

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2026
NAME OF PROVIDER OR SUPPLIER Sorrento		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to reasonably accommodate resident #1s needs and preferences by failing to ensure the call light was maintained within reach for 1 of 5 residents reviewed. This had the potential to affect the resident's safety and timely access to assistance. Based on observation, interview and record reviews the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 4 residents (Resident #1) reviewed for resident safety. The facility failed to ensure Resident #1 had access to a call light to summon assistance as needed. This deficient practice could place residents at risk for delayed staff response, unmet needs, injury, and falls. Findings include: Record review of Resident #1's face sheet, dated 5/19/26, revealed an [AGE] year-old female with an admission date of 7/20/2025. Resident #1 had diagnoses which included brain tumor, (Abnormal growth of cells within the brain or surrounding tissues. It can affect memory, thinking, speech, movement, balance, vision, behavior, and the ability to perform daily activities), osteoarthritis (A degenerative joint disease caused by the breakdown of cartilage in the joints), arthritis, (A general term for inflammation or disease of one or more joints), pain, (An unpleasant physical or sensory experience that may result from injury, illness, chronic disease, or other medical conditions), anxiety, (A mental health condition caused by excessive worry, nervousness, fear, or apprehension), and malnutrition risk (Refers to the likelihood that a person may not receive the adequate nutrition to meet their body's needs). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS (Brief Interview for Mental status) score of 3 out of 15, which indicated severe cognitive impairment. Record review of Resident #1's Care Plan, dated with revisions on 5/22/2026, revealed assistance required for transfers/toileting/bed mobility, limited right-side use, increased fall risk, attempts self-transfers, diagnoses included brain tumor, and malnutrition risk. The call light remains within reach and for staff to respond promptly. Observation on 5/19/2026 at 9:33 a.m. revealed Resident #1 sleeping in bed. The bed was observed in a lower position, and bilateral mats were in place. The call light was observed hanging between the mattress/bed frame extended toward the floor and out of reach. Surveyor attempted a second time to interview Resident #1 on 05/19/2026@11:40a revealed Resident #1 was still sleeping. Interview on 05/19/2026 at 9:45 a.m. with RN Registered Nurse revealed Resident #1 would not be able to reach the call button because it was out of her reach. She would not be able to call for assistance and something bad could happen. Interview on 05/19/2026 at 10:05 a.m. with LVN (Licensed Vocational Nurse) A revealed Resident #1 would not be able to use the call light because it was out of reach. Resident #1 wouldn't be able to ask for help and she could get injured. Interview on 5/19/26 at 5:18 p.m. with the DON revealed his expectations of the staff were to answer the call lights in a timely manner and have it within reach for the residents. They were to attach it to their blanket or wherever the resident wanted it attached, or close to the hand if they're compromised. If they're not able to reach the call button, they won't be able to tell us what their needs were. The DON stated he was (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676378
		If continuation sheet Page 1 of 2

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure the policy for call lights was in training or a checklist for staff. Record review of the Facility Policy Record, date implemented on 10/01/2025 and revised on 12/01/2025, revealed the facility policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Staff will ensure the call light is within reach of residents and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.		