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	03/21/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources are reported immediately to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 of 3 Residents (Resident #1) reviewed for Neglect, in that: The facility did not report an allegation of neglect per facility policy to the State Survey Agency (HHSC) when a medication error for Resident # 1 occurred. This deficient practice could affect any resident and could contribute to further neglect. The findings were: Record review of Resident # 1's face sheet dated 3/20/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis (an illness where kidneys don't function, and a machine is required to filter blood through an artificial kidney), diabetes type 1 (Illness where the pancreas does not produce insulin) and Hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). Record review of Resident # 1's hospital discharge instructions reviewed 3/20/25 at 9:30 AM, dated 3/12/25, revealed an order for insulin Flex Touch U -200 administer 18 units subcutaneously daily and Novo Log administer per sliding scale. Record review of Resident # 1's care plan dated 3/13/25 revealed Resident # 1 has diabetes; interventions administer diabetes medication as ordered. Record review of Resident # 1 Admission MDS dated [DATE] revealed BIMS assessment was left blank, indicating Resident # 1 was unable to complete the interview. Interview with LVN (A) 3/20/25 350 PM revealed that on 3/14/25 1235 PM, she was taking vital signs for Resident # 1, he stated, I Don't Feel well, this is when Resident # 1's family member asked LVN A, Have you given him his Insulin ? LVN (A) went to check the hospital admission orders for Resident #1 and discovered that the hospital orders for insulin had not been transcribed. LVN (A) contacted ADON. (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 03/21/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 1 progress note 3/14/25 at 2 PM revealed Resident # 1 was returned to the facility early from dialysis due to hyperglycemia (high blood sugar) and sent to ER for evaluation. Record review of Resident # 1 hospital records revealed he was admitted to [local hospital] on 3/14/25 at 3:45 PM and diagnosed with Diabetic [NAME] Acidosis (a complication of diabetes in which acids build up in the blood to levels that can be life-threatening. Record review of Texas Unified Licensure Information Portal (TULIP) on 3/20/25 at 12:30 P.M. revealed that no self-reported incidents regarding allegations of Neglect were reported. Interview with NP (B) was attempted on 3/20/25 , 3:00 PM but unsuccessful. Interview with ADON on 3/20/25 at 4:15 PM revealed that LVN (A) contacted him on 3/14/25 estimated time of 12:45 PM that orders for insulin for Resident # 1 had not been transcribed. ADON advised LVN (A) to call the nurse practitioner for orders. Interview with the DON on 3/21/25 at 11:15 AM revealed the administrator was responsible for reporting allegations of Neglect to HHSC; as this is why he did not report the medication error for Resident # 1, however he stated his understanding was allegations of neglect should be reported. Interview with the Administrator on 3/21/25 , at 11:45 A.M. revealed that he did not report the medication error Involving Resident #1, as incident was corrected. However, upon reviewing the neglect guidelines from HHSC, he acknowledged that he should have reported the incident. Record review of facility policy titled, Abuse, Neglect: Prevention of and Prohibition against, dated 2017, revised 10/2022, reflected, Allegations of abuse, neglect, misappropriation of residents property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable time frames.

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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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 5 residents (Resident #1) reviewed for significant medication errors, in that: The facility failed to ensure that Resident #1 was administered Touch U-200 (long-acting insulin) and Novo Log (rapid-acting insulin) for 2 days from 3/12/25 to 3/14/25. The resident was sent to the hospital, admitted and diagnosed with Diabetic [NAME] Acidosis. The non-compliance was identified as IJ past non-compliance. The noncompliance began on 3/12/2025 and ended on 3/17/25. The facility had corrected the non-compliance before the survey began. This failure placed resident at risk for adverse side effects, and life-threatening complications . Findings include: Record review of resident #1's face sheet dated 3/20/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis (an illness where kidneys don't function, and a machine is required to filter blood through an artificial kidney), diabetes type 1 (Illness where the pancreas does not produce insulin) and Hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). Record review of Resident # 1's hospital discharge instructions, reviewed 3/20/25 at 9:30 AM, dated 3/12/25, revealed an order for insulin Flex Touch U-200 administer 18 units subcutaneously daily, and Novo Log to be administered per sliding scale. Record review of Resident # 1's care plan dated 3/13/25 revealed [resident's name] has diabetes; interventions include administering diabetes medication as ordered. Record review of Resident # 1 Admission MDS dated [DATE] revealed BIMS assessment was left blank, indicating resident # 1 was unable to complete the interview. Record review of Resident #1's 3/14/25 blood sugar readings were as follows: at 12:45 PM 600 mg/dl, @ 230 PM 600 mg/dl Record review of Resident # 1 progress note 3/14/25 at 2 PM revealed Resident # 1 was returned to the facility early from dialysis due to hyperglycemia (high blood sugar) and sent to ER for evaluation. Record review of Resident # 1 hospital records revealed he was admitted to [local hospital] on 3/14/25 at 3:45 PM and diagnosed with Diabetic [NAME] Acidosis (a complication of diabetes in which acids build up in the blood to levels that can be life-threatening.) Review of hospital records reveled Resident # 1 remained in the hospital as of 03/21/2025. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #1's medication administration record conducted on March 19, 2025, revealed no orders for Novo Log per the sliding scale and no orders for Flex Touch U-200 for the dates March 13, 2025, to March 14, 2025. Interview with LVN (A) on 3/20/25 at 3:50 PM, revealed that on 3/14/25 1235 PM, she was taking vital signs for Resident # 1, when he stated, I don't feel well. This is when resident # 1's family member asked LVN (A), Have you given him his Insulin ? LVN (A) went to check the hospital admission orders for Resident #1 and discovered that the hospital orders for insulin had not been transcribed. LVN (A) contacted ADON. Interview with ADON on 3/20/25 at 4:15 PM revealed that LVN (A) contacted him on 3/14/25, estimated time of 12:45 PM, that orders for insulin for resident # 1 had not been transcribed. ADON advised LVN (A) to call the Nurse Practitioner for orders. Interview with NP B was attempted on 3/20/25, 3:00 PM but unsuccessful Interview with LVN (B), admitting nurse on 3/18/25 at 1:10 PM, revealed she entered orders for Resident # 1 on Electronic Medical Record (EMR) system when he was admitted on [DATE], she does not know if she possibly missed a page of the admission orders, LVN (B) stated that if a nurse does not transcribe MD orders upon admission, medication errors by omission may occur, leading to the unknown. In an interview with ADON on 03/18/25 at 11:45 PM, the ADON stated he was informed by LVN (A) of the missed order for Touch U-200 (long-acting insulin) 18 units subcutaneously daily and Novo Log (rapid-acting insulin) for Resident # 1 from 3/12/25 to 3/14/25. The ADON confirmed Resident # 1 had not received insulin for 2 days from 03/12/25-03/14/25, putting Resident # 1 at risk for hyperglycemia (elevated blood sugar levels). The ADON stated he expected all nursing staff to confirm discharge instructions and transcribe them to the EMR to ensure the administration of medications. Interview with DON on 3/19/25 at 10:25 A.M. revealed that on 3/14/24, he could not recall a time, ADON notified him that orders for insulin for Resident # 1 had not been transcribed, The DON stated that he expected all Licensed Nurses to follow policy and procedure regarding medication administration as failure to do so could negatively impact residents. DON had the ADON review all new admission orders, and the ADON audited all diabetic residents to ensure their orders were correct. In an interview with the Administrator on 03/19/25 at 1:00 PM, the Administrator stated the facility failed to provide necessary medication to Resident #1 per the Physician's order. The Administrator stated he expected nursing staff to follow Physicians' orders. In an interview with the Medical Director on 3/19/25 at 3:15 PM, he stated he did not recall exactly what Resident #1's admitting orders were, but recalled he did ask the facility to continue hospital orders, and he was not concerned when they told him about the missed long acting and short acting insulin because long-acting insulin continues to work for 36-40 hours. Prior to survey entrance, the facility provided in-service to 100 % of Nursing staff on 3/14/24 - 3/17/24 regarding transcribing MD orders and entering orders on to the Electronic Medical Record (Orders), audit of all new admission and Residents with diagnosis of Diabetes for order accuracy. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility policy named Nursing Administration, revised May 2007, revealed, note and initiate physician orders . This was verified by the following : Interview with LVN (A) on 3/20/25 at 6:10 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (A) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (C) on 3/20/25 at 6:20 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (C) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (D) on 3/20/25 at 6:30 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (D) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (E) on 3/20/25 at 7:05 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (E) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (F) on 3/20/25 at 8:15 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (F) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (G) on 3/20/25 at 8:30 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (G) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (H) on 3/20/25 at 9:20 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (H) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (I) on 3/20/25 at 9:30 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (I) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (J) on 3/20/25 at 9:45 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (J) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (K) on 3/20/25 at 10:00 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (K) was able to verbalize understanding and the information provided in the in-service/training. Interview with LVN (L) on 3/20/25 at 10:15 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: LVN (L) was able to verbalize understanding and the information provided in the in-service/training. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN (M) on 3/20/25 at 11:00 AM, confirmed completion of in-services regarding transcribing MD orders, entering orders on EMR system, admission checklist / Procedure: RN (M) was able to verbalize understanding and the information provided in the in-service/training. Record review on 03/19/2025 of audit performed by ADON revealed admissions from 03/14/2025, to 03/16/2025, new admissions and all diabetic residents electronic medical record was reviewed for accuracy and completion. Observation on 3/19/25 at 1230 PM revealed LVN (B) and RN (M) transcribing and entering MD orders on EMR system . Observation on 3/19/25 at 2:30 P.M. revealed DON randomly checking new admission orders, ensuring MD orders were transcribed and entered on EMR system. The non-compliance was identified as past non-compliance. The noncompliance IJ began on 3/12/25 and ended on 3/17/25. The facility had corrected the non-compliance before the survey began.