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	04/25/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to prepare a comprehensive care plan that included to the extent practicable, the participation of the resident and the resident's representative(s) and failed to review and revise resident care plans after each assessment, for 2 of 4 residents (Resident #1 and #2) reviewed for care plan revision/timing. The facility failed to ensure Resident #1 had quarterly care plan reviews in February 2024 and May 2024 (2 out of 5), and Resident #2 had quarterly care plan reviews in March 2024, June 2024 and January 2025 (3 out of 6). This failure could affect residents care/services and may cause a delay in treatment and/or decline in health. Findings included: Record review of Resident #1's admission Record, dated 04/23/25, reflected a [AGE] year-old female initially admitted [DATE] with diagnoses to include muscle wasting and atrophy, personal history of urinary (tract) infections, and mild cognitive impairment. Record review of Resident #1's quarterly MDS assessment, dated 03/25/25, revealed the resident had a BIMS score of 7 out of 15, indicating severely impaired cognition. Record review of Resident #1's IDT Care Plan Review assessments reflected Resident #1 had care plan reviews in 2024 on 08/06/2024 and 11/11/2024. It further reflected she had a care plan review in 2025 on 02/04/2025. Record review of Resident #2's admission Record, dated 04/23/25, reflected a [AGE] year-old female initially admitted [DATE] with diagnoses to include epilepsy, history of falling, and hypertensive heart disease. Record review of Resident #2's annual MDS assessment, dated 03/10/25, revealed the resident had a BIMS score of 14 out of 15, indicating intact cognition. Record review of Resident #2's IDT Care Plan Review assessments reflected Resident #2 had care plan reviews in 2024 on 09/05/2024 and 10/24/2024. It further reflected she had a care plan review in 2025 on 03/17/2025. (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/25 on 03:44PM, Resident #1's RP stated she could not recall a care plan meeting she had been involved in for Resident #1. She revealed the last care plan review meeting she was involved in was in October 2024. Resident #1's RP revealed it was important to be involved in Resident #1's care so they could provide insight for the facility to provide care they knew Resident #1 needed. Interview on 04/25/25 at 12 PM, Director of Social Services said she was a social worker at this facility since 2023 and she oversaw scheduled care plan review meetings for the residents. She revealed she was trying to play catch up with IDT Care Plan Review assessments. She revealed some care plan review meetings were missed and they did not have a schedule to follow. She revealed she had an open-door policy with residents and families so she could address any concerns they had right away. She further revealed she did not think there needed to be a care plan meeting when she would address grievances and recommendations from family as needed. She revealed it was important to have regular care plan meeting reviews so the facility could review each section of a resident's care plan and get input from family and resident. She further revealed they also printed doctor's orders to review with the resident and the resident's RP to ensure everyone approved of the resident's care. Interview on 04/25/25 at 05:26PM, Resident #2's RP said she had not had a care plan meeting for Resident #2 and had to ask for a meeting to be scheduled to have one in March. She did not know exactly how long it had been and she did not find the resident's care was affected negatively during this time. She revealed the facility addressed her concerns for having care plan meetings moving forward. Interview on 04/25/25 at 06:01PM, the DON and the ADM stated they identified issues with care plan meetings not being on a regular basis for residents in quarter 3 of last year. They revealed regular care plan meetings were important so the loved ones could be aware of their resident's care. Record review of a QAPI meeting sign in sheet, dated 08/26/24, reflected a QAPI meeting occurred. The Administrator revealed via email on 04/25/25 at 07:36PM their QAPI meeting on 08/26/24 included reviewing the new care plan meeting process to ensure every resident had regular care plan meetings. The ADM provided a care plan review meeting schedule via email. Record review of facility's policy Care Planning, revised 05/2007, reflected Scheduling and preparation of the care plan meeting calendar is completed by the MDS Coordinator. Request for a policy reflecting updating care plans and having regular care plan meetings was requested to the DON and Administrator on 04/25/25 at 06:54PM. No policy had been received.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 1 of 6 residents (Resident #1) reviewed for accuracy of records. The facility failed to ensure Resident #1 had documented weekly skin evaluations per the facility policy on 6 out of 7 occasions (08/24/24, 08/31/24, 09/07/24, 09/14/24, 09/21/24, 09/28/24) from 08/21/24 to 10/05/24. This failure could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #1's admission Record, dated 04/23/25, reflected a [AGE] year-old female initially admitted [DATE] with diagnoses to include muscle wasting and atrophy, personal history of urinary (tract) infections, and mild cognitive impairment. Record review of Resident #1's quarterly MDS assessment, dated 03/25/25, revealed the resident had a BIMS score of 7 out of 15, indicating severely impaired cognition. Record review of Resident #1's care plan reflected [Resident #1] has potential for pressure ulcer development r/t personal history of urinary (tract) infections, dated 06/22/23, with intervention to Notify nurse immediately of any new areas of skin breakdown. Record review of Resident #1's August-October 2024 MAR WEEKLY SKIN EVALUATION : (COMPLETE WEEKLY SKIN EVALUATION UDA), order date 08/21/24, reflected LVN A documented I (skin was intact) on 08/24/24, 08/31/24, 09/07/24, 09/14/24, 09/21/24, and 10/05/24 and LVN B documented I (skin was intact) on 09/28/24. Record review of Weekly Skin evaluation (assessments) from August- October 2024 revealed there were no Weekly Skin Evaluations done for any of these dates (08/24/24, 08/31/24, 09/07/24, 09/14/24, 09/21/24, 09/28/24) except for 10/5/24 which reflected skin clean and intact. Interview on 04/24/25 at 01:45PM, the DON confirmed the facility did not do Weekly Skin Evaluations in August or September 2024. Interview on 04/24/25 at 03:03PM, LVN A stated she worked PRN had worked at the facility since July 2024. She revealed she did not recall documenting skin assessments but did assess residents' skin while she worked, reporting, and documenting any changes. She revealed she learned to start documenting skin assessments sometime last year and was currently doing them per doctor's orders and as needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/25 at 10:56AM, LVN C stated she has been the treatment nurse from August 19, 2024-beginning of March 2025, LVN C stated she oversaw nursing staff completing skin assessments for residents per doctor's orders. She revealed at some point she had to educate staff on completing skin assessments per doctor's orders but could not recall the exact time. Interview on 04/25/25 at 06:01PM, the DON stated completed skin assessments were important because skin could breakdown and become worse, and the skin assessments would help nursing staff track and address any concerns with residents' skin. Record review of facility's policy Skin and Wound Monitoring and Management, revised 12.2023, reflected 1. Resident Assessment f. Skin and wound assessment on admission and readmission: A licensed nurse must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings, will be documented on the Initial admission Record . g. Ongoing Skin and Wound Assessments: Areas of breakdown, excoriation, or discoloration, or other unusual findings must be documented in the nursing notes or on the appropriately weekly assessment form. A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident.