on 7/16/2025 at 10:22 AM, CNA D stated he could not find a mechanical lift sling for Resident #6, so he was going use the gait belt. CNA D stated they did not have a lot of mechanical slings, and he looked in the linen closet. CNA D stated Resident #6 usually was transferred with a mechanical lift. He had to leave because he was busy with a resident. CNA D stated Resident #6 was stronger today and was able to pivot. Interview on 7/16/2025 at 10:42 AM, CNA E stated she assisted CNA D with Resident #6's transfer from bed to wheelchair. CNA E stated Resident #6 needed a mechanical lift transfer with a sling]. CNA E stated she did report to her charge nurse. Interview on 7/16/2025 at 2:21 PM Physical Therapist stated Resident #6 stated she could pivot and be transferred with 2 staff with gait belt. Interview with Physical Therapist stated it depended on Resident #6's transfer depended on her anxiety or if she is in pain. Interview with Physical Therapist was off services at this time. Interview on 7/16/2025 at 5:17 PM with ADM/DON stated they updated the care plan for Resident #6 and the risk would be resident could fall, and staff could fall with her. Interview on 7/17/2025 at 9:08 AM with ADM stated no policy.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews failed to ensure the facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 18 (#6) residents with oxygen orders in that: Resident #6 was not wearing her oxygen tubing as ordered. This could affect all resident with Oxygen and could result in residents as ordered. The findings included:Record review of Resident #6's admission Record, dated 07/15/2025, she was [AGE] year documented a female resident who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #6 had diagnoses which included acute respiratory failure with hypoxia (a condition where the body, or a region of the body, is deprived of adequate oxygen supply.), history of pneumonia, cognitive communication deficit, limitation of activates due to disability, dementia (a general term for a decline in mental ability severe enough to interfere with daily life), shortness of breath, muscle weakness, dependence on other enabling machines and devices.Record review of Resident #6's consolidated orders for July 2025 documented Oxygen at 2-4 liters per nasal cannula, every shift related to acute respiratory failure with hypoxia, shortness of breath. Record review of Resident #6's Quarterly MDS, dated [DATE] documented she had a BIMS of 6/15, which indicated the resident was severely cognitively impaired. Resident #6 required a wheelchair to mobilize, she required partial/moderate assistance (does less than half the effort, helper lifts or holds trunk or limbs and provided more than half the effort) for chair/bed to chair transfer and was on oxygen therapy. Record review of Resident #6's care plan, dated 5/26/2025. Documented resident #6 had altered acute respiratory status/difficulty breathing related to hypoxia and also had obstructive sleep apnea-Interventions provide oxygen as ordered per MD orders. Observation on 7/15/25 at 1:17 PM in Resident #6's room revealed the oxygen concentrator was at 2 LPM (liters per minute and the oxygen tubing was not on the resident nasal area. The oxygen was laying across her bed. Observation on 7/15/2025 at 1:35 PM revealed Resident #6 was sitting in her wheelchair, eating lunch and she was not wearing her oxygen tubing on her nasal area. Interview on 7/15/2025 at 1:36 PM, Resident #6 stated she wore her oxygen tubing on at night. Interview on 7/15/25 at 1:38 PM, the ADON stated Resident #6 did not have the oxygen tubing in place as ordered. she had not response to questions.Interview on 7/16/2025 at 5:17 PM with DON stated she updated care plan to say Resident #6 tries to take off oxygen tubing. Interview with DON stated the care plan staff for 500 hall was no longer working as of this last Friday. Interview with DON did not respond to the risk of residents that did not wear their oxygen tubing as ordered. Record review of the facility's policy, Protocol for Oxygen Administration, dated March 2019, documented, Patients with oxygen therapy will have their plan of care updated to reflect their oxygen use. When not in use, oxygen cannulas. will be stored in plastic bags attached to oxygen concentrator tank.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide special eating equipment and utensils for residents who needed them and appropriate assistance to ensure that the resident could use the assistance devices when consuming meals and snacks for 1 of 6 residents (Resident #7) reviewed for assistive devices. The facility failed to ensure Resident #7 had her 2 handed drinking cup as ordered. This failure could place residents at risk of a decrease in independence. The findings includeRecord review of Resident #7's [TF1] [RV2] admission record documented a female resident [AGE] years old, who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominate side (conditions affecting one side of the body. Hemiplegia is characterized by paralysis, while hemiparesis involves weakness, both impacting mobility and daily activities.), need for assistance with personal care, muscle weakness, low vision right eye, contracture of muscle on left hand, muscle wasting and atrophy (the wasting away or decrease in size of a body part, typically a muscle, organ, or tissue, due to cell degeneration, disease, or lack of use) on right and left hand, lack of coordination, cognitive communication deficit and age-related physical debility[TF3] [RV4] . Record review of Resident #7's admission MDS, dated [DATE], documented her BIMS was 12/15, which indicated moderate cognitive impairment. Resident #7 had no range of motion impairments and no mobility devices. Resident #17 ADLs where she required set-up and clean up assistance for eating, and she required partial/moderate assistance upper/lower body dressing. Record review of Resident #7's telephone order, dated 6/16/2025, documented Dietary Adaptive-Two handle plastic cup by LVN F. Record review of Resident #7's lunch ticket dated 7/15/2025, was documented 2 handle cup. Record review of Resident #7's care plan, dated 6/17/2025, documented the resident had an ADL self-care performance deficit and intervention was for Dressing-assist, the resident to choose simple comfortable clothes that enhances the resident ability to dress self and allow sufficient time for dressing and undressing. The resident requires assistance of 1 to 2 staff to dress, and this may fluctuate with weakness, fatigue, and weight bearing status. Resident #7 had potential nutritional problems interventions were OT, PT and ST to screen and provide adaptive equipment for feeding as needed. Observation on 7/15/2025 at 12:30 PM in the main dining room revealed Resident #7's lunch area did not include a 2-handle cup. Observation of Resident #7 had a regular plastic cup. Observation and interview on 7/15/2025 at 12:45 PM, Resident #7 stated her right hand was broken and her left hand was contracted from stroke. Resident #7 stated she could not pick up the plastic cup but could push the cup closer and could drink with a straw. Interview on 7/15/2025 at 12:40 PM, the DM stated the OT provided the 2-handle cup and she was not sure why Resident #7 did not have one at lunch. Attempted interview on 7/16/2025 at 9:37 AM with LVN F was unsuccessful. A voicemail was left. Interview on 7/16/25 at 11:16 AM, the OT stated he did not put the 2-handle cup order in Resident #7's consolidated orders. The OT stated any therapy discipline could address the need for adaptive equipment while eating. The OT stated Resident #7 was not on OT services at this time. The OT stated the risk for residents not having an order available was she would not be able to feed herself while in the dining room. The OT stated Resident #7 had tremors, lack of coordination and it could decrease her independence in feeding herself. Interview on 7/16/2025 at 1:42 PM, the DM stated she did not have the 2 handle cup, so she went to get five of the 2 handle cups from a sister facility. The DM stated she was not sure when the therapy department brought the order for a 2 handed cup. The DM stated the process was the therapy handed the dietary department the order for any equipment required for residents during meals. Record review of the facility's policy, admission protocol, dated January 20024, reflected To ensure the patient and family feel welcome and care is based on physician's admission orders instituted by all departments upon admission. under Dietary, upon admission of the patient, dietary will ensure the following are completed and in place: check diet orders and notify kitchen, proper diet/tray card. Record review of the facility's policy, Dining program, dated April 2025, reflected, 5. A diet rooster must be maintained and audited by the nutrition service director at least once monthly, utilizing the diet listing from the electronic medical record the meal ticket software. 8. A list of adaptive equipment for dining must be maintained and audited by the Nutrition Service Director at least once monthly, unitizing the diet listing form the electronic medical record and the meal ticket software. Record review of the facility policy, Adaptive equipment, dated November 3, 2004, reflected, The facility shall provide adaptive equipment as orders. Recommended by the therapist and/or physician. The ensure that all Residents receive the proper

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for medical records. The facility failed to document all medications administered or withheld in the July 2025 MAR for Resident #1. This failure could place residents at risk of medication errors.Findings included: Record review of Resident #1's face sheet, dated 7/15/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included bipolar disorder (a mental health condition causing mood swings), type 2 diabetes mellitus (a condition resulting from the body's resistance to insulin), and hypertension (high blood pressure). Record review of the quarterly MDS submitted 5/6/2025 reflected a BIMS score of 14, which indicated intact cognition. Record review of Resident #1's July 2025 MAR, printed 7/15/2025, revealed the following: Amoxicillin-Potassium Clavulanate tablet 500-125mg, give one tablet by mouth one time a day for bacterial infection related to pneumonia for 7 days (start date 7/4/2025) 8 PM7/4/2025 8:00 PM: no entry/blankFamotidine oral tablet 40mg, give 1 tablet by mouth at bedtime related to gastroesophageal reflux disease (chronic heartburn)7/14/2025 8:00 PM: no entry/blankInvega oral tablet extended release 24 hour 3mg, give 4 tablets by mouth at bedtime related to bipolar disorder, give 4 tabs to = 12mg (start date 6/30/2025)7/4/2025 8:00 PM: no entry/blank7/14/2025 8:00 PM: no entry/blankLetrozole oral tablet 2.5mg, give 2.5mg by mouth at bedtime for hormone therapy (start date 6/11/2025)7/14/2025 8:00 PM: no entry/blankZetia oral tablet 10mg, give 1 tablet by mouth at bedtime related to hyperlipidemia (high cholesterol) (start date 5/22/2025)7/14/2025 7:00 PM: no entry/blankBenztropine Mesylate oral tablet 0.5mg, give 0.5mg by mouth two times a day for tremors7/14/2025 7:00 PM: no entry/blankCalcium oral tablet 600mg, give 600mg by mouth two times a day for supplement (start date 6/11/2025)7/14/2025 9:00 PM: no entry/blankColace capsule 100mg, give 1 capsule by mouth every 12 hours for constipation (start date 5/22/2025)7/14/2025 8:00 PM: no entry/blankMetoprolol tartrate oral tablet 50mg, give 1 tablet by mouth two times a day related to hypertensive chronic kidney disease (high blood pressure resulting from kidney disease) (start date 5/22/2025)7/5/2025 4:00 PM: no entry/blankOmega 3 oral capsule 1000mg, give 1 capsule by mouth two times a day for prophylaxis (start date 5/22/2025) 7/14/2025 8:00 PM: no entry/blankTegretol-XR tablet extended release 12 hour 400mg, give 1 tablet by mouth every 12 hours related to epilepsy (seizures) (start date 5/22/2025)7/14/2025 8:00 PM: no entry/blankDiclofenac sodium external gel 1%, apply to affected areas topically three times a day for pain related to pain in unspecified joint (start date 6/08/2025)7/4/2025 7:00 PM: no entry/blank7/14/2025 7:00 PM: no entry/blankGlucosamine capsule 500mg, give 1 capsule by mouth with meals related to pain unspecified joint (start date 5/22/2025)7/14/2025 5:30 PM: no entry/blankHydralazine HCl oral tablet 100mg, give 1 tablet by mouth three times a day related to hypertensive chronic kidney disease (start date 5/22/2025)7/5/2025 8:00 PM: no entry/blank7/14/2025: 8:0 PM: no entry/blankSevelamer HCl oral tablet 800mg, give 1 tablet by mouth with meals related to disorder of phosphorus metabolism (start date 5/22/2025)7/14/2025 5:00 PM: no entry/blankHumalog injection solution 100unit/mL, inject as per sliding scale four times a day for DM-2 (start date 5/30/2025)7/5/2025 5:00 PM: no entry/blank7/5/2025 9:00 PM: no entry/blank7/14/2025 5:00 PM: no entry/blank7/14/2025 9:00 PM: no entry/blankRecord review of the facility staffing schedule reflected the following staff members were responsible for administering Resident #1's medications on the following days/shifts:LVN C: 7/4/2025 2:00 PM to 10:00 PMLVN B: 7/5/2025 2:00 PM to 10:00 PMLVN A: 7/14/2025 2:00 PM to 10:00 PMRecord review of Resident #1's progress notes from 7/4/2025 to 7/15/2025 did not reveal documentation regarding missed dosages of medications or documentation regarding the resident being away from the facility during the above listed times. Resident #1 was interviewed on 7/16/2025 at 8:35 AM. She reported the only medication she had not been administered during July 2025 was an unknown antibiotic on the evening of 7/5/2025. She said she reported it to the nurse on duty, but the nurse disagreed with her and told her she received it. She reiterated that all other days in July 2025 she had received her ordered medications, to the best of her knowledge. She denied lingering symptoms of pneumonia, such as cough or shortness of breath, as a result from allegedly not receiving the dose of antibiotic. Resident #1 was unsure if she had been away from the facility in July 2025 during medication administration times. LVN A was interviewed on 7/16/2025 at 8:30 AM. He stated he was the nurse responsible for administering medications to Resident #1 from 2:00 PM to 10:00