STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676158	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sonterra Health Center	18514 Sonterra Place San Antonio, TX 78258

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 - Immediate jeopardy to resident health or safety 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** 39251 Based on observations, interviews, and record review the facility failed to implement a comprehensive person-centered care plan for 2 of 8 residents (Resident #1 and Resident #2) reviewed for Care Plans. 1. The facility failed to ensure Resident #1 was receiving assistance with eating as detailed in his Care Plan and was left unsupervised in his room during the evening meal on [DATE]. Resident #1 was pronounced deceased at the facility on [DATE]. 2. The facility failed to ensure Resident #2 was receiving assistance with eating as detailed in her Care Plan. On [DATE] at 12:13 pm an Immediate Jeopardy (IJ) was identified. While the immediacy was removed on [DATE] at 7:42 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure placed all residents at risk for weight loss, malnutrition, and/or dehydration due to lack of proper assistance. Findings included: 1. Record review of Resident #1's Admission Record, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), dysphagia (difficulty swallowing), lack of coordination, depression (low mood), anxiety (feeling of dread, fear, or uneasiness), PTSD, and cognitive communication dysfunction (difficulty with thinking and language). Record review of Resident #1's imaging report, dated [DATE], revealed: .Swallowing Function .HISTORY: s/s of aspiration at bedside, dysphagia [difficulty swallowing]. Feeding difficulties .Difficulty swallowing . Record review of Resident #1's Care Plan, dated [DATE], revealed: [Resident #1] has elected DNR status . ADL Self Care Performance Deficit .Will safely perform ADLs .EATING: requires staff assistance . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 14, suggesting intact cognition. Further review of this assessment revealed Resident #1 required partial/moderate assistance with eating. Record review of Resident #1's Speech Therapy Notes, dated: [DATE], revealed: .Required verbal cues to complete mastication and swallow bolus .Patient at risk of aspiration of food, liquids, and secretions due to delayed movements and delayed swallow reflex . [DATE], revealed: Patient protruding tongue from oral cavity when trying to consume food requiring tactile cues to move tongue posteriorly to allow for intake . [DATE], revealed: Requires verbal cues to swallow secretions to reduce anterior leakage or episodes of coughing .Patient requiring increase time to facilitate A-P propulsion [second step in the oral phase of swallowing] in order to manage secretions. Frequently exhibits coughing when attempting to swallow built up saliva . Record review of Resident #1's Progress Note, dated [DATE], revealed, .ADLs .Eating: Limited assistance . One-person physical assist . Record review of facility's 24-hour log, dated [DATE], revealed: . [Resident #1] .Assist with feedings . Record review of Resident #1's Progress Notes revealed, Effective Date: [DATE] [11:19 pm] . While in another residents [sic] room assisting CNA's, another staff member called me into another residents [sic] room d/t resident choking. This nurse entered residents' [sic] room approx. [6:57 pm] resident was occasionally coughing and choking. Large amounts of secretions noted expelling from resident's mouth, this nurse wiping secretions from mouth. This nurse instructed staff member to call another nurse for assistance at [6:58 pm]. Resident coughed up dime size piece of broccoli. Other nurse came to render aide immediately, while other and [sic] staff members remained with resident, this nurse called 911 at [7:01 pm]. While on the phone with 911, other nurse and CNA's were performing the Heimlich maneuver. Once this nurse ended call with 911, applied O2 nasal cannula @,d+[DATE] LPM while suctioning secretions from residents [sic] mouth. Resident noted with occasional breath and cough. [Fire Department] arrived approximately [7:11 pm], who then attempted to obtain o2 sat via pulse ox, and applied EKG leads to resident. On call [Physician] called at [8:00 pm] left message for on call physician, and wife [Resident #1's wife] after to inform of incident. Medic [.] stated resident with asystole, [Fire Department] ME pronounced TOD @ [7:16 pm]. ME investigator [sic] notified [.], instructed this nurse to call [Police Department] .Author: [LVN A] . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During telephone interview on [DATE] at 10:34 am, LVN A said she was called by MA A and told Resident #1 was choking. When she arrived in Resident #1's room, she found Resident #1 sitting up in the wheelchair with his tray in front of him. LVN A stated due to Resident #1's condition he was unable to make the universal sign for choking, adding average person would wail or put their hands on their throat LVN A Resident #1 was tense and was holding the seat of the chair tight and we instructed him to let go and sat him up a little more, he had a lot of secretions in his mouth she saw a piece of broccoli come out of his mouth. LVN A said she instructed MA A to get RN A and RN A came immediately. RN A said 911 should be called because Resident #1 was not making the traditional choking signs, LVN A said she was unable to explain the noise Resident #1 was making. LVN A said she called 911 at 7:01 pm and then retrieved the crash cart to give oxygen and suctioning. LVN A said Resident #1 had a lot of secretions, and he took occasional breaths. LVN A stated when EMS arrived, they connected Resident #1 to the pulse oximeter and the EKG leads and EMS stated that he was asystole (absence of heartbeat). LVN A said Resident #1 required assistance with eating but was not sure if it was in his care plan. LVN A said she was not familiar with resident care plans and was not sure if staff were required to review care plans. LVN A added she had not been told resident care plans needed to be reviewed. LVN A said the Kardex did not sound familiar to her. During telephone interview on [DATE] at 12:18 pm, CNA A said on [DATE] she was feeding Resident #1 dinner when a coworker asked for help with a lift transfer, adding she left Resident #1's room and went to help with the other resident. CNA A said while they were in the other resident's room, she heard someone yell out for the nurse and followed the nurse into Resident #1's room. She noticed Resident #1 was having a hard time breathing, adding the resident had some saliva coming out of his mouth. CNA A said she and CNA N attempted to open Resident #1's mouth using a tongue depressor, adding she patted the resident's back and noticed he was having a hard time breathing. CNA A further stated MA A and CNA N stood Resident #1 up and CNA started the Heimlich for a few seconds, no more than 5 she believed, because it was hard to hold him up. CNA A said the nurse instructed someone to get the crash cart and LVN A started suctioning. CNA A and LVN A began to pat Resident #1 on the back. CNA A said when RN A arrived, she told LVN A to call 911. CNA A said she did not know if Resident #1 lost consciousness because she left the resident's room before EMS arrived to assist other residents. CNA A said staff initiated the Heimlich Maneuver because they were not sure if he was choking or if it was saliva. She said she figured if Resident #1 was choking it would make the obstruction come out, but she did not see any food just saliva. CNA A said CNAs did not have individual cards printed for the residents, so she just went by what she was told, adding the only ones that have information regarding the residents' level of assistance required were the nurses. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During telephone interview on [DATE] at 2:01 pm, RN A said she was called by MA A and was told they needed help because Resident #1 was making weird noises. When she arrived in Resident #1's room, he was making weird noises and LVN A and MA A were in the room when she arrived. RN A said she tried to assess Resident #1 and noted he had a lot of secretions coming out of his mouth and he was coughing. She provided Resident #1 with back thrusts. RN A said she told LVN A to call 911. She said CNA N and CNA A entered Resident #1's room and while RN A was thrusting the resident's back the CNAs attempted finger sweeps. RN A said she told LVN A to get the crash cart for the suction. In the meantime, CNA A started the Heimlich, but he did not cough anything up. RN A said LVN A arrived with the suction to see if there was anything in his mouth. RN A said she got secretions and the tiniest piece of broccoli, like half the size of her thumb nail, less than dime size. RN A said she stood behind Resident #1 while he was seated in his wheelchair and tried the Heimlich. RN A said Resident #1's lips were getting cyanotic (blue discoloration) but did not think the resident lost consciousness because his eyes were open and moving around and he was trying to breath and cough the whole time. RN A said she was called to help with Resident #1 but was not familiar with his care plan because she was assigned to another hall. During interview on [DATE] at 3:17 pm, CNA A said every resident had a Kardex in POC where information regarding ADLs was found. CNA A said the Kardex would have said the level of assistance Resident #1 required but did not remember what his Kardex said on [DATE]. 2. Record review of Resident #2's Admission Record, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Encephalopathy (conditions that cause brain dysfunction), dysphagia (difficulty swallowing), dementia (group of thinking and social symptoms that interferes with daily functioning), and cognitive communication deficit (difficulty with thinking and language). Record review of Resident #2's Care Plan, dated [DATE], revealed: [Resident #2] ADL Self Care Performance Deficit r/t ENCEPHALOPATHY .EATING: requires x1 staff assistance with feeding . Record review of Resident #2's Comprehensive MDS assessment, dated [DATE], revealed a BIMS score of 5, suggesting severe cognitive impairment. Record review of Resident #2's Kardex, dated [DATE], revealed: EATING: level of assistance ranges from substantial/maximal assistance to complete dependence on staff . Record review of Resident #2's Progress Notes, dated [DATE] and [DATE], revealed, .ADLs .Eating: Extensive assistance .One-person physical assist . During observation and interview on [DATE] at 8:34 am, Resident #2 was sitting in the hallway with another resident eating breakfast on her own. LVN D said Resident #2 and the other resident enjoyed eating in the hallway together and added Resident #2 did not require assistance during meals. Further observation at 8:55 am revealed Resident #2 was still eating her breakfast in the hallway unassisted. During an interview on [DATE] at 12:22 pm, CNA B said Resident #2 was not assigned to her but to her knowledge Resident #2 was required to be fed all three meals. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on [DATE], beginning at 12:40 pm and ending at 12:53 pm, revealed Resident #2 sitting at a table in the dining room eating without staff assistance. Resident #2 was observed eating very slowly, taking her second bite at 12:43 pm. At 12:46 pm, Resident #2 attempted to take a third bite but brought the empty spoon to her mouth. Resident #2 took a third bite of food at 12:47 pm, followed by 2 empty spoons at 12:50 pm and 12:51 pm. During an interview on [DATE] at 1:35 pm, LVN C said he had not heard nurses were required to review care plans. LVN C further stated he did know where resident care plans were found and reviewed care plans when there was additional information, he needed to learn about a particular resident. LVN C said he felt care plans should always be reviewed prior to providing care. LVN C further stated, as a nurse, reviewing care plans would probably be expected to learn what the residents' needs were. LVNC further stated it was important to review care plans so that care was provided according to the residents' needs. During an interview on [DATE] at 2:13 pm, LVN D said if a care plan said a resident required staff assistance for eating it could be for set up or encouragement, cuing, or actual feeding and if a resident required assistance x1, staff fed the resident. During interview on [DATE] at 2:29 pm, (translated from Spanish) Resident #2 nodded her head when asked by the state investigator if she needed help eating and shook head, as in no when asked if she received help. Another resident which sat next to Resident #2 in the hallway said Resident #2 did not receive assistance with meals and so she did not eat unless she received encouragement. During an interview on [DATE] at 2:38 pm LVN O said nurses were shown how to find resident care plans but did not know if they were required to review care plans. LVN O further stated care plans were where all the information about the residents' care was found. During interview on [DATE] at 2:52 pm, CNA C said she told the nurse Resident #2 seemed to be declining, sometimes the resident ate and others she sat in a daze. CNA C further stated she chose to start assisting Resident #2 with dinner because she did not want her to lose weight. CNA C said she did not know what Resident #2's Kardex said regarding eating, adding she fed the resident due to decline and not due to what the Kardex said. During observation and interview on [DATE] at 5:46 pm, CNA C was assisting Resident #2 with her evening meal. CNA C said Resident #2 required assistance with eating because otherwise she would not eat or brought the spoon to her mouth empty. During interview on [DATE] at 6:17 pm, LVN C said he did pass out the lunch trays to the residents in the dining room on [DATE] but was not familiar with the residents and was not aware Resident #2 required assistance with eating. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 12:12 pm, CNA E said she did not know how to access the residents' Kardex prior to [DATE] and had just learned because she only worked on the weekends. CNA E said if she was not familiar with a resident, she asked the nurse about the residents' level of care. CNA E further stated she fed Resident #2 because the family said that she would not eat. CNA E said Resident #2's plan said assisted feeder but that she fed Resident#2 because she wanted to make sure she ate. CNA E said assisted feeder meant that the resident was able to eat independently but needed cues. She stated it was required that someone sit with Resident #2 through all her meals. CNA E demonstrated how to access POC, Resident #2's POC notes on [DATE] in the eating tab said Resident #2 was dependent on staff for eating. Record review of facility's policy, titled Policy/Procedure - Nursing Administration .Care and Treatment . ADL's & Staffing, undated, revealed: .4. Assist with care as required based off resident needs that include but not limited to .feeding . This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 12:13 pm. The DON was notified and was provided with the IJ template on [DATE] at 1:05 pm. The following Plan of Removal submitted by the facility was accepted on [DATE] at 4:47 pm and included the following: [Facility] Plan of Removal [DATE] Per the information provided in the IJ Template given on [DATE], the facility failed to keep Resident #1 safe from Accident Hazards by not providing the proper supervision during evening meal on [DATE]. Immediate Action o Medical Director notified of Immediate Jeopardy on [DATE] at 8 :26pm. o Resident #1 is no longer in the facility. o Resident# 2 was assessed for signs of aspiration. o Resident's# 2 Primary Care Physician will be notified resident wasn't assisted for 12min with feeding, o 100 % audit was completed on care plans to ensure care plan is resident specific to residents [sic] need of assistance with eating. Audit was started on [DATE] and will be completed by [DATE] at noon. The MDS nurse will be responsible for completing the care plan audit by [DATE] at 12 (noon). o The MDS nurse will revise the care plan [sic] and Kardex to ensure all needs are being meet [sic]. This process started on [DATE] and will be ongoing. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o CNA C received a one-on-one in-service [sic] on [DATE], on remaining with the resident through the whole entire meal when assisting a resident with eating. o All licensed staff and CNAS were in-serviced [sic] on accessing the Kardex. Ln-services [sic] started on [DATE] at 12 (noon) and will be completed [DATE] By 12 (noon). Any staff not receiving in-service [sic] will be removed from the schedule until the in-service [sic] has been completed. o 100 % of Licensed Nurses were in-serviced [sic] on how to access the care plans and review the plan of care. In-service [sic] started on [DATE] and will be completed by [DATE]. Any staff not receiving in-service will be removed from the schedule until the in-service [sic] has been completed. o Ln-service [sic] on verification of meal trays was completed with 100 % Licensed and registered nurses. In-service [sic] started on ,d+[DATE] /24 and completed on [DATE]. Any staff not receiving in-service [sic] will be removed from the schedule until the in-service [sic] has been completed. o In-service [sic] on assisting a resident with feeding was done 100 % with licensed staff and CNAS. In-service [sic] started on [DATE] at 12 (noon) and will be completed [DATE] By 12 (noon). o In-service [sic] on ADL coding for Licensed staff and CNAs' for [sic] eating was started [DATE] and will be completed by [DATE]. Any staff not receiving in-service [sic] will be removed from the schedule until the in-service [sic] has been completed. o The assistant director of nursing will be responsible to ensure that PRN staff, agency staff, and any new hires receive all training related to the IJ. Any staff not receiving in-service [sic] will not be on the schedule until all in-services [sic] have been completed. The DON and the Administrator will monitor this process starting [DATE]. o Any resident who requires assisted dining and choses to stay in the room will have a CNA assigned to assist with dinning [sic] in their room and will be logged in a log with the name of the CNA assigned to feed. Process started on [DATE]. This will be monitored by the nurse managers daily and charge nurses will assign CNAs to residents who need assisted dining and want to dine in their room. o LVN C received one on one in-serviced [sic] regarding Kardex and care plans to learn levels of assistance for resident cares and ADL's, completed [DATE]. Identification of Others Affected All residents have the potential to be affected by this alleged deficient practice. Systemic Change to Prevent Re-occurrence. 1. The dietary manager will update meal ticket to reflect resident need for assisted dinning [sic]. This will begin on [DATE]. Meal tickets will be audited weekly by the ADON and the dietary manager to ensure residents needs are reflected. 2. Charge Nurses will initial meal ticket to ensure proper meal is served and will document by checking (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents name and signing log once meal has been verified. This process started on [DATE]. 3. Kardex have been updated to reflect ADL specific assistance for eating. Kardex update was started on [DATE] and will be completed by [DATE] at noon. 4. Any resident who requires assisted dining and choses [sic] to stay in the room will have a CNA assigned to assist with dining [sic] in their room and will be logged in a log with the name of the CNA assigned to feed. Process started on [DATE]. 5. An off cycle QAPI was conducted on [DATE] to review Plan of removal. 6. A log was created that contains the date/start/end of shift, Kardex, care plan, any changes, if any and nurse manager signature, this process started on [DATE]. 7. The DON created a mandated schedule for a nurse manager to hold huddles at start and end of shift in order to review and ensure staff know of any changes/updates to the care plan and to ensure current interventions in place, this process was started [DATE]. 8. Nurse managers at that time will be responsible to updating care plans and flagging care plans for the next shift to review, this process started on [DATE]. 9. Any agency/contract, new hired staff is required to see nurse manager prior to start of shift for care plan and Kardex review, this process started on [DATE]. 10. Kardex to be used for shift change report, this process started on [DATE]. 11. All nursing staff was in-serviced [sic] on how to refer to Kardex in POC and care plan in PCC, in addition to the care plan binder printed out and stored at the nurse's station, this process started on [DATE] and will be at 100% by [DATE] at 3:00PM. Monitoring 1. Nurse manager will be present for every meal to ensure residents that require assisted dining [sic] are assisted. This process was started on [DATE]. 2. MDS nurse and Nurse Managers will monitor Kardex daily to ensure any changes needed if any, have been updated to Kardex. This was process started on [DATE]. 3. Nurse Manager and MDS nurse would review care plan/Kardex binder daily to ensure if any changes needed and if any will be updated. This process started on [DATE] at 6pm. 4. Nurse managers will review log daily for residents eating in room to ensure they are being assisted by a staff member. This Process was started on [DATE]. 5. Nurse Manager will monitor Kardex to ensure it is being used for shift change report, this process started on [DATE] at 10:00PM. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:09 pm, RN B said she assisted in the dining room and remained in the dining room through the entirety of the meal service to ensure CNAs were feeding appropriately and for safety (choking, etc.). RN B said the floor nurses were responsible for the residents eating in their rooms and assignments for the CNAs assisting residents eating in their rooms. During an interview on [DATE] at 6:29 am, CNA L said he received in-services regarding where to find resident information in POC and added staff were not allowed to leave the resident unattended during meals if they required assistance. During an interview on [DATE] at 11:58 am, CNA H said she was in-serviced regarding ADLs, Kardex, and determining how much assistance the residents required during meals. CNA H further stated the in-services included assisting residents with feeding, communicating with residents, and providing cues during meals. CNA H said staff were not allowed to leave residents unattended when assisting with eating because the resident could choke or put something in their mouth that they should not be eating. CNA H said she was able to check the Kardex at any time and during shift report and was expected to review the Kardex during shift change to familiarize herself with resident care required. CNA H said staff were now expected to review the Kardex with the oncoming shift prior to providing care. During interview on [DATE] at 12:39, pm CNA H said she received several in-services on [DATE] and [DATE] regarding the Kardex and care plans, adding they were available in a binder at the nurses' station. CNA H further stated the in-services included ADL coding and said the definitions of each term was located on the wall by the nurses' station. CNA H said the Kardex included how residents transferred, hygiene (showers), and if they needed assistance with eating. CNA H said supervision while eating meant staff watched while the resident ate (they might have swallowed issues) and staff had to stay with the resident for the whole meal. CNA H said if a resident required assistance, it could be just for cues and reminders (like if they had dementia, they might need reminders) or if they needed help using utensils. CNA H said when a resident was assisted with meals they should not be left alone; you should finish the meal with them. CNA H said extensive/dependent meant the resident needed to be fed small bites, making sure they were clearing their mouth (not pocketing) and giving sips in between every few bites (like 3 or 4). CNA H said the residents' Kardex needed to be reviewed every day during report because it could change every day, and staff needed to ensure there were not any changes to resident care. During interview on [DATE] on 1:38 pm, LVN L said she did receive in-services regarding shift report, Kardex and care plans, including changes. LVN L further stated staff were to review care plans and Kardex, including changes, with the oncoming shift during report. LVN L said care plans were expected to be reviewed before care was provided to residents, adding this was always the expectation. LVN L said she assigned CNAs to assist residents that required assistance with eating. LVN L said supervision during meals meant residents needed to be overseen while they ate. LVN L further stated if a resident required assistance, it meant the resident was taken to the dining room or assigned a CNA to help them eat, adding the staff was required to stay with the resident during the entire meal. During interview on [DATE] at 1:46 pm, the ST said she received in-services regarding ADL coding, Kardex, and care plans. The ST said the care plans and Kardex were found in PCC under the resident's tab. The ST further stated the care plans/Kardex contained information regarding the residents' level of care, such as, transfers, eating, and bed mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER: Sonterra Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18514 Sonterra Place San Antonio, TX 78258	

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:52 pm, the PT said he received in-service regarding ADL coding (defined the functional levels) and making sure they had a list of residents that required assistance with eating. During an interview on [DATE] at 2:56 pm, LVN J said each nurse manager was assigned a shift and were to observe shift change report, provide education, and answer questions. During joint interview on [DATE] at 3:34 pm, LVN D said he received in-services regarding the Kardex and care plans. LVN B said the in-services included ADL coding, updating the Kardex and care plans, nurse rounds, and observing huddles (shift change report) for CNAs and nurses. LVN B said if a resident required assistance with feedings, staff were not allowed to leave the resident unattended during the meal. LVN B said she and LVN D were responsible for updates to the care plans and communication with the therapy team and nursing staff regarding any changes. LVN B said the audits of the care plans and Kardex were completed, and no discrepancies were found. LVN D said care plans were made more specific and resident driven. During interview on [DATE] at 3:53 pm, MA A said she did receive in-services on [DATE] and [DATE] regarding the Kardex, where to find them in the POC, and if she was unable to locate it, it was at each nurses' station in a binder. MA A demonstrated how to access the Kardex in POC and where to find binder at the nurses' station with each resident's care plan and Kardex. During interview on [DATE] at 4:00 pm, LVN A said she did receive in-services regarding the Kardex and care plans, how to access them, and what they each included. LVN A said the care plans were more detailed, for nursing, and the Kardex were for CNAs. LVN A further stated it was her responsibility, as the nurse, to ensure CNAs assisted residents that required assistance with meals and ensured that they stood with the residents until the meal was completed. LVN A said she was expected to review care plans during shift change report for each resident she was assigned to and notified management if there were any changes that needed to be made. During interview on [DATE] at 4:08 pm, CNA B said she did receive in-services over the last few days regarding the Kardex and how to access them, and definitions of ADL terms. CNA B demonstrated how to access the Kardex and said she was expected to review it during shift change report and as needed. During interview on [DATE] at 4:14 pm, CNA A said she did receive in-services regarding using the Kardex during rounds and shift change report. CNA A said if a resident required assistance with eating staff were not supposed to leave their side, were required to be attentive to the resident, and not talk on the phone or other people. During interview on [DATE] at 4:25 pm, LVN N said did receive in-services regarding the Kardex, ADLs and coding, feeding assistance. LVN N said her responsibility was to identify which residents required assistance with eating, which wanted to eat in the dining room, and which wanted to eat in their rooms prior to beginning her shift. LVN N further stated the residents that required assistance with eating and chose to stay in their room, staff were required to always stay in the r[TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 39251 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 8 residents (Residents #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 was not left unsupervised in his room during the evening meal on [DATE]. Resident #1 was pronounced deceased at the facility on [DATE]. On [DATE] at 4:21 pm an Immediate Jeopardy (IJ) was identified. While the immediacy was removed on [DATE] at 7:42 pm, the facility remained out of compliance at scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure placed all residents at risk for serious injury, harm, and/or death due to lack of appropriate supervision. Findings included: Record review of Resident #1's Admission Record, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Dysphagia (difficulty swallowing), lack of coordination, Depression (low mood), Anxiety (feeling of dread, fear, or uneasiness), PTSD, and cognitive communication dysfunction (difficulty with thinking and language). Record review of Resident #1's imaging report, dated [DATE], revealed: .Swallowing Function .HISTORY: s/s of aspiration at bedside dysphagia. Feeding difficulties .Difficulty swallowing . Record review of Resident #1's Care Plan, dated [DATE], revealed: [Resident #1] has elected DNR status . ADL Self Care Performance Deficit .Will safely perform ADLs .EATING: requires staff assistance . Record review of Resident #1's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 14, suggesting intact cognition. Further review of this assessment revealed Resident #1 required partial/moderate assistance with eating. Record review of Resident #1's Speech Therapy Notes, dated: [DATE], revealed: .Required verbal cues to complete mastication and swallow bolus .Patient at risk of aspiration of food, liquids and secretions due to delayed movements and delayed swallow reflex . [DATE], revealed: Patient protruding tongue from oral cavity when trying to consume food requiring tactile cues to move tongue posteriorly to allow for intake . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], revealed: Requires verbal cues to swallow secretions to reduce anterior leakage or episodes of coughing .Patient requiring increase time to facilitate A-P propulsion in order to manage secretions. Frequently exhibits coughing when attempting to swallow built up saliva . Record review of Resident #1's Progress Note, dated [DATE], revealed, .ADLs .Eating: Limited assistance . One person physical assist . Record review of facility's 24-hour log, dated [DATE], revealed: . [Resident #1] .Assist with feedings . Record review of Resident #1's Progress Notes revealed, Effective Date: [DATE] [11:19 pm] . While in another residents [sic] room assisting CNA's, another staff member called me into another residents [sic] room d/t resident choking. This nurse entered residents' [sic] room approx. [6:57 pm] resident was occasionally coughing and choking. Large amounts of secretions noted expelling from resident's mouth, this nurse wiping secretions from mouth. This nurse instructed staff member to call another nurse for assistance at [6:58 pm]. Resident coughed up dime size piece of broccoli. Other nurse came to render aide immediately, while other and [sic] staff members remained with resident, this nurse called 911 at [7:01 pm]. While on the phone with 911, other nurse and cna's were performing the Heimlich maneuver. Once this nurse ended call with 911, I applied O2 nasal cannula @,d+[DATE] LPM while suctioning secretions from residents [sic] mouth. Resident noted with occasional breath and cough. [Fire Department] arrived approximately [7:11 pm], who then attempted to obtain o2 sat via pulse ox, and applied EKG leads to resident. On call [Physician] called at [8:00 pm] left message for on call physician, and wife [Resident #1's wife] after to inform of incident. Medic [.] stated resident with asystole, [Fire Department] ME pronounced TOD @ [7:16 pm]. ME investigator [sic] notified [.], instructed this nurse to call [Police Department] .Author: [LVN A] . During an interview on [DATE] at 3:36 pm, RN D said Resident #1 required staff assistance with meals because he ate very slow. RN D further stated if a resident required assistance with meals staff were expected to be with the resident throughout the entire meal. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 10:34 am, LVN A said she was called by MA A and told Resident #1 was choking. When she arrived in Resident #1's room, she found Resident #1 sitting up in the wheelchair with his tray in front of him, LVN A further stated due to Resident #1's condition he was unable to make the universal sign for choking, he was tense, average person would wail or put their hands on their throat, but Resident #1 was holding the seat of the chair tight and we instructed him to let go and sat him up a little more, he had a lot of secretions in his mouth she saw a piece of broccoli come out of his mouth. LVN A said she instructed MA A to get RN A she came immediately and said we should call 911 because he was not making the traditional choking signs, LVN A said she was unable to explain the noise Resident #1 was making. LVN A said she called 911 at 7:01 pm and then retrieved the crash cart to give oxygen and suctioning. LVN A said Resident #1 had a lot of secretions, and he took occasional breaths. LVN A when EMS arrived, they connected Resident #1 to the pulse oximeter and the EKG leads and EMS stated that he was asystole (absence of heartbeat). LVN A said Resident #1 needed some assistance with meals but was able to feed himself, he moved very slow due to his condition, he opened his mouth really slow, and he chewed very slow, and drooling was normal for him, so he did have a lot of secretions. LVN A said Resident #1 did require assistance with eating. LVN A further stated Resident #1 was on a mechanical soft diet and received mechanical soft diet on [DATE]. LVN A said if a resident required assistance with eating the staff were required to sit with the resident for the entire meal but did not know if they were able to leave the room or not. LVN A said she was not specifically told Resident #1 required assistance with eating, but it was in the reports that he needed assistance. LVN A further stated she was not sure why Resident #1 required assistance with eating but said it might have been for safety. During a telephone interview on [DATE] at 12:18 pm, CNA A said on [DATE] she was feeding Resident #1 dinner when a coworker asked for help with a lift transfer, adding she left Resident #1's room and went to help with the other resident. CNA A said while they were in the other resident's room, she heard someone yell out for the nurse and followed the nurse into Resident #1's room and noticed Resident #1 was having a hard time breathing, adding the resident had some saliva coming out of his mouth. CNA A said she and CNA N attempted to open Resident #1's mouth using a tongue depressor, adding she patted the resident's back and noticed he was having a hard time breathing, CNA A further stated MA A and CNA N stood Resident #1 up and CNA started the Heimlich for a few seconds, no more than 5 she believed because it was hard to hold him up. CAN A the nurse instructed someone to get the crash cart and LVN A started suctioning and CNA A and LVN A began to pat Resident #1 the back. CNA A said when RN A arrived, she told LVN A to call 911. CNA A said she did not know if Resident #1 lost conscience because she left the resident's room before EMS arrived to assist other residents. CNA A said Resident #1 was assisted with meals because he was a slow eater and required assistance guiding the spoon or cup to his mouth. CNA A said she was told to assist Resident #1 and she did, she added that as far as she knew she was not expected to stay with Resident #1 while she assisted him with his meal. CNA said she did not know what the facility's protocol was regarding assisted dining and no one had told her what the procedures were for assisting residents with meals. CNA A further stated she was not specifically told to stay in the room, just to assist Resident #1 with meals. CNA A said staff initiated the Heimlich Maneuver because they were not sure if he were choking or if it were saliva, so said figured if Resident #1 were choking it would make the obstruction come out, but she did not see any food just saliva. CNA A said CNAs did not have individual cards printed for the residents, so she just went by what she was told, adding the only ones that have information regarding the residents' level of assistance required were the nurses. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 2:01 pm, RN A said she was called by MA A and was told they needed help because Resident #1 was making weird noises, adding when she arrived in Resident #1's room he was making weird noises and LVN A and MA A were in the room when she arrived. RN A said she tried to assess Resident #1 and noted he had a lot of secretions coming out of his mouth and he was coughing, adding she provided Resident #1 with back thrusts. RN A said she told LVN A to call 911 and CNA N and CNA A entered Resident #1's room and while RN A was thrusting the resident's back the CNAs attempted finger sweeps. RN a said she told LVN A to get the crash cart for the suction and in the meantime CNA A started the Heimlich, but he did not cough anything up. RN A said LVN A arrived with the suction to see if there was anything in his mouth. RN A said she got secretions and the tiniest piece of broccoli, like half the size of her thumb nail, less than dime size. RN A said she stood behind Resident #1 while he was seared in his wheelchair and also tried the Heimlich. RN A said Resident #1's lips were getting cyanotic (blue discoloration) but did not think the resident lost consciousness because his eyes were open and moving around and he was trying to breath and cough the whole time. RN A said she was called to help with Resident #1 but was not familiar with him because she was assigned to another hall. During an interview on [DATE] at 2:45 pm, CNA B said when assisting residents with eating staff were not allowed to leave the resident's room for any reason because they can choke or aspirate. During an interview on [DATE] at 3:17 pm, CNA A said she did know that staff were required to stay with the residents for the entire meal if the resident was dependent on staff for eating. but if the resident just needed assistance with eating, the staff monitored the resident in case the resident needed help; in which case the staff were allowed to leave the room if needed. CNA A further stated Resident #1 was not dependent on staff for eating and just needed assistance with eating. CNA A said on [DATE], before she left the room, she left the table in front of Resident #1 in case he needed a drink but moved the plate back where he was unable to reach it. During an interview on [DATE] at 11:03 am, LVN B said if a resident required assistance with eating it meant they required staff assistance, and some residents needed to be fed. LVN B further stated this information was found in the residents' Kardex. LVN B said when a resident required assistance with eating it meant staff just helped the resident with setting up their tray or if the resident needed water, adding staff were not required to stay in room with the resident. LVN B said Resident #1 required assistance with eating, but he ate by himself or was sometimes fed by the family. LVN B said staff were not required to stay with Resident #1 during meals and as far as she knew he did not require supervision while eating. During an interview on [DATE] at 2:13 pm, LVN D said if a resident required staff assistance for eating staff were required to be in the room with the resident throughout the entire meal. LVN D further stated if they had to leave the resident's room during a meal, the staff needed to get someone to relieve them, adding the resident should not be left alone at any time during the meal. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:38 pm, LVN O said if a resident required assistance with eating and staff were required to stay with the resident for the entire meal and were not allowed to leave the room unless there was an emergency. LVN O further stated this was important because staff were to monitor the resident for choking, signs of aspiration, and how much he ate. LVN O said nurses were responsible for ensuring staff stayed in the room when assisting residents with eating. LVN O said she did not believe Resident #1 was able to feed himself. LVN O further stated if the staff were feeding Resident #1 on [DATE], her expectation was for the staff to stay in room with him for the entire meal, adding this was important in case anything happened, such as aspiration or the incident on [DATE]. LVN O said the nurses on the floor were responsible for ensuring staff were with the resident's during meals if they required assistance. During interview on [DATE] at 4:06 pm, the DM said Resident #1 was supervised when he ate in the dining room because he was a very slow eater but did not know if he required assistance or supervision. The DM said Resident #1 received a mechanical soft diet on [DATE] which he ate in his room. During interview on [DATE] at 5:11 pm, the DOR said she was not very familiar with Resident #1, but the ST worked with him during his stay and was told by the ST Resident #1 fluctuated, sometimes he ate independently and sometimes he needed assistance. The DOR further stated he needed supervision for verbal cues and assistance with eating. The DOR said supervision with eating meant someone should be sitting with the resident throughout the entire meal and the expectation was that staff was to remain in the room with Resident #1 while he ate, adding staff should not have left the room. The DOR further stated it was important that staff remained with Resident #1 to monitor his eating, to ensure he swallowed his food, was drinking between bites, safety, and to ensure he tolerated the diet he was ordered without any risks, such as aspiration. During a telephone interview on [DATE] at 9:58 am, the ST said Resident #1 was very slow to move due to his disease process and she worked with him on communication and eating. The ST said Resident #1 did require some cueing to swallow his saliva. The ST said Resident #1 he did not require someone with him while he ate. The ST further stated Resident #1 did not have issues with mastication or aspiration and her only requirement was that he be up in his wheelchair. The ST said there was always a risk for choking due to of Resident #1's disease process. During a telephone interview on [DATE] at 11:49 am, the ST said the details of her [DATE] progress note was communicated to nursing, adding CNAs on the floor were very good with Resident #1 and went into his room several times to check on him. The ST further stated Resident #1 had a lot of saliva and needed cues to swallow throughout the day. The ST said in her opinion Resident #1 did not require constant supervision during meals, but staff always checked on him because he was slow to eat and spent more time with him when he was having a hard day. The ST said Resident #1 aspirated on his own secretions but there is nothing that could done about that. Record review of facility's policy, titled Policy/Procedure - Nursing Administration .Care and Treatment . ADL's & Staffing, undated, revealed: It is the policy of this facility to ensure the safety and comfort of the resident .2. Observe resident for .safety .4. Assist with care as required based off resident needs that include but not limited to .feeding . This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:21 pm. The DON was notified and was provided with the IJ template on [DATE] at 7:45 pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following Plan of Removal submitted by the facility was accepted on [DATE] at 11:04 am and included the following: [Facility] Plan of Removal [DATE] Per the information provided in the IJ Template given on [DATE], the facility failed to keep Resident #1 safe from Accident Hazards by not providing the proper supervision during evening meal on [DATE]. Immediate Action o Medical Director notified of Immediate Jeopardy on [DATE] at 8 :26pm. o Resident #1 is no longer in the facility. o Resident# 2 was assessed for signs of aspiration. o Resident's# 2 Primary Care Physician will be notified resident wasn't assisted for 12 min with feeding, o 100 % audit was completed on care plans to ensure care plan is resident specific to residents 'need of assistance with eating. Audit was started on [DATE] and will be completed by [DATE] at noon. The MDS nurse will be responsible for completing the care plan audit by [DATE] 12 noon. o The MDS nurse will revise the care plan and Kardex to ensure all needs are being met. This process started on [DATE] and will be ongoing. o CNA A received a one-on-one in-service on [DATE], on remaining with the resident through the whole entire meal when assisting a resident with eating. o All licensed staff and CNAS were in-serviced on accessing the Kardex. In-service started on [DATE] at 12 noon and will be completed [DATE] By 12 NOON. Any staff not receiving in-service will be removed from the schedule until in-service has been completed. o 100 % of Licensed Nurses were in-serviced on how to access the care plans and review the plan of care. In-service started on [DATE] and will be completed by [DATE]. Any staff not receiving in-service will be removed from the schedule until in-service has been completed. o in-service on verification of meal trays was completed with 100 % Licensed and registered nurses. in-service started on ,d+[DATE] /24 and completed on [DATE]. Any staff not receiving in-service] will be removed from the schedule until in-service has been completed. o in-service on assisting a resident with feeding was done 100 % with licensed staff and CNAS. in-service started on ,d+[DATE] /24 at 12 noon and will be completed [DATE] By 12 (noon). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o in-service on ADL coding for Licensed staff and CNAs for eating was started [DATE] and will be completed by [DATE]. Any staff not receiving in-service will be removed from the schedule until in-service has been completed. o The assistant director of nursing will be responsible to ensure that PRN staff, agency staff, and any new hires receive all training related to the IJ. Any staff not receiving in-service will not be on the schedule until all in-services have been completed. The DON and Administrator will monitor this process starting [DATE]. o Any resident who requires assisted dining and choses to stay in the room will have a CNA assigned to assist with dining in their room and will be logged in a log with the name of the CNA assigned to feed. Process started on [DATE]. This will be monitored by the nurse managers daily and charge nurses will assign CNAs to residents who need assisted dining and want to dine in their room. Identification of Others Affected All residents have the potential to be affected by this alleged deficient practice. Systemic Change to Prevent Re-occurrence. 1. Dietary manager will update meal ticket to reflect resident need for assisted dining. This will begin on [DATE]. Meal tickets will be audited weekly by the ADON and the dietary manager to ensure residents needs are reflected. 2. Charge Nurses will initial meal ticket to ensure proper meal is served and will document by checking residents name and signing log once meal has been verified. This process started on [DATE]. 3. Kardex have been updated to reflect ADL specific assistance for eating. Kardex update-was started on [DATE] and will be completed by [DATE] at noon. 4. The Nurse Managers will monitor staff to ensure the Kardex and care plan are followed this will occur every shift, they will sign a log once they have observed staff this will be started on [DATE] at 2:00PM. 5. Any resident who requires assisted dining and chooses to stay in the room will have a CNA assigned to assist with dining in their room and will be logged in a log with the name of the CNA assigned to feed. Process started on [DATE]. 6. An off cycle QAPI was conducted on [DATE] to review Plan of removal. Monitoring 1. Nurse manager will be present for every meal to ensure residents that require assisted dining are assisted. This process was started on [DATE]. 2. MDS nurse and Nurse Managers will monitor Kardex daily to ensure any changes needed if any, have been updated to Kardex. This was process started on [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sonterra Health Center	18514 Sonterra Place San Antonio, TX 78258

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

3. Nurse managers will review log daily for residents eating in room to ensure they are being assisted by a staff member. This process was started on [DATE].

4. Nurse Managers will be monitoring staff to ensure care plans and Kardex are being reviewed by staff.

5. Any issues identified with residents dining needs will be corrected immediately on the meal ticket Kardex and care plan. This process will start [DATE] and will be on going. Any issues identified will be reviewed in the QAPI monthly meeting.

6. Summary of IJ and corrective action to be reviewed by QAPI monthly until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance.

Verification of POR:

Record review of facility's In-service Training Report sign-in sheets dated [DATE]-[DATE], revealed 87 out of 87 active nursing/therapy staff were in-serviced in-person and via telephone regarding the following topics: feeding residents, assisting residents with meals, abuse/neglect, and ADL coding.

During interviews between [DATE] and [DATE], with 6 nursing staff and 2 therapy staff on the 6 am - 2 pm shift (4 LVNs, 2 CNAs, 1 ST, and 1 PT), 7 nursing staff on the 2 pm - 10 pm shift (1 RNs, 2 LVNs, 3 CNAs, and 1 CMA), and 3 CNAs on the 10 pm - 6 am shift, staff said they had been in-serviced regarding ADL coding, and feeding residents.

During interview on [DATE] at 1:49 pm, LVN E said she had received in-services on [DATE] regarding resident diets, and reviewing care plans. LVN E said she must assign a CNA to each resident that required assistance with meals and ensure that residents was not left alone during meals and they are positioned correctly.

During interview on [DATE] at 2:02 pm, LVN F said she had received in-services during the last three days (starting Thursday or Friday) regarding feeding residents and ADL coding. LVN F further state she was expected to review care plans every day for changes at the beginning at the shift.

During interview on [DATE] at 2:06 pm, LVN G said he had received in-service on [DATE] regarding how mealtimes would operate, the duties of the nurses and CNAs during meals, and protocols regarding feeding residents. LVN G further stated staff were instructed on how to feed residents and staff were expected to stay with the resident for the entire meal.

During interview on [DATE] at 11:03 pm, CNA F said when staff were feeding residents they were not allowed to leave a resident alone and must stay with the resident throughout the entire meal.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 11:12 pm, CNA J said she received in-service regarding taking care of the resident and feeding if the resident needed help eating. CNA J further stated she staff were not allowed to leave a resident unattended while assisting them with eating. CNA J said ADL terms were reviewed during the in-service. CNA J said if a resident required supervision it meant the staff just watched because the resident was able to eat independently (monitoring for choking of if help was needed) . CNA J further stated a if a resident required 1-person assist then one staff was required to be with that resident assisting them to eat and was required to stay with the resident during the entire meal. During meal observation on [DATE], beginning at 1:15 pm, Residents #2, 3, and 4 were fed their meals by staff. Residents' meal tickets read assisted dining. During interview on [DATE] at 5:09 pm, RN B said she assisted in the dining room and I remained in the dining room through the entirety of the meal service to ensure the CNAs were feeding appropriately and for safety (choking, etc.). RN B said the floor nurses were responsible for the residents eating in their rooms. RN B further stated the charge nurses made assignments for the CNAs assisting residents eating in their rooms. During interview on [DATE] at 6:29 am, CNA L said he received in-service regarding feeding residents, adding staff were not allowed to leave residents unattended during meals if they required assistance. During interview on [DATE] at 11:58 am, CNA H said she was in-serviced regarding ADLs, determining how much assistance the resident requires during meals and assisting the residents with feeding. CNA H said staff were not allowed to leave residents when assisting with eating because they can choke or put something in their mouth that they should not be eating. During interview on [DATE] at 12:39, pm CNA H said she received several in-services on [DATE] and [DATE] regarding ADL coding, that was located by the nurses station, posted on the wall. CNA H said if a resident required supervision when eating staff watched while they ate because they might have issues with swallowing and were required to stay with the resident the whole time. CNA H further stated if a resident required assistance with eating it could mean the resident needed cues or reminders (like if they had dementia) or if they needed help using utensils. CNA H said when assisting resident with eating, the resident must not be left alone; you should finish the meal with them. CNA H said if a resident required extensive/dependent assistance, it meant staff fed the resident small bites and made sure the resident was clearing their mouth (not pocketing food) and was required to stay with the resident throughout the meal. During an interview on [DATE] on 1:38 pm, LVN L said she received in-service . LVN L said her responsibility was to ensure a can was assigned to assist residents that require assistance with eating. LVN L further stated if a resident required supervision during meals they needed to be overseen when eating. LVN L said if a resident required assistance when eating she took the resident to the dining room or assigned a CNA to assist them with their meal. LVN L further stated if a resident required assistance when eating staff were required to stay with the resident for the entirety of the meal. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:46 pm, the ST said she received in-service regarding ADL coding and feeding residents. The SR said the facility added the level of assistance each resident needed to the meal tickets. The different types of abuse and who we report it to, the administrator/abuse coordinator. The ST said the definitions for the ADL coding was on the wall by the kiosks and the nurses' station. During an interview on [DATE] at 1:52 pm, the PT said he received in-service regarding ADL coding (defined the functional levels) and received a list of residents that required assistance with eating. During joint interview on [DATE] at 3:34 pm, LVN D said he received in-services regarding ADL coding,. LVN B said if a resident required assistance with feedings staff were not allowed to leave the resident unattended during the meal. LVN D said care plans were made more specific and resident driven. During interview on [DATE] at 4:00 pm, LVN A said she did receive in-services. LVN A said CNAs were assigned to the residents that required assistance with eating and the nurses ensured the CNAs stood with the resident until the meal was complete. During interview on [DATE] at 4:08 pm, CNA B said she did receive in-service over the last few days regarding feeding residents and definitions of ADL terms. CNA B demonstrated how to access the Kardex, said she was expected to review it during shift change report and as needed. During interview on [DATE] at 4:14 pm, CNA A said she did receive in-service regarding feeding residents. CNA A said if a resident required assistance with eating staff we are not supposed to leave their side and had to stay attentive to the resident. During interview on [DATE] at 4:25 pm, LVN N said she did receive in-service regarding ADLs coding and feeding assistance. LVN N said she was now required to identify which residents required assistance with eating, who wanted to stay in their room and who wanted to go to the dining room. LVN N further stated those residents that chose to eat in their room and required assistance was assigned a staff to stay in the room whole they ate. During interview on [DATE] at 4:35 pm, RN A said she did receive in-service regarding resident that eat in the dining room, documenting residents eating in their rooms and assigning CNAs to assist with eating. RN A said if a resident was not eating independently, she assigned a CNA to assist that resident. RN A further stated she was required to keep a log of each resident that required assistance with eating and the CNA assigned to assist with the meal. During interview on [DATE] at 4:44 pm, CNA M said she received in-service regarding how to feed residents and ADL coding, which describes how to assist the resident and how to feed them. CNA M said staff could not leave a resident alone when they assisted them with their meals. During a joint interview on [DATE] at 5:17 pm with the nurse managers, LVN K said the charge nurse logged each residents who chose to eat in their room and required assistance with eating. LVN K further stated the charge ensured staff stayed in the room with the resident throughout the entire meal. LVN J said they had to sign the log after the meal verifying the nurse managers checked to ensure the residents were assisted and the staff remained with them in the room for the entity of the meal. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a joint interview on [DATE] at 5:23 pm, the DON said an audit of all of the care plans was completed to ensure that all the Kardex had clear verbiage of the ADL coding and in-serviced the staff as well so that they are more familiar with the functional level meanings. The DON further stated he would be auditing the logs and conducting meal observations (making sure that the staff are staying with the residents and not leaving the residents unattended. The DON said there will be a nurse manager in the dining room for all meals to ensure the CNAs assisted residents without distractions and ensured safety. During an interview on [DATE] at 5:34 pm, the DM said management made sure residents were not left alone if they required assistance with dining. The DM further stated the meal tickets now said if the resident required assistance with eating, adding, it said assisted dining. During an interview on [DATE] at 5:43 pm, the Administrator said he and the DON created a daily checklist to make sure all agency and PRN completed in-services prior to their next shift and to ensure that shift change has been completed with a nurse manager and ensuring that in the dining services were conducted appropriately. The DON and Administrator were informed the Immediate Jeopardy (IJ) was removed on [DATE] at 7:42 pm. The facility remained out of compliance at scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.