

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access for 1 of 5 Residents (Resident #1) reviewed for medication storage: The facility failed to ensure Resident #1 did not have a medication cup with pills and a medication cup with a medication in powder form at the bedside. These failures could affect residents who received medications in the facility and place them at risk for not receiving the correct medications, medication misuse or drug diversion. The findings included: Record review of Resident #1's face sheet date 6/17/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included diabetes (condition in which the body does not use insulin properly), muscle weakness, dementia (decline in memory, thinking, and reasoning abilities that is severe enough to interfere with daily life), prostatic hyperplasia (a noncancerous enlargement of the prostate gland) with lower urinary tract symptoms, hypertension (high blood pressure), depression (a mental health disorder characterized by persistent feelings of sadness, hopelessness, loss of interest in activities that were once enjoyable), and pain in joints of right hand, right shoulder, and left shoulder. Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills. Record review of Resident #1's Order Summary Report reflected the following:- Aricept 5 mg, give 1 tablet by mouth one time a day for dementia with order date 3/23/26 and no end date- Aspirin 81 mg tablet, give 1 tablet by mouth one time a day for heart health with order date 11/6/25 and no end date- Docusate Calcium Oral Capsule 240 mg, give 1 capsule by mouth one time a day for daily chronic constipation with order date 12/11/25 and no end date- Flomax capsule 0.4 mg, give 1 capsule by mouth one time day for benign prostatic hyperplasia with order date 11/6/25 and no end date- Losartan Potassium oral tablet 100 mg, give 1 tablet by mouth one time a day for hypertension hold if systolic blood pressure is less than 100 with order date 11/6/25 and no end date- Metamucil Oral Powder 48.57%, give 30 ml by mouth one time a day for constipation with order date 3/19/26 and no end date- Multiple Vitamin Tablet, give 1 tablet by mouth one time a day for supplementation with order date 11/6/25 and no end date- Myrbetriq Oral Tablet Extended Release 24-hour 50 mg, give 1 tablet by mouth one time a day for bladder spasms with order date 2/1/26 and no end date- Venlafaxine Oral Capsule Extended Release 24-hour 150 mg, give 1 capsule by mouth one time a day for depression to be taken with Venlafaxine 37.5 mg daily with order date 2/11/26 and no end date- Venlafaxine Oral Capsule Extended release 24-hour 37.5 mg, give 1 tablet by mouth one time a day for depression to be taken with Venlafaxine 150 mg daily with order date 11/25/26 and no end date- Lyrica Capsule 200 mg, give 1 capsule by mouth two times a day for pain with order date 11/6/25 and no end date. Record review of Resident #1's Medication Administration Record for June 2026 reflected Aricept, Aspirin, Docusate Calcium, Flomax, Metamucil, Multiple Vitamin, Myrbetriq, Venlafaxine, and Lyrica were scheduled for administration at 7:00 a.m. During an observation and interview on 6/17/26 at 11:20 a.m., Resident #1 was sitting up in a (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regular chair in his room and was observed with one medication cup with several pills in it and one medication cup with a tan color powder placed on top of the bedside table placed in front of the resident. Resident #1 stated the nursing staff provided medications to him and was not allowed to keep medications at the bedside I might misuse them. Resident #1 stated the tan color powder in the medication cup was for constipation and the pills in the other medication cup were his morning medications. Resident #1 stated his morning medication times varied and were usually administered at 10:00 a.m. or so. Resident #1 stated the nurse did not provide him with his morning medications and stated he received the morning medication from the medication aide. Resident #1 stated the medication aide was female but did not know her name. Resident #1 stated, when the medication aide provided him with the morning medications, he told the medication aide he wanted to sleep. Resident #1 stated, the medication aide told him, That's fine, I'll leave them and you can take them later. During an interview on 6/17/26 at 11:33 a.m., LVN A stated she had administered insulin to Resident #1 earlier in the morning and the medication aides administered other scheduled medications. LVN A stated, residents in the facility were not allowed to keep medications at the bedside and was not sure if Resident #1 was allowed to self-administer medications. LVN A stated residents who were allowed to self-administer medications required a physician's order and it also needed to be care-planned. During an observation and interview on 6/17/26 at 11:38 a.m., LVN A observed the medication cup with pills and the medication cup with the tan powder left on Resident #1's bedside table and asked Resident #1 if he was going to consume them. Resident #1 stated, she (the Medication Aide) left the medications at around 10:30 a.m. and I went back to sleep and wanted to take the medications now. LVN A stated she would discard the medications left at the bedside and would dispense a new set of medications. LVN A stated she would make the DON aware of the medications left at Resident #1's bedside and would notify the physician. During an interview on 6/17/26 at 11:44 a.m., the DON stated that medications cannot be left at the resident's bedside, and the nursing staff were supposed to stay and watch the resident consume their medications. The DON stated there were no residents in the facility that could self-administer medications. The DON stated that if a resident wanted to self-administer medications, they would need to be assessed to ensure safety and then the doctor would have to be notified to obtain an order, and it would have to be care-planned. The DON stated once a resident was assessed and cleared to safely self-administer medications, a re-assessment to self-administer was done quarterly. During an interview on 6/17/26 at 11:55 a.m., Medication Aide B stated she was assigned to administer medications to Resident #1 and tried to wake him up, and the resident did get up and while he got up in my head I'm thinking he's (Resident #1) gonna take them (the medications) right now, so I went to his roommate in the next bed and started to prepare the roommates medications. Medication Aide B stated she did not recall the actual time she left Resident #1's medications on the bedside table, and stated the resident was allowed to consume his morning medications between 7:00 a.m. and 10:00 a.m. Medication Aide B stated she believed she left Resident #1's medications on the bedside table around 8:00 a.m. Medication Aide B stated, Resident #1 would take his medications when he is ready and she was going to report to LVN A about the resident not willing to take the medications but got busy and didn't report to LVN A. Medication Aide B stated, by that time State was here and it was a blow out. Medication Aide B stated she was not supposed to leave medications at the beside because other residents who wandered could consume them and they could die and she was supposed to make sure she observed Resident #1 consumed his medications. Record review of the facility document titled Medication Administration - Oral with revision date 5/2007 reflected in part, .It is the policy of this facility to accurately prepare. Administer and document oral medications. Procedures. Essential Points. The nurse or med aide preparing the drug administers it. The person administering medication must remain with the resident until all medication has been swallowed. Record review of the facility document titled Medication Access and Storage with revision date 5/2007 reflected in part, .It is the policy of this facility to store all drugs and biological(s) in locked compartments under proper (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.		