

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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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 06/07/2026
NAME OF PROVIDER OR SUPPLIER Sonterra Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with State and Federal Laws for 1 of 4 medication carts (300 hall medication cart) reviewed for storage of drugs and biologicals. The facility failed to ensure the medication cart for 300 hall was locked and secured when it was unattended. This failure could place residents at risk of medication misuse or drug diversion. Findings included: During an observation on 06/07/2026 from 8:58 a.m. to 9:01 a.m. on 300 hall there was an unlocked medication cart by the workstation, with the lock sticking out in the fullest position. Observation revealed the drawers to the medication cart were towards the hallway and anyone who walked by could open the drawers. There was no nurse within sight of the unlocked medication cart and 2 residents were sitting in wheel chairs about 6 feet away from the unlocked medication cart. CNA B walked by the unattended, unlocked medication cart as he pushed a meal cart down the hallway. During an observation and interview on 06/07/2026 at 9:02 a.m., RN A walked down the 300 hallway over to the unlocked medication cart. As RN A approached the unlocked medication cart, the surveyor opened the top drawer of the medication cart and asked the nurse if it was locked, and she stated No. During an interview on 06/07/2026 at 9:07 a.m., RN A stated she had removed a medication from the 300 hall medication cart, went to a resident's room and forgot to lock it before she walked away; and stated I know better, I have been doing this long enough to know it needed to be locked. During an interview on 06/07/2026 at 4:25 p.m., the DON said, If it [the medication cart] is out of site, it needs to be locked. The DON said anyone could get into the medication cart if it was unlocked and unattended, so it needed to be always locked. The DON stated as she walked by medications carts, she would look at the cart locks to see if they were pushed in to monitor them to determine if they were locked. During an interview on 06/07/2026 at 4:40 p.m., the Executive Director stated the medication carts should be locked when they were unattended, and the harm that could result was theft of medications by an employee, visitor, or by a resident. The Executive Director stated if a resident took medication from the unlocked cart, it could be dangerous to them. The Executive Director stated staff received training on ensuring the medication cart was locked when it was unattended; and Every time you find one [unlocked medication cart], you lock it, emphasize it has to be locked [to the staff], but never how much you in-service them, they are human and make mistakes at times. Record review of the facility's undated policy titled Medication Access and Storage, revealed, It is the policy of this facility to store all drugs in locked compartments. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications: 2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.		

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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