

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 04/19/2024
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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 5 (Residents #6, #17, #19, #53 and #67) out of 24 residents reviewed for MDS assessments.</p> <ol style="list-style-type: none"> 1. Facility failed to ensure Resident #6's quarterly MDS assessment with an ARD of 03/23/2024 reflected resident receiving hospice services. 2. Facility failed to ensure Resident #17's significant change MDS assessment with an ARD of 03/12/2024 reflected resident receiving hospice services. 3. Resident #19's quarterly MDS assessment with an ARD of 04/01/2024 inaccurately reflected her pressure sore status, interventions, and treatments as none when she had a Stage 3 (full thickness tissue loss) pressure sore to her sacrum (a shield shaped bony structure located at the base of the spine and connects the pelvis (the area of the body below the abdomen that contains the hip bones, bladder and rectum)), with interventions and treatment. 4. Resident #53's quarterly MDS assessment with an ARD of 03/16/2024 inaccurately reflected he was frequently incontinent of bowel and bladder when he was always incontinent of bowel and bladder. 5. Resident #67's admission MDS assessment dated [DATE] inaccurately reflected he was always incontinent of bladder instead of not rated because he had an indwelling urinary catheter. <p>These deficient practices could affect residents with MDS assessments and could result in inaccurate care.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #6's physician orders dated 04/17/2024 revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that included: acute pulmonary edema, heart failure, unspecified, chronic kidney disease stage 3 unspecified, dementia, acute kidney failure, hyperlipidemia, type 2 diabetes mellitus with hyperglycemia, unspecified atrial fibrillation, essential hypertension, and type 2 diabetes mellitus with other circulatory complications. <p>Record review of Resident #6's Quarterly MDS assessment, dated 03/23/2024, documented hospice care was not performed during the last 14 days.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #6's physician order summary active as of 03/23/2024, dated 04/17/2024, revealed an order dated 09/19/2023 to Admit to [company name] Hospice for Palliative Care Hospice Terminal Diagnosis: Diastolic Heart Failure with preserved ejection fraction.</p> <p>Record review of Resident #6's comprehensive care plan initiated on 02/19/2024 revealed Focus: [resident's name] has a terminal prognosis r/t heart failure. [resident's name] has elected the services of [company name] Hospice:</p> <p>During an interview on 04/19/2024 at 3:10 p.m. with MDS A and MDS B. MDS A stated Resident #6's Quarterly MDS assessment was coded incorrectly but was not sure why he miscoded it. MDS B stated Resident #6's should have been coded for hospice due she was receiving hospice at the time. MDS B further stated the importance of coding it properly was to trigger the care plan.</p> <p>2. Record review of Resident #17's face sheet, dated 04/19/2024, revealed Resident #17 was admitted to the facility on [DATE] with diagnoses which included: dementia, atherosclerotic heart disease of native coronary artery without angina pectoris, peripheral vascular disease, chronic kidney disease stage 3, essential hypertension, acute kidney failure, and Alzheimer's disease.</p> <p>Record review of Resident #17's Significant Change MDS assessment, dated 03/12/2024, documented hospice care was not performed during the last 14 days.</p> <p>Record review of Resident #17's physician order summary, dated 04/19/2024, revealed an order dated 03/07/2024 to Admit Patient to [company name] Hospice with dx of dementia.</p> <p>Record review of Resident #17's comprehensive care plan initiated on 03/18/2024, revealed Focus [resident's name] has admitted to [company name] Hospice Services /c terminal prognosis r/t dementia.</p> <p>During an interview on 04/19/2024 at 3:06 p.m. with MDS A and MDS B. MDS A stated hospice should have been coded on Resident #17's significant change MDS assessment and he had coded it wrong. MDS A stated it was the reason for the significant change MDS as resident was place on hospice services. MDS B stated Resident #17 had been receiving hospice services since 03/07/2024. MDS B further stated the importance of proper coding was based on CMS guidelines and it would also trigger the care plan. MDS B stated both her and MDS A were responsible for the MDS for this section of the MDS assessment.</p> <p>During an interview on 04/19/2024 at 3:30 p.m. with the DON stated MDS accuracy was a reflection of patients condition and patients care whether it was improvement. The DON further stated the interdisciplinary team is responsible for the accuracy of the MDS assessments. The DON stated the MDS assessment affects the care plan if it was inaccurate as it helped with the direction of the care plan.</p> <p>3. Record review of Resident #19's electronic face sheet dated 04/16/2024 reflected she was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), psychotic disorder with hallucinations (where a person hears, sees, and, in some cases, feels, smells, tastes things that do not exist outside their mind but it can feel very real for the person affected), muscle weakness (commonly due to lack of exercise, ageing or muscle injury), myocardial infarction (occurs when blood flow decreases or stops in one of the coronary arteries of the heart causing tissue death) and unsteadiness on feet (a pattern of walking that is unstable).</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #19's quarterly MDS assessment with an ARD of 04/01/2024 reflected Section M-Skin Conditions, Resident #19 was at risk of developing pressure ulcers and did not have any unhealed pressure ulcers. 1200-Skin and ulcer Treatments did not reflect any treatment or intervention such as a pressure reducing device on bed or turning or repositioning. She scored a 02/15 on her BIMS which signified she was severely cognitively impaired.</p> <p>Record review of Resident #19's comprehensive care plan revised on 03/28/2024 reflected Focus, has stage 3 pressure ulcer to sacrum r/t immobility, Interventions, LAL mattress, administer treatments as ordered.</p> <p>Record review of Resident #19's Weekly Pressure Ulcer Review dated 04/04/2024 reflected Onset Date: 01/30/2024, Site 1, Sacrum, Stage 3, 1.8x1.4 cm by .6 cm's deep .Interventions: Medi honey/Alginate/Dry dressing daily (supports removal of necrotic tissue and aides in wound healing), LAL mattress and Turn and Reposition.</p> <p>Record review of Resident #19's Active Orders as of: 04/16/2024 reflected wound care to sacrum: cleanse with ns or wound cleanser, pat dry, Medi honey, calcium alginate, cover with foam dressing QD and PRN, active date 03/21/2024.</p> <p>Observation on 04/17/2024 at 03:15 PM of Resident #19 as she received her wound care treatment revealed she had a healing stage 3 wound to her sacrum.</p> <p>Interview on 04/19/2024 at 02:53 PM with MDS A revealed he did not know how Resident #19's stage 3 wound, treatment and interventions were missed on the quarterly MDS. He stated the MDS needed to be accurate to show the resident and their condition to guide and communicate their care needs to staff and an inaccurate MDS could lead to missed care. He stated that he and MDS B were accountable for the MDS's.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed she reviewed the MDS's and signed off on them. She stated all the staff was accountable to provide accurate information so that the MDS was an accurate clinical picture of the resident, so the resident received the required care or it could be missed.</p> <p>4. Record review of Resident #53's electronic face sheet dated 04/18/2024 reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: epilepsy (a neurological disorder marked by sudden episodes of sensory disturbance, loss of consciousness or convulsions associated with abnormal electrical activity in the brain), unsteadiness on feet (a pattern of walking that's unstable), repeated falls (older adults who fall more than once per year), weakness (state of condition of lacking strength) and other malaise (a general feeling of discomfort).</p> <p>Record review of Resident #53's quarterly MDS assessment with an ARD of 03/16/2024 reflected he scored a 15/15 on his BIMS which signified he was cognitively intact. He was frequently incontinent of bowel and bladder. He was dependent for his ADLS's except for eating which he only required set up. Toilet transfer was not attempted.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #53's comprehensive care plan revised date 12/11/23 did not reflect he was incontinent of bowel and bladder, and only reflected Focus, ADL self-care performance deficit r/t epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), Interventions, Toilet Use, requires staff assistance.</p> <p>Observation on 04/18/2024 at 03:59 PM of CNA C and CNA D perform incontinent care for Resident #53 revealed he was totally dependent on bowel and bladder care and did not get transferred to the toilet or use a urinal or bedpan.</p> <p>Interview on 04/19/2024 at 10:00 AM with Resident #53 revealed he was incontinent since he was readmitted to the facility and his legs did not support weight, and he did not get transferred to the toilet. He stated he was always incontinent of bowel and bladder, and did not use the toilet, urinal, or bedpan.</p> <p>Interview on 04/19/2024 at 1:00 PM with CNA E who worked with Resident #53 during the look back period of his quarterly MDS dated [DATE] revealed Resident #53 was always incontinent of bowel and bladder and did not get taken to the toilet.</p> <p>Interview on 04/19/2024 at 02:53 PM with MDS B revealed she knew at one time therapy was working with Resident #53 to try to toilet him, when asked about the week of 03/16/2024, she stated no and the MDS should have reflected he was always incontinent of bowel and bladder. She stated the MDS needed to be accurate to show the resident and their condition to guide and communicate their care needs to staff and an inaccurate MDS could lead to missed care.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed she reviewed the MDS's and signed off on them. She stated all the staff was accountable to provide accurate information so that the MDS was an accurate clinical picture of the resident, so the resident received the required care or it could be missed. She stated it was important for staff to know that Resident #53 did not get taken to the toilet and was dependent on incontinent care.</p> <p>5. Record review of Resident #67's electronic face sheet dated 04/16/2024 reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: lack of coordination (a neurological sign of impaired muscle movements), muscle weakness (decrease in strength in one or more muscles), anxiety (a feeling of worry, nervousness, or unease) and neurogenic bladder.</p> <p>Record review of Resident #67's comprehensive care plan with a revised date of 02/19/2024 reflected Focus, has an indwelling urinary catheter r/t neurogenic bladder (normal bladder function is disrupted due to nerve damage).</p> <p>Record review of Resident #67's admission MDS assessment dated [DATE] reflected he scored a 15/15 on his BIMS which signified he was cognitively intact. He was marked a 3 for Section H - Bladder and Bowel which signified he was always incontinent, when he should have been marked a 9 which signified not rated related to having an indwelling catheter. He required extensive assistance with his ADL's.</p> <p>Record review of Resident #67's re-admission nursing assessment dated [DATE] reflected he had an indwelling urinary catheter.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/18/2024 at 09:42 AM of CNA F and CNA D perform catheter care for Resident #67 revealed he had an indwelling urinary catheter.</p> <p>Interview on 04/19/2024 at 10:15 AM with Resident #67 revealed he had an indwelling urinary catheter since his re-admission to the facility.</p> <p>Interview on 04/19/2024 at 02:53 PM with MDS A revealed he did not know why he did not mark a 9 instead of a 3 on Resident #67's admission MDS dated [DATE]. He stated that was inaccurate. He stated the MDS needed to be accurate to show the resident and their condition to guide and communicate their care needs to staff and an inaccurate MDS could lead to missed care. He stated that he and MDS B were accountable for the MDS's.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed she reviewed the MDS's and signed off on them. She stated all the staff was accountable to provide accurate information so that the MDS was an accurate clinical picture of the resident, so the resident received the required care or it could be missed.</p> <p>During an interview on 04/19/2024 at 3:30 p.m. with the DON stated MDS accuracy was a reflection of patients condition and patients care whether it was improvement. The DON further stated the interdisciplinary team is responsible for the accuracy of the MDS assessments. The DON stated the MDS assessment affects the care plan if it was inaccurate as it helped with the direction of the care plan.</p> <p>Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, October 2019 reflected The RAI process has multiple regulatory requirements . (1) the assessment accurately reflects the resident's status.</p> <p>44020</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619</p> <p>Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 residents (Residents #19, #53 and 127) of 24 residents reviewed for care plans.</p> <ol style="list-style-type: none"> 1. Facility failed to implement Resident #19's care plan which reflected she required a floor mat beside her bed as a fall prevention. 2. Facility failed to ensure Resident #53's bowel and bladder incontinence was reflected in his comprehensive care plan with a revised date of 12/11/2023. 3. Facility failed to ensure Resident #127's hospice services were reflected in his comprehensive care plan with a revised date of 02/18/2024. <p>These deficient practices could affect residents who required specific care, services and interventions by placing them at risk of not receiving necessary care and services.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #19's electronic face sheet dated 04/16/2024 reflected she was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), psychotic disorder with hallucinations (where a person hears, sees, and, in some cases, feels, smells, tastes things that do not exist outside their mind but it can feel very real for the person affected), muscle weakness (commonly due to lack of exercise, ageing or muscle injury), myocardial infarction (occurs when blood flow decreases or stops in one of the coronary arteries of the heart causing tissue death) and unsteadiness on feet (a pattern of walking that is unstable). <p>Record review of Resident #19's quarterly MDS assessment with an ARD of 04/01/2024 reflected she scored a 02/15 on her BIMS which signified she was severely cognitively impaired. She had 2 or more falls since admission and was dependent on care for her ADL's.</p> <p>Record review of Resident #19's comprehensive care plan revised on 02/29/24 reflected Focus, had actual fall on 02/29/2024 r/t poor safety awareness, Interventions, environmental check completed, fall mat placed.</p> <p>Record review of Resident #19's Active Orders as of: 04/2024 reflected fall mat, check placement active date 02/29/2024.</p> <p>Record review of Resident #19's Fall Risk assessment dated [DATE] reflected she scored a 17 which signified she was at high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/18/2024 at 10:00 AM revealed Resident #19 was lying on a LAL mattress, in a low bed, and a floor mat was partially folded up between the nightstand and the head of the bed.</p> <p>Observation on 04/18/2024 at 2:00 PM revealed Resident #19 was lying in bed on a LAL mattress, in a low bed, and a floor mat was completely folded up between the nightstand and the head of the bed.</p> <p>Observation on 04/18/2024 at 2:30 PM with the DON and CNA G revealed Resident #19 was lying in bed on a LAL mattress, in a low bed, and a floor mat was completely folded up between the nightstand and the head of the bed.</p> <p>Interview on 04/18/2024 at 2:35 PM with CNA G, who was assigned to Resident #19 revealed she was so busy making rounds, she did not even notice Resident #19's floor mat was not in place. She stated the resident could fall and hurt herself if the mat were not in place.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed the resident's care plans are focused on the care and interventions they require, along with goals. She stated Resident #19 had falls and it was an intervention that required staff to be aware of to prevent her from being hurt from her bed if she did have a fall.</p> <p>2. Record review of Resident #53's electronic face sheet dated 04/18/2024 reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: epilepsy (a neurological disorder marked by sudden episodes of sensory disturbance, loss of consciousness or convulsions associated with abnormal electrical activity in the brain), unsteadiness on feet (a pattern of walking that's unstable), repeated falls (older adults who fall more than once per year), weakness (state of condition of lacking strength) and other malaise (a general feeling of discomfort).</p> <p>Record review of Resident #53's quarterly MDS assessment with an ARD of 03/16/2024 reflected he scored a 15/15 on his BIMS which signified he was cognitively intact. He was frequently incontinent of bowel and bladder. He was dependent for his ADLS's except for eating which he only required set up. Toilet transfer was not attempted.</p> <p>Record review of Resident #53's comprehensive care plan revised date 12/11/23 did not reflect he was incontinent of bowel and bladder, and only reflected Focus, ADL self-care performance deficit r/t epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), Interventions, Toilet Use, requires staff assistance.</p> <p>Observation on 04/18/2024 at 03:59 PM of CNA C and CNA D perform incontinent care for Resident #53 revealed he was dependent on bowel and bladder care and did not get transferred to the toilet or use a urinal or bedpan.</p> <p>Interview on 04/19/2024 at 10:00 AM with Resident #53 revealed he was incontinent since he was readmitted to the facility and his legs did not support weight, and he did not get transferred to the toilet. He stated he was always incontinent of bowel and bladder, and did not use the toilet, urinal, or bedpan.</p> <p>Interview on 04/19/2024 at 1:00 PM with CNA E who collaborated with Resident #53 revealed he was always incontinent of bowel and bladder and did not get taken to the toilet.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 04/19/2024 at 02:53 PM with MDS B revealed Resident #53's comprehensive care plan should have reflected he was incontinent of bowel and bladder because that was the care he required.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed it was important for staff to know that Resident #53 did not get taken to the toilet and was dependent on incontinent care and that his comprehensive care plan was inaccurate and this could result in missed care or communication.</p> <p>3. Record review of Resident #127's electronic face sheet dated 04/17/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: myopathy (disease of muscle fiber), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis of partial or total body function on one side of the body and one-sided weakness from a stroke to the brain), muscle weakness (lack of muscle strength) and anxiety (a feeling of worry, nervousness, or unease).</p> <p>Record review of Resident #127's admission MDS assessment dated [DATE] reflected he scored a 10/15 on his BIMS which signified he was moderately cognitively impaired. He was dependent on staff for his ADL's.</p> <p>Record review of Resident #127's comprehensive care plan revised date 02/19/24 did not reflect he was on hospice services.</p> <p>Record review of Resident #127's Physician Telephone/Verbal Order dated 03/12/2024 reflected he was admitted to hospice services with a terminal diagnosis of cardiovascular accident (a stroke or brain attack, an interruption in the flow of blood cells in the brain).</p> <p>Interview on 04/19/2024 at 02:53 PM with MDS B revealed Resident #127's comprehensive care plan should have reflected he was on hospice services. She stated when there is an order change by the provider or services, then it should be reflected in the care plan as soon as possible.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed it was important for staff to know that Resident #127 received hospice services because that was part of his care.</p> <p>Record review of the facility policy and procedure titled Care Planning (undated) revealed It is the policy of this facility that the interdisciplinary team shall develop a comprehensive care plan for each resident.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619</p> <p>Based on observation, interviews and record reviews, the facility failed to review and revise the comprehensive person-centered care plan for one (Resident #56) out of 24 residents reviewed for comprehensive care plans.</p> <p>Resident #56's comprehensive care was not revised to reflect he was on an LCS/NAS regular texture diet.</p> <p>This deficient practice could affect residents placing them at risk for not receiving necessary care.</p> <p>The findings included:</p> <p>Record review of Resident #56's electronic face sheet dated 04/17/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), syncope and collapse (fainting and passing out), dysphagia (difficulty swallowing) and weakness (lack of strength).</p> <p>Record review of Resident #56's quarterly MDS assessment with an ARD of 01/03/2024 reflected he scored a 04/15 on his BIMS which signified he was severely cognitively impaired. He could understand and be understood. He only required setup for eating or clean up assistance. He was on a therapeutic diet but not on a mechanically altered diet.</p> <p>Record review of Resident #56's comprehensive care plan revised date 06/23/23 reflected Focus, is at risk for impaired nutrition r/t GERD (gastro esophageal reflux disease (stomach acid repeatedly flows back into the tube connecting the mouth and stomach), Interventions, diet as ordered by the physician NAS (no added salt), mechanical soft texture, thin liquids.</p> <p>Record review of Resident #56's Active Orders as of 04/17/2024 reflected NAS diet, regular texture, thin liquids, start date 06/28/2023.</p> <p>Observation on 04/16/2024 at 1:00 PM of Resident #56's lunch revealed he had meatloaf with tomato sauce, scalloped potatoes, peas and sliced peaches, regular texture.</p> <p>Record review of Resident #56's meal ticket on 04/16/2024 reflected NAS, regular texture, thin liquids.</p> <p>Interview on 04/19/2024 at 1:30 PM with Resident #56 revealed he was always on a regular diet texture and could not remember getting soft textured food.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/19/2024 at 02:53 PM with MDS B revealed Resident #56's comprehensive care plan should have reflected he was on a diet with regular texture not mechanical soft. She stated the care plan needed to be updated right after the quarterly MDS which was in January. She stated the care plan needed to reflect the MDS assessment so the resident would get appropriate care and not the wrong diet.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed it was important for staff to know that Resident #56 was on a regular texture diet. She stated his quality of life could be affected with the wrong diet texture.</p> <p>Record review of CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2019 revealed Care Plan Completion .the resident's care plan must be reviewed after each assessment, as required by S483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 resident (Residents #53) reviewed for incontinent care.:</p> <p>While providing incontinent care for Resident #53, CNA C did not return Resident #53's foreskin to the original position.</p> <p>This deficient practice could place residents at-risk for infection, paraphimosis (urologic emergency in uncircumcised males) and skin break down due to improper care practices.</p> <p>The findings were:</p> <p>Record review of Resident #53's electronic face sheet dated 04/18/2024 reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: epilepsy (a neurological disorder marked by sudden episodes of sensory disturbance, loss of consciousness or convulsions associated with abnormal electrical activity in the brain), unsteadiness on feet (a pattern of walking that's unstable), repeated falls (older adults who fall more than once per year), weakness (state of condition of lacking strength) and other malaise (a general feeling of discomfort).</p> <p>Record review of Resident #53's quarterly MDS assessment with an ARD of 03/16/2024 reflected he scored a 15/15 on his BIMS which signified he was cognitively intact. He was frequently incontinent of bowel and bladder. He was dependent for his ADLS's except for eating which he only required set up. Toilet transfer was not attempted.</p> <p>Record review of Resident #53's comprehensive care plan revised date 12/11/23 did not reflect he was incontinent of bowel and bladder, and only reflected Focus, ADL self-care performance deficit r/t epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), Interventions, Toilet Use, requires staff assistance.</p> <p>Observation on 04/18/2024 at 03:59 PM of CNA C and CNA D performing incontinent care for Resident #53 revealed CNA C pulled Resident #53's foreskin back to clean his penis and did not return the foreskin to its original position.</p> <p>Interview on 04/18/2024 at 4:15 PM with CNA C, she stated she did not know why she did not return Resident #53's foreskin to its original position after she retracted it to clean his penis. She stated she was nervous. She stated she was trained to return the foreskin of a male during incontinent care and if it were not returned it could cause irritation, swelling and infection of the penis.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/18/2024 at 4:20 PM with CNA D, she stated she assisted CNA C with Resident #53's incontinent care and did not realize CNA C had not pulled the foreskin back down after cleaning Resident #53's penis. She stated she was trained on how to pull the foreskin back down on an uncircumcised (refers to penis that has a foreskin) male during incontinent care and she was not thinking at the time. She stated if the foreskin does not get pulled back to the original position, Resident #53 could get an infection or irritation to the area.</p> <p>Interview on 04/19/2024 at 03:27 PM with the DON revealed she stated C NA C needed to put Resident #53's foreskin back to the normal position because of the potential complications such as infection and prevention of blood circulation to the area. She stated competencies were completed for CNA C and CNA D and provided a copy to the surveyor.</p> <p>Record review of CNA C's Competency Checklist dated 04/08/2024 reflected she satisfactorily completed the checklist for incontinent care for a male to include: Reposition foreskin if retracted.</p> <p>Record review of CNA D's Competency Checklist dated 04/08/2024 reflected she satisfactorily completed the checklist for incontinent care for a male to include: Reposition foreskin if retracted.</p> <p>Record review of the facility policy and procedure titled Perineal Care (undated) reflected procedures, male without catheter, dry area carefully, remembering to draw foreskin of the uncircumcised male back over the head of the penis.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>46677</p> <p>Based on interview, and record review, the facility failed to ensure the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility, reviewed for registered nurse coverage.</p> <p>RN 8-hour coverage was not available for 7 days in the period 11/04/23 to 12/15/23.</p> <p>This deficient practice had the potential to affect all residents in the facility by leaving staff without supervisory coverage of an RN.</p> <p>The findings included:</p> <p>Record review of facility's RN hour time sheets from November 2023 to March 2024 revealed no 8 hours of RN coverage on the following days:</p> <p>11/04/23=0 hours</p> <p>11/05/23=0 hours</p> <p>11/18/23=0 hours</p> <p>11/19/23=0 hours</p> <p>11/25/23=0 hours</p> <p>11/26/23=0 hours</p> <p>12/07/23=0 hours</p> <p>12/15/23=0 hours</p> <p>Interview with DON on 4/19/24 at 12:45PM revealed the facility had a scheduler that was responsible to ensure RN coverage of at least 8 hours per day. The DON stated she worked Monday to Friday 8 hours a day and covered weekends if RN hours were not covered. The DON also stated she was on-call when there was no RN on duty. The DON confirmed that there were no RN hours listed for 11/4/23, 11/5/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23, 12/7/23, 12/15/23 and did not provide evidence that RN hours were covered. DON stated it was important to have an RN on duty at least 8 hours to ensure that a qualified person completes treatments.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with CNA H, on 4/19/24 at 1:52 PM revealed she was the scheduler in November and December 2023. CNA H stated that she scheduled RN coverage at least 8 hours per day but the RN scheduled might be scheduled for administrative duties, not on the floor. CNA H did not recall any day where there was not RN coverage at least 8 hours a day in November or December 2023. CNA H did not provide evidence that there was RN coverage on 11/04/23, 11/5/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23, 12/7/23, 12/15/23.</p> <p>Interview with Administrator, on 4/19/24 at 2:30 PM revealed the facility did not have a policy regarding RN coverage but the facility follows the SOM (State Operations Manual) Appendix PP and TAC (Texas Administrative Code) regarding RN hour regulation. The Administrator stated the scheduler was responsible for scheduling RN's at least 8 hours a day and if coverage was not found the DON was responsible to cover. The Administrator also stated there was no evidence that the facility had RN coverage on 11/04/23, 11/5/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23, 12/7/23, 12/15/23.</p> <p>Record review of facility provided SOM Appendix PP, page and date not listed, revealed Per F727 (rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22), S483.35(b)(l) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44020</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for kitchen sanitation.</p> <p>The facility failed to ensure Cook I prepared the pureed pasta salad in a sanitary fashion.</p> <p>The facility failed to ensure insulated plate lids and insulated plate bases were air dried prior to stacking them with water droplets and meal prep.</p> <p>These failures could place resident who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <p>Observation on 04/18/2024 at 9:47 a.m. revealed DA J take the washed insulated plate lids and insulated bases after coming out of the dish washing machine and stacked them on top of each other on a 3-tiered cart without allowing them to air dry with water droplets visible on both.</p> <p>Observation on 04/18/2024 at 11:30 a.m. revealed the insulated plate lids and insulated bases had been moved to the serving line from the 3-tiered cart face up with droplets of water still on them.</p> <p>Observation and interview on 04/18/2024 at 11:35 a.m. revealed Cook A while he prepared the puree pasta salad took the lid off the robo [NAME], then took his bare finger, ran it up the bowl scrapper which was attached to the lid of the robo [NAME], and tasted the pasta salad, then placed the lid with scrapper attached back on to the machine, ran it again, then placed the pasta salad in to the serving container, wrapped with plastic wrap, dated it and placed in the refrigerator. Cook I stated having taken his finger, tasted the pasta, and replaced the lid and running the machine again he contaminated the pasta salad. Cook I further stated he could have risked bacteria getting into the food that might have been on his hands and make the residents sick who ate it.</p> <p>Observation on 04/18/2024 at 12:30 p.m. during lunch meal service revealed DA J placing the insulated plate lids and insulated bases with droplets of water remaining on them over and under plates as the plates were prepared. DS observed the water droplets and provided staff towels to dry the lids off prior to serving the remaining plates.</p> <p>During an interview on 04/18/2024 at 2:12 p.m. DA J stated he would typically place the plate lids and bases on the cart and there was no where in the kitchen for them to air dry. DA J further stated if the food was to come in contact with the water on the lids or bases it could cause cross contamination.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/18/2024 at 3:50 p.m. with the DS stated the kitchen staff are supposed to let the lids and bases sit and dry prior to stacking when they come out of the dishwasher. The DS further stated she believed they were rushed, and DA J just pulled them and stacked them. The DS stated the reason for air drying was due to the droplets could drop on the food and cause cross contamination. The DS stated this could cause the resident to get sick. The DS stated regarding Cook I having placed the lid with scraper back in the machine running it after having taken his finger and tasted the pasta by licking his finger was cross contamination. The DS further stated Cook I should have washed the lid off and could have made a new puree pasta salad.</p> <p>During an interview on 04/19/2024 at 3:50 p.m. the ADM stated it was not sanitary to place the insulated lids and the insulated bases on the plates with water droplets. The ADM further stated it could cause food borne illness. The ADM stated it was policy items must be air dried completely.</p> <p>Review of facility policy Cleaning Dishes/Dish Machine, no date, Policy: All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use .Procedure: Allow the dishes to air dry on the dish racks. Do not dry with towels.</p> <p>Review of facility policy Employee Sanitary Practices, no date, Policy: All kitchen employees will practice standard sanitary procedures. Procedure: 7. Use clean spoons when tasting food and do not return them to the food.</p>		