STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455713	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING & REHAB CENTER	**50 BRIGGS ST SAN ANTONIO, TX 78224**

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 4 residents (Resident #1, #2 and #3) reviewed for COVID-19 symptom monitoring: 1. Resident #1's vital signs (typically include temperature, oxygen saturation, heart rate, and blood pressure) for COVID-19 were not recorded in the residents medical record as required. 2. Resident #2's vital signs for COVID-19 were not recorded in the residents medical record as required. 3. Resident #3's vital signs for COVID-19 were not recorded in the residents medical record as required. This deficient practice placed residents at the facility at risk for inaccurate documentation due to vital signs not accurately documented for COVID-19 and could place them at risk for not having continuity of care. The findings were: 1. Review of Resident #1's face sheet, dated 9/18/20 revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's vital signs recorded in the computerized medical record revealed: -no vital signs were recorded as required on 9/4/20-9/16/20 -vital signs were recorded only one time on 9/17/20 2. Review of Resident #2's face sheet, dated 9/18/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's vital signs recorded in the computerized medical record revealed: -no vital signs were recorded as required on 9/12/20, 9/15/20, or 9/16/20. -vital signs were recorded only one time on 9/13/20 and 9/17/20 3. Review of Resident #3's face sheet, dated 9/18/20 revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's physician orders [REDACTED]. Review of Resident #3's vital signs recorded in the computerized medical record revealed: -no vital signs were recorded as required on 9/5/20, 9/6 20, 9/8/20, 9/9/20, 9/10/20, 9/15/20, 9/16/20 and 9/18/20 -vital signs were recorded only one time on 9/1/20, 9/2/20, 9/4/20, 9/7/20, and 9/13/20 Interview on 9/18/20 at 2:30 PM with LVN A confirmed vital signs had not been documented at least once a shift or every 8 hours as required as part of the COVID assessment for Residents #1, #2 and #3. Further interview with LVN A revealed the CNA's were responsible for performing vital signs on the residents as part of the COVID assessment. LVN A stated the CNA's typically document the vital signs on a piece of paper which is given to the charge nurse. It is the charge nurse's responsibility to place the vitals in the computer as part of each resident's medical record. LVN A stated in the case of Resident #1 there had been an error in the medical record so they old record was deleted, and a new record started. LVN A stated there was no way to retrieve the information from the old chart because it had been deleted. Interview on 9/18/20 at 2:45 PM with the DON confirmed the computerized medical chart was the only place the vital signs would be recorded. The DON confirmed Resident #1, 2 and 3 did not have vital signs documented every shift. Further interview with the DON revealed a full set of vital signs should be taken and documented in the residents computerized medical record 3 times a day. The DON further confirmed the facility used HHSC LTC guidance as their guide for caring for residents related to COVID-19. Review of a facility policy, titled COVID-19 Plan dated 3/12/20 revealed: Resident Screening: Any new admission or readmission will be screened upon admission then every shift for 14 days using the visitor restriction criteria. This facility will also: Review CDC guidance for infection prevention and control recommendations . Review of HHSC COVID-19 Response for Nursing Facilities version 3.5 dated 8/18/20 revealed: page 36 Monitoring: Actively monitor all residents upon admission and at least three times daily for fever and respiratory symptoms.

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

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.