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	08/22/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 8 residents (Resident #36) reviewed for resident rights. CNA M told Resident #36, just go in your brief and I'll come back to change you when Resident #36 asked to be taken to the restroom. This failure could place residents at risk for diminished quality of life, loss of dignity, and self-worth. The findings included: Record Review of Resident #36's admission Record, dated 08/22/2025, reflected a [AGE] year-old resident with an admission date of 08/08/2025 and diagnoses including: acute and chronic respiratory failure, type 2 diabetes, irritable bowel syndrome, and hyperlipidemia. Record Review of Resident #36's MDS Assessment, dated 08/12/2025, reflected that Resident #36 had, No impairment in her upper and lower extremities and used a walker as a mobility device. Further review reflected that Resident #36 required, Partial/Moderate assistance for the functional ability, Sit to stand. Section H, Bowel and Bladder, reflected that the resident was always incontinent of bowel and bladder. Resident #36's BIMS score was reflected to be a 9, indicating moderate cognitive impairment. Record review of Resident #36's Comprehensive Person-Centered Care Plan, dated 08/22/2025, reflected that Resident #36 had an ADL self-care performance deficit r/t unsteady gait, poor trunk control, with interventions including, Encourage the resident to participate to the fullest extent possible with each interaction. Observation on 08/21/2025 at 3:58 PM, Resident #36 was observed to be vocalizing in her room with her call light on. Staff member CNA M responded to the call light and Resident #36 asked to be taken to the restroom. CNA M told Resident #36 to, just go in your brief and I'll come back to change you. Interview on 08/21/2025 at 4:01 PM, CNA M stated she was uncertain if Resident #36 was a fall risk and was having a more difficult time ambulating, so she told the resident to use her brief yesterday and today. CNA M stated she felt that if someone asked to be taken to the restroom they should be taken to the restroom. In an interview on 08/21/2025 at 4:03 PM, the ADON stated that if a resident was able to transfer safely, they should be taken to the restroom. The ADON stated it was a dignity concern if residents were not taken to the restroom and just told to use their own brief, and that it was not acceptable to tell a resident to use their brief if they requested to be taken to the toilet. Interview on 08/22/2025 at 11:53 AM, the DON stated it was not acceptable to tell a resident to just use their brief and his expectation was that, if the resident was incontinent or not, to let them know they would be back and look at the resident's functional toileting ability and get help if necessary. Record review of the facility's policy, revised February 2021, reflected, Employees shall treat all residents with kindness, respect, and dignity.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promote the resident's right to request, refuse, and/or discontinue treatment and to formulate an advance directive for 1 (Resident #25) of 22 residents reviewed for advance directives, in that:Resident #25's OOH-DNR was not signed twice by all parties and was therefore invalid.This deficient practice could result in the resident's wishes regarding end-of-life treatment being dishonored.The findings were:The findings were:Record review of Resident #25's face sheet, dated 08/22/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Paraplegia, Unspecified Cirrhosis of Liver, and Sepsis Unspecified Organism.Further review revealed, Advance Directive: DNR (Do Not Resuscitate).Record review of Resident #25's comprehensive MDS assessment, dated 08/08/2025, revealed a BIMS score of 14 which indicated intact cognition.Record review of Resident #25's care plan, initiated 04/14/2025, revealed [Resident #25] requests Code Status of: DNR. Record review of Resident #25's OOH-DNR, dated 06/23/2023, revealed the instructions for the last section of the document, All persons who have signed above must sign below, acknowledging that this document has been properly completed.Further review of Resident #25's OOH-DNR revealed the resident, two witnesses, and the resident's physician had signed above the last section, but only the physician's signature was present in the last section.During an interview with the Social Worker on 08/22/2025 at 10:20 a.m., the Social Worker confirmed that two signatures were required for all parties who signed an OOH-DNR form, the resident's signature and the witnesses' signatures were missing from the last section of Resident #25's OOH-DNR., and the missing signature rendered the form invalid. The Social Worker stated it was her responsibility to ensure OOH-DNR forms were correctly executed and the invalid form was an oversight. During an interview with the Administrator on 08/22/2025 at 3:00 p.m., the Administrator confirmed that she expected all OOH-DNR forms to be completed fully and accurately.Record review of the Texas Health and Human Services webpage titled, Out of Hospital Do Not Resuscitate Program, updated 03/25/2019, revealed, Frequently Asked Questions for DNR: What happens if the form is not filled out correctly or EMS has doubts about any of the information? Health professionals can refuse to honor a DNR if they think: The form is not signed twice by all who need to sign it or is filled out incorrectly.Record review of the facility's policy, Advance Directives, dated March 2025, revealed, The Social Worker or designee must verify the Advance Directive report for accuracy.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for 1 of 8 residents (Resident #79) reviewed for environment. Resident #79's recliner's footrest was broken and had a metal piece sticking out of it. This failure could place residents at risk of a diminished quality of life due to an exposure to an environment that is unpleasant, unsanitary, or unsafe. The findings included:Record review of Resident #79's admission Record, dated 08/21/2025, reflected an [AGE] year-old resident, initially admitted on [DATE], with diagnoses including muscle wasting and atrophy, chronic obstructive pulmonary disease, type 2 diabetes, and hypothyroidism. Record review of Resident #79's MDS Assessment, dated 08/06/2025, reflected that Resident #79 had a BIMS score of 15, indicating that the resident's cognition was intact. Record review of Resident #79's Comprehensive Person-Centered Care Plan, dated 08/21/2025, reflected that Resident #79, expresses desire for little or no activity involvement. Interview and observation on 08/20/2025 at 9:40 AM, reflected that Resident #79's foot rest for her recliner was broken and had a metal piece, which was typically part of the mechanical system that held up the foot rest sticking out. Resident #79 stated her foot rest had been broken since she was moved to this room [ROOM NUMBER] days prior. Resident #79 stated she had not told anyone about it, and that it had not hurt her as she was careful not to hit her leg against the metal piece. Record review of Resident #79's Census Report reflected Resident #79 had been moved into her room on 08/15/2025. Interview on 08/21/2025 at 1:00 PM, the Maintenance Director stated that Resident #79's recliner was replaced on 08/20/2025 after it was found to have been broken. The Maintenance Director stated he typically tried to fix things such as this as soon as he was made aware of them, which is what happened with Resident #79's recliner. Interview on 08/21/2025 at 1:30 PM, the Administrator stated they had replaced Resident #79's recliner as soon as they realized it had been broken. The Administrator stated no one noticed the recliner was broken until 08/20/2025, and it was immediately replaced to prevent any injury to the resident. The Administrator stated that her expectation was for staff to report any concerns with the resident environment to the Maintenance Director so that it is addressed accordingly. Record review of the facility's policy titled, Homelike Environment, dated revised 02/2021, reflected, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: .clean, sanitary, and orderly environment.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System for 5 (Resident #2, #44, #54, #136, #310) of 24 residents reviewed for MDS accuracy and completion. Residents #2, #44, #54, #136, and #310 did not have discharge MDS's completed. This failure could result in MDS inaccuracies. The findings included: Record review of Resident #2's Electronic Health Record did not reveal a completed discharge MDS, at least 30 days after discharge. Record review of Resident #44's Electronic Health Record did not reveal a completed discharge MDS, at least 30 days after discharge. Record review of Resident #54's Electronic Health Record did not reveal a completed discharge MDS, at least 30 days after discharge.Record review of Resident #136's Electronic Health Record did not reveal a completed discharge MDS, at least 30 days after discharge.Record review of Resident #310's Electronic Health Record did not reveal a completed discharge MDS, at least 30 days after discharge. Record Review of the facility's policy titled, Electronic Transmission of the MDS, dated revised November 2019, reflected, All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data. Record review of the RAI Manual OBRA Assessment Summary, dated October 2019, revealed, Discharge refers to the date a resident leaves the facility or the date the resident ' s Medicare Part A stay ends but the resident remains in the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are three types of discharges: two are OBRA required-return anticipated and return not anticipated; the third is Medicare required-Part A PPS Discharge. A Discharge assessment is required with all three types of discharges. Further review revealed Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident ' s Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay, as defined below). This assessment includes clinical items for quality monitoring as well as discharge tracking information. Continued review revealed OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated. [.] Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, observation, and record review, the facility failed to ensure the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 (Residents #12) of 8 residents reviewed for care plans. The facility failed to implement fall interventions (Lateral Supports as appropriate, initiated 08/13/25, Provide Reclining W/C as appropriate, initiated 08/13/25, Tilt Wheelchair, initiated 08/13/24, Raised Toilet Seat, initiated 08/13/25) from Resident #12's care plan. This failure could place residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing. The findings included: Record Review of Resident #12's admission record, dated 08/22/25, reflected Resident #12 was an [AGE] year-old female, initially admitted [DATE] and re-admitted [DATE], with diagnosis to include restlessness and agitation, lack of coordination, muscle weakness, reduced mobility, and need for assistance with personal care. Record Review of Resident #12's MDS assessment for significant change in status, dated 08/01/25, reflected resident had a BIMS of 08 out of 15, indicating moderate impaired cognition. Record Review of Resident #12's care plan reflected The resident is risk for falls r/t decreased mobility. 7/14/25 ACTUAL FALL UNWITNESSED8/7/25 actual fall unwitnessed OOB no injury8/8/25 un-witnessed fall with no injury8/13/25 un-witnessed fall, initiated 08/08/25 and revised 08/14/25. With interventions to include Lateral Supports as appropriate, initiated 08/13/25, Provide Reclining W/C as appropriate, initiated 08/13/25, Tilt Wheelchair, initiated 08/13/24, Raised Toilet Seat, initiated 08/13/25. Observation on 08/19/25 at 03:24 PM revealed Resident #12 had her bed in lowest position, 2 quarter handrails, and a scoop mattress. Resident #12 appeared confused and was trying to get up on her own. Interview on 08/22/25 at 11:07 AM, LVN D and LVN A revealed after a fall occurred, they filled out the fall incident report, which triggered fall risk assessment and fall intervention checklist. They reflected they looked at Kardex, care plans, and fall intervention checklist for fall interventions for residents. LVN A revealed Resident #12 was non-compliant with her care plan interventions like she did not like her fall mats, but Resident #12 had good days and bad days and would cooperate on her good days. Interview on 08/22/25 at 11:13 AM, CNA B and CNA C revealed they did not work in Resident #12's hallway, but for fall interventions they used residents' Kardex to ensure residents' interventions were in place. They further revealed they also did the basics like made sure resident had water close to them, call light within reach, remove obstacles, and frequent monitoring. Interview on 08/22/25 at 12:17 PM, ADON F revealed the IDT discussed falls in the morning meetings and updated interventions in the care plans. He revealed CNAs used the Kardex to ensure they were implementing fall interventions, and the nurses used the care plans to ensure they were implementing fall interventions. Interview and observation on 08/22/25 at 02:56 PM, Hospice CNA P revealed Resident #12 did not have a raised toilet seat or tilted wheelchair. She revealed the facility was in charge of ensuring Resident #12 had their appropriate interventions implemented. Interview and observation on 08/22/25 at 03:06 PM, CNA R and LVN Q revealed they did not know what a tilted wheelchair or lateral supports looked like. CNA R revealed Resident #12 did not have a raised toilet but Resident #12 would throw the raised toilet seat so it would not help Resident #12. CNA R revealed she did not tell anyone that this intervention was not working, and to take it off Resident #12's care plan and Kardex. CNA R and LVN Q revealed they did not know Resident #12 needed a raised toilet seat, tilted wheelchair, or lateral supports. Interview on 08/22/25 at 04:45 PM, the ADM and Regional Director of Clinical Services stated they were aware that the care plans needed to be updated prior to the beginning of survey and were updating residents' care plans but had not gotten to every resident yet. They revealed CNAs looked at the Kardex and nurses looked at the care plan for resident care. The Regional Director of Clinical Services revealed the goal for Resident #12 was to prevent fall with injury because the resident was going to fall due to her current health condition. Interview on 08/22/25 at 05:08PM, the ADM, DON, and Regional Director of Clinical Services revealed interventions were in incident reports but not in care plans or Kardex and should have been. They revealed there was no concern that Resident #12 would injure herself because staff were able to tell them what fall interventions to do for Resident #12 and there was only a concern of updating the care plans. Record Review of the facility's policy Fall Management Guidelines, dated November 2022, reflected 3. Initiate Fall Risk Plan of Care for each Patient at risk for falls and update as needed. Include those interventions listed on the Intervention Check List as part of the Fall

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 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 interviews and record reviews, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, for 1 of 3 residents (Resident #11) reviewed for dialysis services. The facility failed to complete Resident #11's post dialysis assessment on 8/4/2025, 8,6/20205, 8/8/2025, and 8/11/2025. This failure could place residents at risk for neglect by not being assessed and documenting the assessment. The findings included:A record review of Resident #1's admission record dated 8/22/2025 revealed an admission date of 5/21/2025 with diagnoses which included end stage renal disease with dialysis (kidney failure with a medical treatment that acts as artificial kidneys, removing waste products and excess fluid from the blood when the kidneys are unable to perform these functions.) A record review of Resident #11's quarterly MDS assessment dated [DATE] revealed Resident #11 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 14 out of a possible 15 which indicated no cognizant impairment. A record review of Resident #11's care plan dated 8/22/2025 revealed Resident #11 received recurring dialysis services three times a week on Monday, Wednesday, and Fridays, (Resident #11) needs hemodialysis related to end stage renal disease, dialysis Mondays Wednesdays and Fridays . monitor document report as needed the following signs and symptoms; edema, weight gain of over 2 pounds a day, neck vein distension, difficulty breathing, increased heart rate, elevated blood pressure, skin temperature, peripheral pulses, level of consciousness, monitor breath sounds for crackles . A record review of Resident #11's medical record from 5/21/2025 through 8/22/2025 revealed LVN assessed and documented Resident #11's pre dialysis assessments on 8/4/2025, 8/6/2025, 8/8/2025, and 8/11/2025. Further review revealed no post dialysis assessments for those dates. During an interview on 8/22/2025 at 10:36 AM with LVN I, he stated he was the Monday through Friday 6:00 AM through -2:00 PM nurse for Resident #11. LVN I stated Resident #11 was diagnosed with ESRD and was supported with offsite dialysis 3 times a week from 10:00 AM to 3:00 PM. LVN I stated prior to Resident #11's dialysis, he would initiate a dialysis communication record, assess Resident #11, and document the assessment. LVN I stated he would give report to the 2:00 PM to 10:00 PM nurse that Resident #11 was attending dialysis and had an open dialysis communication form which required a post dialysis assessment. LVN I stated Resident #11 would be assessed at the dialysis center by the dialysis nurse and would be sent back to the facility with a dialysis summary report. LVN I stated there was no dedicated 2:00 PM to 10:00 PM nurse and some of the 2:00 PM to 10:00 PM nurses were LVN A, LVN J, and LVN K. LVN I stated the policy and expectation for the post dialysis communication was for the 2:00 to 10:00 PM nurse to assess Resident #11 after the dialysis treatment, to document the assessment, and to include the data transcription from the dialysis summary form sent with the Resident from the dialysis center. During an interview on 08/22/2025 at 1:00 PM with ADON G, she stated she was the ADON for Resident #11 who was diagnosed with ESRD and was supported with dialysis services on Mondays, Wednesdays, and Fridays from mid-morning to midafternoon. ADON G stated the expectation for dialysis communication assessments was for the 6:00 AM to 2:00 PM nurse to assess residents prior to dialysis treatment and for the 2:00 PM to 10:00 PM nurse to assess residents post dialysis treatments which included the transcription of data from the post dialysis summary report sent by the dialysis center. ADON G stated every morning she would generate an audit report for incomplete assessments from the previous day and recognized that on 8/4/2025, 8/6/2025, 8/8/2025 and 8/11/2025, the post dialysis assessment was not completed. ADON G stated LVN A worked on 8/4/2025 and had failed to assess Resident #11 after dialysis and failed to document the assessment. ADON G stated she also recognized the dialysis center had failed to send the post dialysis documentations and had called the DON at the dialysis center to report the failures. During an interview on 8/22/2025 at 1:56 PM, LVN A stated he worked the 2:00 PM to 10:00 PM shift on 8/4/2025 and received Resident #11 back from dialysis therapy. LVN A stated Resident #11 was sent back from dialysis without any post dialysis report. LVN A stated he could not recall if he had assessed and documented Resident #11's post dialysis status. LVN A stated the expectation for the post dialysis nurse would be to transcribe the report into the residents' medical record. LVN A stated the post dialysis expectation was for nursing to assess post dialysis and to document the assessment. LVN A stated the assessment would include the condition of the dialysis port, vital signs, respirations, and swelling. LVN A stated the possible potential negative outcome for failing to document a post dialysis status for residents

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 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 ensure that all licensed staff possessed the competency, and specific skill sets necessary to care for resident's needs for all nursing staff for 1 of 1 facility reviewed for competencies. The facility failed to ensure licensed nurses were appropriately updating Resident #12 for fall interventions when they were filling out the Nursing Fall Intervention Checklist. This failure could place residents at risk for harm due to staff who lack the appropriate skills, knowledge, and competencies to safely meet the residents' needs. Findings included: Record Review of Resident #12's admission record, dated 08/22/25, reflected Resident #12 was an [AGE] year-old, initially admitted [DATE] and re-admitted [DATE], with diagnoses to include restlessness and agitation, lack of coordination, muscle weakness, reduced mobility, and need for assistance with personal care. Record Review of Resident #12's MDS assessment for significant change in status, dated 08/01/25, reflected the resident had a BIMS of 08 out of 15, indicating moderate impaired cognition. Record Review of Resident #12's care plan, undated, reflected The resident is risk for falls r/t decreased mobility. 7/14/25 ACTUAL FALL UNWITNESSED8/7/25 actual fall unwitnessed [sic] no injury8/8/25 un-witnessed fall with no injury8/13/25 un-witnessed fall, initiated 08/08/25 and revised 08/14/25. With interventions to include Lateral Supports as appropriate, initiated 08/13/25, Provide Reclining W/C as appropriate, initiated 08/13/25, Tilt Wheelchair, initiated 08/13/24, Raised Toilet Seat, initiated 08/13/25. Record review of In-Service Training Report on 07/18/25 reflected the nursing department was educated on Post Fall Intervention Checklist to include Do not complete the fall interventions checklist Section B is completed by IDT. It further reflected 12 licensed nurses to not include nurses on the IDT signed that they received this training. Record review of staff roster, undated, reflected 35 licensed nurses to not include nurses on the IDT. Interview on 08/22/25 at 10:13 AM, LVN A revealed Resident #12 had interventions to include fall mats, bed in lowest position, and scoop mattress. He revealed the IDT were the ones to add appropriate fall interventions. Interview on 08/22/25 at 11:07 AM, LVN D and LVN A revealed after a fall occurred, they filled out the incident report for the fall, which triggered fall risk assessment and fall intervention checklist. They revealed they looked at Kardex, care plans, and fall intervention checklist for fall interventions for residents. LVN A revealed he followed the prompts to fill out the Nursing Fall Intervention Checklist. He was not aware if Intervention Checklist was for interventions in place or for suggested interventions. Interview on 08/22/25 at 11:15 AM, LVN D revealed for fall interventions he looked at a residents' care plan and Kardex. He revealed the nurse manager oversaw completing the fall intervention checklist and made sure the interventions on the care plan were added appropriately. He further revealed after a new fall, there would be new interventions like if resident already had a low bed and falls mats, the facility would add a new intervention. Interview on 08/22/25 at 12:17 PM, ADON F revealed the IDT discussed falls in the morning meetings and updated interventions in the care plans during the meeting. He revealed CNAs used the Kardex for fall interventions and the nurses used the care plans for fall interventions. He revealed the ADONs and DONs were able to oversee care plans to ensure they were updated, as needed. Interview on 08/22/25 at 12:31 PM, ADON G revealed witnessed and unwitnessed falls were documented in the incident reports. She revealed nurse managers (ADON, MDS, DON) and therapy discussed falls in the morning meetings. She revealed they added interventions for falls in the morning as they pertained to the circumstances that caused a fall. She revealed nursing staff were in-serviced on fall interventions after the IDT decided what interventions to add to residents' care plans. She revealed the MDS nurse oversaw updating care plans but the ADONs could also ensure the care plans were updated appropriately. She revealed the nurses looked at care plans for updated interventions and CNAs looked at the Kardex for updated interventions. She revealed she was not aware of the Nursing Fall Intervention Checklist entailed. Interview on 08/22/25 at 01:41 PM, the MDS nurse revealed Nursing Fall Intervention Checklist was a new assessment and she was not aware of what the fall intervention checklist was. She revealed falls were discussed the next day with the IDT team so they could review interventions. She revealed they would analyze what had been working and what not, and add interventions as needed. Interview and observation on 08/22/25 at 03:06 PM, CNA R and LVN Q revealed they did not know what a tilted wheelchair or lateral supports looked like. CNA R revealed Resident #12 did not have a raised toilet but would throw this raised toilet seat if she had it in her restroom, so it would not help the resident. CNA R revealed she did not tell anyone that this intervention was not working to take this intervention off Resident

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	676378	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sorrento	2739 Babcock San Antonio, TX 78229

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #79) reviewed for medication administration. The facility provided Resident #79 with the medication Hydralazine HCl outside of physician parameters. This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: Record review of Resident #79's admission Record, dated 04/04/2025, reflected an [AGE] year-old resident with diagnoses including muscle wasting and atrophy, chronic obstructive pulmonary disease, type 2 diabetes, and hypothyroidism . Record review of Resident #79's quarterly MDS assessment, dated 08/06/2025, reflected Resident #79 was assessed with a BIMS score of 15, indicating the resident was cognitively intact. Record review of Resident #79's Comprehensive Person-Centered Care Plan, dated 08/21/2025, reflected Resident #79 had hypertension with interventions including, Give all anti-hypertensive medications as ordered. Record review of Resident #79's Medication Administration Record , dated printed 08/20/2025, reflected an order for hydralazine HCl Oral Tablet 50 MG (Hydralazine HCl) Give 1 tablet by mouth at bedtime for Hold SBP <110 DBP <60 and HR 60 related to ESSENTIAL (PRIMARY) HYPERTENSION for 30 days, indicating the medication should not be provided to the resident if their systolic blood pressure (the top number, which measures the pressure in your arteries when your heart beats) was over 110, their diastolic blood pressure (bottom number) was over 60, or when the residents heart rate was under 60 beats per minute with a start date of 08/03/2025.Further review of Resident #79's Medication Administration Record for August 2025, dated 08/20/2025, reflected that Resident #72 could have been provided Hydralazine 15 times from 08/01/2025 through 08/20/2025 and was administered Hydralazine outside of parameters as follows: 1. On 08/06/2025, LVN N administered Hydralazine to Resident #79 while her DBP was 57.2. On 08/07/2025, LVN O administered Hydralazine to Resident #79 while her DBP was 53.3. On 08/15/2025, LVN N administered Hydralazine to Resident #79 while her DBP was 53.4. On 08/19/2025, LVN O administered Hydralazine to Resident #79 while her DBP was 56. Interview on 08/22/2025 at 11:53 AM, the DON stated that his expectation was for medications to be given within parameters and if parameters were not clear, to reach out to the physician. Record review of facility policy titled, Medication Administration,, undated, did not reflect information regarding medication parameters.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure all drugs and biologicals were stored and locked in compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 7 medication carts (800 hall medication cart) reviewed for safe and secure drug storage. The facility failed to ensure the 800-hall medication cart was secured and locked when LVN L utilized it and left it unlocked and unattended. This failure could place residents at risk for harm by accessing medications not prescribed for them, misappropriation, and not receiving the therapeutic effects of the medications as prescribed by their physicians. The finding included: During an observation on 8/19/2025 at 12:16 PM revealed the 800-hall medication cart was in the 800-hallway by a resident's room with a closed door. The medication cart was unattended and out of line of sight by the nurse who was assigned the cart. The drawers of the medication cart were able to be opened revealing many medications prescribed to residents of the 800-hall. A brief review reveled acetaminophen, aspirin, docusate, and vitamin c. During an observation and interview on 8/19/2025 at 12:22 PM LVN L exited resident room [ROOM NUMBER] and recognized the 800-hall medication cart was unattended and unlocked. LVN L stated the lock had malfunctioned and could not lock. LVN L stated she was assigned the medication cart at 6:00 AM and had not reported the malfunction and believed the facility had known of the malfunction. During an interview on 8/19/2025 at 12:28 PM ADON F stated he was not aware the 800-hall medication cart lock had malfunctioned. ADON F stated he would immediately address the issue and either correct the failed lock or replace the medication cart. During an interview on 8/22/2025 at 7:00 PM the DON stated the expectation for nursing staff who were assigned medication carts was for the cart to be locked whenever the nurse was away from the medication cart. The DON stated if a cart was to malfunction the nurse should immediately report the malfunction. The DON stated the potential risk to residents was the loss of security for their medications. A policy was requested of the Administrator via email on 8/22/2025 at 3:34 PM and, as of 8/25/2025, a policy had not been provided.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure that residents (1 of 1 facility) had suitable, nourishing meals and snacks outside of scheduled meal service times. The facility failed to ensure residents were offered snacks at bedtimes. This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for, unplanned weight loss, and side effects from medication given without food, and diminished quality of life. The findings were:Record review of [NAME] PATIENT MEAL TIMES, revised 5/16, reflected Breakfast, Lunch, Dinner, and no snack time. Interview and observation on 08/21/25 at 07:10 PM, Confidential Resident #144 was observed to not have a snack and they revealed they did not receive a snack, but they would like one. They revealed they did not want the facility to know that they were asking for a snack. Interview and observation on 08/21/25 at 07:10 PM, Confidential Resident #145 was observed to not have a snack and they revealed they did not know if the facility was giving out snacks at night, but they would like to be offered one when they get hungry at night. They revealed they would like to not let the facility know it was them that mentioned having nighttime snacks. Interview on 08/21/25 at 7:34 PM, the ADM and ADON F revealed they gave snacks to all the diabetics and then gave leftover snacks to whoever asked for them. The ADM revealed they did not go to every resident's room to offer snacks. They revealed snacks get passed out by nursing staff around at about 8PM typically, when the kitchen is done cleaning up after dinner. Interview and observation on 08/21/25 at 07:36 PM, the Certified Dietary Manager (CDM) was pushing the snack cart and revealed they only made snacks that came from doctor's orders. She further revealed there were some extra snacks too. Record review of the facility's Order Listing Report, dated 08/22/25, reflected 39 residents (total census was 96 residents) were listed for an evening snack. Policy for snack was requested from the ADM on 08/22/25 at 10:11 PM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 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 observations, interviews, and record reviews the facility failed to ensure the establishment and maintenance of an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 8 [KA1] (Resident #139) residents reviewed for infection isolation protocols. HK S failed to wear a N95 FFR while providing housekeeping services for Resident #139. This failure could place residents and staff at risk for harm by contracting and spreading the Covid-19 virus. The findings included: A record review of Resident #139's admission record dated 8/22/2025, revealed an admission date of 8/15/2025 with diagnoses which included Covid-19 (a contagious disease caused by the coronavirus SARS-CoV-2.) A record review of Resident #139's admission MDS dated [DATE] revealed Resident #139 was an [AGE] year-old male admitted for covid-19 recovery. A record review of Resident #139's physician order dated 8/19/2025 revealed the physician prescribed for Resident #139 to be under isolation droplet protocol, order summary: Droplet precautions every shift for Covid . A record review of Resident #139's care plan dated 8/19/2025 revealed, The Resident has infection - COVID . During an interview on 8/19/2025 at 10:00 AM ADON F stated Resident #139 was under droplet precautions isolation due to his diagnosed Covid-19 infection. ADON F stated Resident #139 was admitted with Covid-19 and the physician had ordered Covid-19 isolation until the doctor would order the discontinuation of the isolation. During an observation on 8/20/2025 at 10:03 PM revealed Resident #139's room was designated to be under droplet precautions. The room presented with signage at the door prior to entry which read, STOP DROPLET PRECAUTIONS. During an observation and interview on 8/20/2025 at 3:09 PM revealed Resident #139's room door opened with HK S walking in and out of Resident #139's room to utilize the housekeeping cart stationed directly outside of Resident #139's room. HK S was observed to wear PPE which included a gown, gloves, face shield, and a surgical mask. Resident #139 was observed to be in his room and did not wear a respiratory mask. Resident #139 was observed to have a visitor who identified herself as a private care giver. The private care giver was observed to wear a surgical mask as her only PPE. The private care giver stated she was not trained on what PPE to wear while in Resident #139's room and wore the surgical mask as her own common sense. During an interview HK S stated she was providing housekeeping services for Resident #139 and wore her PPE which included her surgical mask as per the signage posted. HK S stated she used the PPE stored in the 2-drawer cabinet at Resident #139's doorway. An observation of the storage cabinet revealed no N95 FFR's. During an interview and observation on 8/20/2025 at 3:13 PM LVN T stated she was the charge nurse for Resident #139 and Resident #139 was under droplet precautions for a positive covid-19 infection. LVN T observed Resident #139's door opened with the housekeeping cart directly outside of the door and observed HK S to wear a surgical mask as a PPE FFR. LVN T stated HK S's PPE FFR should have been an N95 FFR. LVN T reviewed the PPE cabinet and stated there were no N95 FFR's within the cabinet. LVN T alerted ADON F and the DON. During an interview on 8/20/2025 at 3:29 PM ADON F stated Resident #139 was recovering from a Covid infection and all staff who entered his room should wear PPE to include a N95 FFR and not a surgical mask. ADON F stated the signage for the droplet precaution outside of Resident #139's room had not specified Covid-19 precautions which included the use of N95 FFR for the Prevention of Covid-19 cross-contamination. ADON F reviewed the PPE cabinet by Resident #139's room and stated the cabinet had no N95 FFR's within. During an interview on 8/22/2025 at 5:10 PM the DON stated Resident #139 was recovering from a Covid-19 infection on 8/20/2025 and was ordered by the physician to be under Covid-19 isolation precautions. The DON stated residents who were on Covid-19 precautions should have their door closed, should be encouraged to wear a surgical mask as source control measures, and all staff should wear Covid-19 isolation precautions PPE which included the use of a N95 FFR. The DON stated the potential risk for residents who received care from staff who had not worn Covid-19 PPE could be cross-contamination and spread of Covid-19. A record review of the Untied States of America's Centers for Disease Control and Prevention's website titled Covid-19; Infection Control Guidance: SARS-CoV-2 accessed 8/20/2025 https://www.cdc.gov/covid/hcp/infection-control/ revealed, Personal Protective Equipment; HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face)