STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676158	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents have the right to decline pneumococcal vaccine administration for 1 of 1 resident (Resident #214) reviewed for resident rights in that: 1. Resident #214 received the pneumococcal vaccination after their responsible party had signed a declination form for Resident #214 not receive the vaccination. This deficient practice could affect residents who declined administration of a pneumococcal vaccine and could place them at risk of having their rights denied regarding refusing care, treatment and having services performed against their wishes. The findings were: 1. Record review of Resident #214's face sheet, dated 09/16/2020, indicated the resident was admitted [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #214's Electronic Medical Record revealed a pneumococcal Immunization Informed Consent declining permission for the Facility to administer a pneumococcal vaccination. The form was signed by the Responsible Party on 07/21/2020. The admission packet contained information related to immunizations and the ability to accept or decline the immunization. Record review of Resident #214's Electronic Medical Record revealed a Pneumococcal Immunization Informed Consent declining permission for the Facility to administer a pneumococcal vaccination. The form was signed by the Responsible Party on 07/21/2020. The physician ordered the pneumococcal vaccine and there was an entry to the Medication Administration Record [REDACTED]. During an interview on 09/16/2020 at 11:33 a.m., the Director of Nurses confirmed Resident #214 had the signed declination in the medical record. The nurse who administered the vaccine stated she only say the acceptance and did not check the name. The wrong request was scanned to resident #214's record.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a significant change assessment within 14 days after the facility determined, or should have determined, that there had been a significant change in the resident's physical and mental condition for 1 of 13 Residents (#25) whose records were reviewed for MDS assessments. 1. MDS staff failed to complete a significant change assessment when Resident #25 had a decline in his overall physical function after contracting COVID and going out to the hospital on 2 separate occasions. This deficient practice could affect any Resident and could contribute to an inaccurate representation of the Residents' needs. The findings were: Review of Resident #25's face sheet dated 9/18/20 revealed he was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of an annual MDS assessment dated [DATE] revealed Resident #25 had trouble with falling asleep, staying sleeping or sleeping too much; he required extensive assistance by 1 person for bed mobility; extensive assistance by 2 + persons for transfers; limited assistance with locomotion by 1 person on the unit, extensive assistance by 1 person with locomotion off the unit; supervision and set up for eating; extensive assistance by 1 person for dressing and hygiene; extensive assistance by 2 persons for toileting and total support by 1 person for baths/showers and he was not receiving physical therapy. Review of progress notes dated 7/4/20 revealed Resident #25 was transferred to the hospital per family arrangement. Review of progress note dated 7/5/20 revealed Resident #25 arrived to the facility with new orders. Further review revealed Resident #25 tested positive for Covid-19 and was diagnosed with [REDACTED]. Review of a discharge MDS assessment dated [DATE] revealed Resident #25 was transferred to an acute hospital. Review of an entry MDS dated [DATE] revealed Resident #25 was returned to the facility from an acute hospital. Review of a 5-day MDS dated [DATE] revealed Resident #25 had little interest or pleasure in doing things; was feeling down, depressed or hopeless; was feeling tired or had little energy for 12-14 days; he required extensive assistance by 2 persons for bed mobility; assistance by 2 + persons for transfers (only occurred once or twice; assistance with locomotion by 1 person on the unit (only occurred once; he did not go off the unit during this assessment period; extensive assistance by 2 + persons for dressing and hygiene; extensive assistance by 1 person for eating; total dependence by 2 persons for toileting and total support by 2 + person for baths/showers. Further review revealed he was receiving oxygen therapy, and he was only able to tolerate physical therapy 1 day. Interview on 9/14/20 at 9:17 AM with Resident #25 revealed he went to the hospital and tested positive for COVID-19 and then was hospitalized again about a week afterwards where he remained for 10 days. He stated prior to his hospitalization he was able to walk with a cane and stated now he was using a wheelchair. He stated he could not get out of bed and did not want to eat. Resident #25 commented he thought he was going to die. Interview on 9/17/20 3:00 PM with MDS Coordinator/LVN confirmed he did not complete significant change MDS for Resident #25 because he believed Resident #25's ADL decline was a result of contracting COVID. He stated he believed Resident #25's condition would resolve within 14 days; but, confirmed Resident #25's decline in ADL condition exceeded 14 days. LVN stated Resident #25 received skilled services after his return from the hospital and was back on case load with the Rehab department to further address and provide services for his ADL decline. Review of active physician orders [REDACTED].T. to evaluate and treat as indicated. Telephone order 09/14/2020.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews ad record reviews the facility failed to ensure resident assessments accurately reflected the resident's status for 1 of 12 residents (Resident #52) whose MDS assessments were reviewed in that: Resident #52's Discharge MDS indicated the resident was transferred to the hospital, when the resident went to another nursing facility. This deficient practice could affect residents discharged from the facility and result in an inaccurate assessment. Findings include: Record review of Resident #52's face sheet, dated 9/18/20, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The record also revealed Resident #114 discharged on [DATE] at 10:53 AM with a length of stay of 1624 days to a skilled nursing facility. Review of Resident #52's Discharge MDS, dated [DATE], revealed the resident was discharged to an acute care hospital. Record review of Resident #52's electronic Progress Notes: -A Nurse's Note, dated 8/13/2020, revealed Resident discharged to (nursing facility) (transport company's name) transport. Resident left with purse and 2 bags of clothes. Vitals were within normal limits and resident was stable at time of transport. Family aware and gave verbal consent for paperwork. ( ). During an interview on 9/17/20 at 1:06 p.m., MDS Coordinator LVN D confirmed Resident #52's Discharge MDS indicated the resident discharged to an acute care facility. MDS Coordinator LVN D reported Resident #52 transferred to another nursing facility and that the MDS was incorrect.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 13 residents (Resident #27 and #102) reviewed for pharmacy services, in that: 1. Resident #27's September MAR indicated [REDACTED]. 2. Resident #102 was administered a dose of [MEDICATION NAME] Tablet 2.5 MG and [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG (medication to lower blood pressure for those experiencing high blood pressure) when the medication should have been held as ordered by the physician. These deficient practices could place residents receiving hypertensive medication, enteral feedings, insulin and water flushes at risk for receiving less than therapeutic benefits from medications. The findings were: 1. Record review of Resident #27's face sheet, dated 9/18/20, revealed an admission date of [DATE] with a readmission on 6/03/18 with [DIAGNOSES REDACTED]. Record review of Resident #27's Annual MDS, dated [DATE], revealed the resident had a Cognitive Skills for Daily Decision-Making score of 3 which indicated severely impaired for daily decision making. The record also revealed the resident did not have any significant weight loss or weight gain and received his nutrition and fluid through a feeding tube. Furthermore, the record indicated the resident received insulin injections. Record review of Resident #27's electronic Care Plan, dated with a revision on 9/11/20, revealed focuses of: - (Resident #27) has potential for a nutritional problem r/t NPO, Dementia, Dysphagia and presence of a PEG Tube. - (Resident #27) has Diabetes Mellitus II. Record review of Resident # 27's Order Summary Report, dated 9/18/20, revealed orders for: - Enteral Feed Order in the morning Bolus feeding 120ml of Glucerna 1.5 with a start date of 9/09/20 and no end date. - [MEDICATION NAME] Solution 100 UNIT/ML (Insulin Detemir) Inject 26 unit subcutaneously at bedtime for DM with a start date of 8/20/20 and no end date. - Enteral Feed Order five times a day for hydration H2O flush 75cc before and after each bolus feed (per PEG) with a start date of 9/08/20 and no end date. Record review of Resident #27's MAR for September 2020, reviewed on 9/15/20, revealed the resident was coded for the following medications: [REDACTED]. -For the [MEDICATION NAME] Solution 100 UNIT/ML (Insulin Detemir) 26 units on 9/07/20 and 9/11/20 at 10:00 p.m. revealed blanks indicating the doses were not administered. -For the Enteral Feed Order five times a day for hydration H2O flush on 9/08/20 at 5:00 pm and 9:00 pm as well as on 9/09/20 at 6:00 am, 9:00 am and 1:00 pm revealed blanks indicating these doses were not administered. Record review of Resident #27's Progress Notes, revealed the resident was in the facility on 9/07, 9/08, 9/09 and 9/11/20. The record did not reveal any notes indicating the resident refused the doses of the medication or any other reason for the medications not being administered. 2. Record review of Resident #102's face sheet, dated 9/18/20, revealed the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #102's Admission MDS revealed it had not been completed yet. Record review of Resident #102's Order Summary Report, dated 9/15/20, revealed the following active orders: - [MEDICATION NAME] Tablet 2.5 MG Give 1 tablet by mouth one time a day for hypertension Hold if SBP<110 or DBP<60 or HR<60 with an order date of 9/11/20 and no end date. - [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for Hypertension Hold is SBP<110 or DBP<60 or HR<60 with an order date of 9/11/20 and no end date. Review of Resident #102's MAR for September 2020 revealed the resident was coded for the following medications: [REDACTED]. - [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG on 9/15/2020 at 9:00 a.m., revealed the resident had a B/P of 94/56 which is less than 110/60 and the medication was administered when it should have been held. Record review of Resident #102's Progress Notes, revealed the resident was in the facility on 9/15/20. The record also revealed an eMAR-Medication Administration Note on 9/15/20 at 8:22 am which indicated the resident was lethargic. However, there were not any notes indicating the medication administration personnel held the medication and marked the MAR indicated [REDACTED]. The DON also confirmed Resident #102's hypertensive medication was administered when it was less than the prescribed parameters. The DON reported she would look into the MAR questions for the residents and get back to the surveyor. During an interview with the DON on 9/17/20 at 10:37 a.m., the DON reported for Resident #27's bolus feeding on 9/09/20 and the flushes on 9/08-9/09/20 were not administered because the orders were put in, but the nursing staff have to confirm the order and then there is a start date and they begin administering the orders. The DON confirmed the MAR blanks can't be removed. The DON reported there was not a reason for why the insulin for Resident #27 was not marked as administered on 9/07/20 and 9/11/20. The DON also reported there was not justification for why Resident #102's hypertensive medications were not held when the resident did not meet the blood pressure parameters
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview, and record review, the facility failed to follow menus for 1 of 1 resident meal (dinner meal) reviewed for menus, in that: The dinner meal service on 9/16/20 revealed: - Residents receiving a mechanical soft and puree diets were not served gravy as per the menu. - The kitchen did not prepare enough dinner rolls and 5 residents were served a slice of bread when the menu called for a dinner roll to be served. - All the residents not on a pureed diet were served pureed potato chip breaded chicken tenders with a #10 scoop instead of a #8 scoop as per the menu. These deficient practices could affect residents who received food from the kitchen by contributing to dissatisfaction, poor intake, and/or weight loss. The findings included: Record review of the Week at a Glance Menu Temple Base S/S 2020 -Week 2 Wednesday 9/16/20 Day 11, revealed residents were to receive for dinner: potato chip breaded chicken tenders, honey mustard dipping sauce, broccoli rice and cheese casserole, green beans w/ sauted onions, dinner roll, and frosted cake. Record review of the Diet Spreadsheet for Temple Base S/S 2020 -Week 2 Wednesday 9/16/20 Day 11, revealed resident on a: -mechanical soft diet were to receive ground potato chip breaded chicken tenders with gravy, broccoli rice and cheese casserole, green beans w/ sauted onions, dinner roll, and frosted cake. -puree diet were to receive pureed potato chip breaded chicken tenders with gravy, honey mustard dipping sauce, pureed broccoli rice and cheese casserole, puree green beans w/ sauted onions, puree dinner roll, and puree frosted cake. During an observation and interview of the dinner meal preparation on 9/16/20 at 4:14 p.m. in the kitchen, Cook A prepared the pureed potato chip breaded chicken tenders. Cook A put 15 pieces of potato chip breaded chicken tenders and 4 ounces of chicken broth in a robo coupe and pureed the mixture until it had a smooth consistency. Cook A confirmed that was how much of the chicken tenders and chicken broth he added to the robo coupe for the pureed potato chip breaded chicken tenders. There was no observation of gravy being used. During an observation and interview of the dinner meal preparation on 9/16/20 at 4:35 p.m. in the kitchen, Cook A prepared the ground potato chip breaded chicken tenders by adding 30 chicken tenders into the robo coupe and mechanicalizing it. Cook A confirmed he only added chicken to the robo coupe to make the mechanical chicken. There was no observation of gravy being used to make the mechanical soft chicken. Observation of the dinner meal service on 9/16/20 at 5:16 p.m. in the kitchen, revealed no gravy on the steam table or the stove. Cook A started plating the meal for the dinner meal service. Observation of the dinner meal service on 9/16/20 at 5:27 p.m. in the kitchen, revealed Cook A plated residents on the 400 hall with a mechanical soft order diet without gravy. During an interview on 9/16/20 at 5:27 p.m., Cook A and the Dietary Manager confirmed there was not any gravy made for the residents ordered a mechanical soft and/or puree diet as per the menu. Cook A reported he did not know the menu called for gravy because it stated the residents were to get the honey mustard dipping sauce. During an observation on 9/16/20 at 5:27 p.m., Cook A plated the dinner meal for resident order a pureed diet. Cook A serviced the pureed potato chip breaded chicken tenders with a #10 scoop (3.20 ounces) instead of a #8 scoop (4 ounces) which would be providing the residents with less pureed chicken then the menu stated. During an observation and interview on 9/16/20 at 6:00 p.m., Cook A ran out of dinner rolls but there were still 5 residents on a regular diet plates to be served. Cook A confirmed he ran out of dinner rolls because he didn't' make enough. Cook A retrieved from the dry storage a loaf of white bread and served that to those 5 remaining plates. During an interview with Cook A and the Dietary Manager on 9/16/20 at 6:01 p.m., the Dietary Manager confirmed Cook A should not have run out of dinner roll because he should have baked enough or a little extra to be able to service all of the residents. The Dietary Manager confirmed the facility had not admitted any new residents to the facility after the lunch meal that would have increased their number of dinner plates to prepare for the dinner meal service. During an interview with Cook A and the Dietary Manager on 9/16/20 at 6:03 p.m., Cook A and the Dietary Manager confirmed the scoop sizes used for the puree chicken tenders and the pureed green beans was not correct as per the menu. During an interview the Dietary Manager on 9/14/20 at 1:50 p.m., the Dietary Manager revealed the kitchen used the TFER as their policy and procedures manual.

F 0806 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received, and the facility provided food that accommodated resident allergies [REDACTED].#20 and 208) reviewed for dietary services, in that: Residents #20's and #208's food preferences were not honored at 1 of 1 observed meal (dinner). This deficient practice could affect residents with preferences/dislikes and place them at-risk by contributing to poor intake and/or weight loss. The findings were: Record review of Resident #20's undated face sheet, dated 9/18/20, revealed an admission date of [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #20's MDS assessments revealed an Admission MDS had not been completed for the resident yet. Record review of Resident #20's care plan, dated revised on 7/17/20, revealed a focus of (Resident #20) has potential nutritional problem related to [MEDICAL CONDITION] with late onset, hypertension, diarrhea: Diet: Regular diet, regular texture thin liquids consistency with an intervention to honor resident rights to make personal dietary choices and provide dietary education as needed. Record review of Resident #208's undated face sheet, dated 9/18/20, revealed an admission date of [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Record review of

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F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Resident #208's MDS assessments revealed an Admission MDS had not been completed for the resident yet. Record review of Resident #208's care plan dated revised on 9/07/20 revealed a focus of (Resident #208) has potential nutritional problem r/t DMII,[MEDICAL CONDITION] an intervention to honor resident rights to make personal dietary choices and provide dietary education as needed. Record review of the Week at a Glance Menu Temple Base S/S 2020 -Week 2 Wednesday 9/16/20 Day 11, revealed residents were to receive for dinner: potato chip breaded chicken tenders, honey mustard dipping sauce, broccoli rice and cheese casserole, green beans w/ sauted onions, dinner roll, and frosted cake. Observation of the dinner meal service on 9/16/20 at 5:16 p.m. in the kitchen, revealed alternate side available and prepared on the steam table or the stove. Cook A started plating the meal for the dinner meal service. Observation in the kitchen during the dinner meal service on 9/16/20 at 5:28 p.m., revealed Resident #20's meal ticket that indicated the resident had a dislike of broccoli. Cook A prepared Resident #20's plate with potato chip breaded chicken tenders with gravy, broccoli rice and cheese casserole, green beans w/ sauted onions, dinner roll, and frosted cake; and Dietary Aide E placed the plate on the hall cart. The surveyor intervened and informed Cook A and Dietary Aide E Resident #20's meal ticket indicated she disliked broccoli. Cook A and Dietary Aide E conferred and decided to give Resident #20 two servings of green beans. During an interview with the Dietary Manager on 9/16/20 at 5:28 p.m., the surveyor went and informed the Dietary Manager and the facility's Consultant Dietitian of Resident #20's dislike of broccoli and that they had served her two servings of green beans. The Dietary Manager reported they would serve the resident a salad instead. Observation in the kitchen during the dinner meal service on 9/16/20 at 5:48 p.m., revealed Resident #208's meal ticket that indicated the resident had a dislike of broccoli, salad, cauliflower, sausage, orange juice and tomatoes. Dietary Aide E informed Cook A Resident #208 disliked broccoli and salad. Cook A stated to give Resident #208 two servings of green beans. Cook A prepared Resident #208's plate with potato chip breaded chicken tenders with gravy, broccoli rice and cheese casserole, green beans w/ sauted onions, dinner roll, and frosted cake; and Dietary Aide E placed the plate on the hall cart. The surveyor intervened and informed the Dietary Manager and the Consultant Dietitian Resident #208 disliked broccoli and salad, and that Cook A served the resident 2 servings of green beans. The Dietary Manager revealed they had some carrots that could be cooked to serve the resident. During an interview with the Dietary Manager and the Consultant Dietitian on 9/16/20 at 6:03 p.m., the Consultant Dietitian reported Cook A may have been nervous from the surveyor being in the kitchen, but they usually have a substitute vegetable prepared so that they can serve it to the resident's that have a dislike for the main vegetable. The Regional Consultant confirmed Cook A should have had a substitute vegetable already prepared.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interviews 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 reviewed for kitchen sanitation in that: 1. The can opener had dark black-brown grease substance on the shaft and gear. 2. A stored serving scoop had a dried reddish food substance on the surface where it would come in contact with food. 3. Cook A opened a bag of potato chip breaded chicken with a person pocket knife that he retrieved from his back right pocket to his pants. 4. Cook A did not sanitize the thermometer before inserting it into a food item. 5. Cook A touched the trash can lid while preparing the meal service and did not wash his hands before preceding with the next task. 6. Cook A did not let a dirty spatula sit in the sanitizing solution for 1 minutes as the posted sign on the wall read. 7. Cook A opened a hot dog bun with his bare hands. These deficient practices could place residents who received meals and snacks from the kitchen at risk for food borne illness. The findings were: 1. During an observation in the kitchen with the Dietary Manager on 9/14/20 at 9:51 a.m., revealed a manual can opener in a holder secured to a prep table. The can opener once removed from the holder revealed a black-brownish sticky substance on the shaft and gears. During an observation on 9/14/20 at 9:51 a.m., the Dietary Manager confirmed the can opener was dirty and gave it to a dietary staff member to take to the dishwasher. 2. During an observation in the kitchen with the Dietary Manager on 9/14/20 at 9:52 a.m., revealed in a drawer there was a serving scoop which had a dried reddish food substance on the inside of the scoop. During an observation on 9/14/20 at 9:52 a.m., the Dietary Manager confirmed the serving scoop had a dried reddish food substance on the inside of the scoop. The Dietary Mangere reported it must not have been cleaned properly and took it to the dish room. Record review of the TFER, dated 10/11/25, 228.113(l)-(3) revealed equipment, food-contact surfaces, nonfood-contact surfaces, and utensils shall be clean to sight and touch. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 3. During an observation in the kitchen during dinner meal preparation on 9/16/20 at 4:08 p.m., revealed Cook A preparing to fry potato chip breaded chicken tenders for the dinner meal. Cook A retrieved a pocket knife from his right back pant's pocket and then opened the pocket knife and used it to open the box and cut open the bag to the tenders. During an observation in the kitchen during dinner meal preparation on 9/16/20 at 4:30 p.m., revealed Cook A opened a second box of the potato chip chicken tenders to fry for the dinner meal with his pocket knife. During an observation in the kitchen during dinner meal preparation on 9/16/20 at 4:45 p.m., revealed Cook A opened a third box of the potato chip chicken tenders to fry for the dinner meal with his pocket knife. During an interview on 9/16/20 at 4:45 p.m., Cook A confirmed he was opening the boxes and packages of chicken tenders with his personal pocket knife. Cook a confirmed it had not been cleaned before he used it. Record review of the TFER, 228.113(l)-(3) revealed equipment, food-contact surfaces, nonfood-contact surfaces, and utensils shall be clean to sight and touch. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 4. During an observation in the kitchen during dinner meal preparation on 9/16/20 at 4:13 p.m., revealed Cook A frying the potato chip breaded chicken tenders. Cook A pulled a thermometer out of the plastic sleeve from a shoulder pocket on his chef's jacket. Cook A then inserted the thermometer in the fried tenders to get a cook temperature of the chicken without sanitizing the thermometer first. He used the same used alcohol wipe to sanitize the temperature after testing food temperatures. During an observation in the kitchen on 9/16/20 at 5:06 p.m., Cook A was recording temperature of food items on the steam table. Cook A record the temperature of the regular broccoli rice casserole and wiped it with an alcohol swab, then he inserted into the green beans w/ sauted onions and wiped the thermometer with the same sanitizer wipe. During an interview on 9/16/20 at 5:06 p.m., Cook A confirmed he used the same swab to clean the thermometer after temping the broccoli rice casserole and the green beans w/ sauted onions. Record review of the TFER, dated 10/11/25, 228.114 (a)(1) (A)-(E) revealed equipment food-contact surfaces and utensils shall be cleaned: except as specified in paragraph (2) of this subsection, before each use with a different type of raw animal food such as beef, fish, lamb, pork, or poultry; each time there is a change from working with raw foods to working with ready-to-eat foods; between uses with raw fruits and vegetables and with time/temperature control for safety (TCS) food; before using or storing a food temperature measuring device; and at any time during the operation when contamination may have occurred. 5. During an observation in the kitchen on 9/16/20 at 4:38 p.m., Cook A was throwing out an empty plastic bag from the chicken tenders. Cook A lifted the trash can lid with his hands and threw in the plastic bag. Cook A then closed the lid and grabbed a bowl of cooked chicken tenders to go collect the rest of the prepared chicken tenders. An interview with the Dietary Manager on 9/16/20 at 4:38 p.m., the Dietary Manager confirmed Cook A must wash his hands after touching the trash can lid. Record review of the TFER, 228.38 (d)(6) and (9) revealed When to Wash. Food employees shall clean their hands and exposed portions of their arms as specified in subsection (b) of this section immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: ( ) during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; ( ) after engaging in other activities that contaminate the hands. 6. During an observation on 9/16/20 at 4:23 p.m., Cook A was observed removing a white spatula from a pitcher full of a clear liquid on the prep table to scoop out the prepared puree chicken tenders from the robo coupe. The Dietary Manager told Cook A to use another spatula. Cook A took the white spatula to the 3-compartment sink. Cook A washed the spatula in the wash compartment, moved to the rinse compartment and rinsed the spatula, and then he dipped the spatula in the sanitizer compartment and immediately took it out and placed it on the drying section of the 3-compartment sink. A undated sign posted over the sanitizer section of the 3-compartment sink read to leave the items in the sanitizing solution for at least a minute. During an interview on 9/16/20 at 4:23 p.m., the Dietary Manager confirmed Cook A did not leave the spatula in the sanitizing solution for a minute. 7. During an observation during the dinner meal service on 9/16/20 at 5:49 p.m., Cook A was preparing a hotdog for a resident meal tray.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676158	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) Cook A grabbed the hotdog bun with tongs and placed it on a plate. Cook A then opened the hotdog bun with his left hand and then went to grab the hotdog wiener out of a pot on the range. During an interview with Cook A on 9/16/20 at 5:49 p.m., Cook A confirmed he opened the hotdog bun with his hands. Record review of the TFER, dated 10/11/15, 228.65(a)(3) revealed food employees shall minimize bare hand and arm contact with exposed food that is not in a ready-to-eat form.