STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675968	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Oak Care Center	505 Madison Oak Dr 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for 2 of 4 residents (Residents #2 and #3), reviewed for freedom from abuse, neglect, and exploitation. The facility failed to report the incident of suspected abuse on 6/5/25 when the visitor was noted pounding hard on the bed of Resident # 2 , yelling WAKE UP! . These failures could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. The findings were: Record review of Resident # 2's face sheet, dated 6/25/25, revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: Alzheimer's disease (a neurodegenerative disease that destroys cells in your brain, causing loss of some brain functions, including memory and language), Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome) and Hyperlipidemia (abnormally high levels of fats in the blood) Record review of Resident #2's admission MDS assessment, dated 06/10/2025, revealed the resident's BIMS score was 01, which indicated severe cognitive impairment. The admission MDS assessment further revealed Resident #2 required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for sit to lying, chair/bed to chair transfer, was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for toileting hygiene, upper body dressing, and lower body dressing. Record review of Texas Unified Licensure Information Portal (TULIP) on 6/25/25 at 9:21 A.M. revealed that no self-reported incidents regarding allegations of neglect were reported. Resident record review of Resident #2's progress notes, dated 06/05/2025, revealed noticed visitor, pounding hard on bed angrily yelling wake up, also noted Resident # 1 asking visitor, why are you always so mean to me. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA M on 6/25/25 at 2:20 PM revealed while assisting ,Resident # 2's roommate with activities of daily living on 6/5/25, she heard visitor for Resident # 2 pounding hard on Resident #2's bed, yelling, Wake up, followed by Resident # 1 stating, Why are you always so mean to me? CNA M stated she pulled the curtain and said, Excuse me, to the visitor, and reported the incident to LVN L. CNA M stated she did not report the incident to the Administrator because she was under the impression that LVN L would handle that. She stated that by her not reporting abuse and neglect to the administrator, Resident # 2 risked further abuse from possibly occurring. During an interview with LVN L on 6/25/25 at 3:45 PM, LVN L stated . She documented an incident CNA M reported to her during shift on 6/5/25. CNA M reported that a visitor for Resident #2 had been vigorously pounding on Resident #2's bed and yelling, Wake up, after which Resident #2 said, Why are you always so mean to me? LVN L stated she reported the incident to her ADON N and not her Administrator because of the chain of command. LVN L stated by her not reporting abuse and neglect to the administrator, Resident # 2 could have been abused. The interview with ADON N on 6/26/25 at 1:10 PM stated , she did not remember any specific report of abuse or neglect involving Resident #2 by LVN L. ADON N stated that any reports of abuse or neglect should be directed to the administrator. During an interview on 06/25/2025 at 12:30 PM, Resident #2 stated she did not want to discuss the incident regarding the visitor pounding hard on her bed. During an interview on 06/26/2025 at 4:18 PM, the Administrator confirmed she did not receive a report about Resident #2's incident with a visitor and had not seen the nursing note dated 6/5/25 before the surveyor's intervention. She explained she would have reported and investigated the abuse allegation involving Resident #2 after reviewing the note. The Administrator acknowledged that failing to report the allegation could have resulted in Resident #2 being subjected to abuse. Review of the facility policy, Abuse Guidance effective February 2017, read: It is the responsibility of our team members, consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, Types of abuse; Verbal abuse is the use of oral, written, or gestured language that willfully includes the use of disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability ,should a family member or visitor be accused or suspected of abuse, that individual will be removed from the community; thus, preventing the individual from entering the community. Report alleged or suspected abuse to HHSC by email reporting or via TULIP reporting within the designated time frames under HHSC's PL 19-17 are reported immediately, but not later than 2 hours after the allegation is made.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to have evidence all allegations of abuse, neglect or mistreatment were thoroughly investigated and documented for 1 of 5 residents (Resident #2) reviewed for abuse. The facility failed to have evidence that a thorough investigation was conducted following the allegation Resident #2 was yelled at and had her bed pounded by a visitor. These failures could place residents at risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. The findings were: Record review of Resident # 2's face sheet, dated 6/25/25, revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: Alzheimer's disease (a neurodegenerative disease that destroys cells in your brain, causing loss of some brain functions, including memory and language), Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome) and Hyperlipidemia (abnormally high levels of fats in the blood) Record review of Resident #2's admission MDS assessment, dated 06/10/2025, revealed the resident's BIMS score was 01, which indicated severe cognitive impairment. The admission MDS assessment further revealed Resident #2 required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for sit to lying, chair/bed to chair transfer, was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for toileting hygiene, upper body dressing, and lower body dressing. Resident record review of Resident #2's progress notes, dated 06/05/2025, revealed noticed visitor, pounding hard on bed angrily yelling wake up, also noted Resident # 2 asking visitor, why are you always so mean to me. Interview with CNA M on 6/25/25 at 2:20 PM revealed while assisting Resident # 2's roommate with activities of daily living on 6/5/25, she heard visitor for Resident # 2 pounding hard on Resident #2's bed, yelling, Wake up, followed by Resident # 2 stating, Why are you always so mean to me? . During an interview on 06/26/2025 at 4:18 PM, the Administrator stated that if what was documented in the progress note for Resident # 2 by LVN L was correct, it should have been a self-report to HHSC requiring her to investigate it. The Administrator mentioned she had not investigated the incident with Resident #2, as she was unaware and had not read the progress note before the surveyor's intervention. Finally, she acknowledged that not reporting the alleged incidents could have led to resident abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Abuse Guidance effective February 2017, read: It is the responsibility of our team members, consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, Types of abuse; Verbal abuse is the use of oral, written, or gestured language that willfully includes the use of disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability ,should a family member or visitor be accused or suspected of abuse, that individual will be removed from the community; thus, preventing the individual from entering the community. Report alleged or suspected abuse to HHSC by email reporting or via TULIP reporting within the designated time frames under HHSC's PL 19-17 are reported immediately, but not later than 2 hours after the allegation is made.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 did not elope from the facility without staff knowing from 05/10/25 at 06:03 PM to 05/11/25 at 12:50 AM (approximately 6 hours and 47 minutes). The noncompliance was identified as PNC. The IJ began on 05/10/25 and ended on 05/11/25. The facility had corrected the noncompliance before the investigation began. This deficient practice could place residents at-risk of harm, serious injury, or death. The findings included: Record review of Resident #1's admission Record, dated 06/24/25, reflected Resident #1 was a [AGE] year-old female admitted [DATE] with diagnoses to include vascular dementia (type of dementia caused by brain damage from impaired blood flow) and Alzheimer's disease (a degenerative brain disorder that primarily affects memory, thinking, and cognitive abilities). Record Review of Nursing Admission/readmission assessment, authored by LVN A on 05/10/25 at 03:19 PM, reflected Resident #1 was alert but some disorientation or forgetfulness, able to verbalize needs & wants. It further reflected Resident #1 was not physically able to leave the building on their own so resident did not need an Exit Seeking care plan. Record Review of Resident #1's MDS assessment, dated 05/15/25, reflected a BIMS score of 1 out of 15, indicating severe cognitive impairment. It reflected Resident #1 had a behavior of wandering in the last 1 to 3 days. It reflected the wandering did not place the resident at significant risk of getting to a potentially dangerous location to include outside of the facility. Record review of the Investigation Timeline, undated, created by the ADM, reflected as follows: On 05/09/25: The Admissions Coordinator gave wander guard device to LVN D who then placed it in 600 med cart. The Admissions Coordinator updated community dashboard with Resident #1 admission needs wander guard in the nurses cart On 05/10/25: *At 02:45 PM Resident #1 admitted to community with family and LVN A completed head to toe assessment (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*At 04:30 PM: video surveillance revealed LVN A opened up 600 hall med cart and took out the wander guard then placed it back. *At 04:35 PM: LVN A went on break and gave report to LVN B without mention of any supervision for Resident #1 *At 05:55 PM: LVN A came back from break *At 06:03 PM: RN C opened the door and let Resident #1 out of the facility. There was no inclement weather and Resident #1 was dressed appropriately. *At 06:45 PM: The nearby hospital called the facility stating Resident #1 was at the hospital. *At 06:59 PM: Head count was done, and all other residents were in the facility. All doors, windows, and wander guard system was checked. Resident with a wander guard were checked for placement and functionality. On 05/11/25: *At 12:50 AM: Resident #1 returned to the community and placed in the secured unit. MD and RP were notified. Head to toe assessment was completed. Record review of the provider investigation report for this incident, dated 05/11/25, reflected, On 05/10/25 at approximately 06:30 PM [Resident #1] who admitted earlier that day exited the community and walked across the parking lot to the neighboring hospital. The hospital staff notified the community that the resident was there and out of an abundance of caution resident was evaluated and discharged back to the facility. Resident's assigned MD and RP were made aware. Upon resident's return to facility, she was assessed and placed on the secured unit and on-going monitoring is in place. Resident is at usual physical and emotional baseline status, no [signs and symptoms] of emotional or physical trauma. IDT has reviewed/update the plan of care accordingly. Observation on 06/24/25 at 10:50 AM revealed Resident #1 was in the secured unit and was not able to provide answers to questions asked. Interview on 06/24/25 at 11:14 AM, the ADM revealed Resident #1 needed to have a wander guard out of precaution because the facility was told Resident #1 wandered in and out of rooms at her previous facility. She revealed LVN A failed to put a wander guard on Resident #1. She revealed Resident #1 was not put in the secured unit because they were told Resident #1 did not ambulate. She revealed RN C let Resident #1 opened the door and let Resident #1 out of the facility. Interview on 06/24/25 at 12:06 PM, RN C revealed she saw Resident #1 waiting by the front door to the facility, opened the door for her, and let her out of the building. RN C revealed she did not know Resident #1 was a resident. Interview on 06/24/25 at 01:15 PM, LVN A revealed she did not remember Resident #1 or any elopement incident that happened in May 2025. Voicemail was left for LVN B on 06/24/25 at 01:43 PM with no call back from LVN. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/24/25 at 02:26 PM, the Admissions Coordinator revealed the DON did as assessment for Resident #1 at Resident #1's previous facility and told her on 05/09/25 that Resident #1 needed a wander guard when Resident #1 was going to be admitted on [DATE]. The Admissions Coordinator revealed she gave the wander guard on 05/09/25 to LVN D to put in her med cart and expected LVN D to pass along the information that Resident #1 needed this wander guard to the oncoming shifts until Resident #1 admitted to the facility. The Admissions Coordinator revealed she also updated the dashboard in the electronic medical record (EMR) and staff knew to look at for updates for resident care. Voicemail was left for LVN D on 06/24/25 at 02:45 PM with no call back from LVN. Interview on 06/24/25 at 03:11 PM, the ADM and DON revealed they had assessed Resident #1 at her previous facility and learned Resident #1 was considered a wanderer but was not exit seeking. They revealed this was why they had a wander guard ready for when Resident #1 was admitted . The ADM revealed LVN A knew she needed to put the wander guard on Resident #1 because it was in her med cart and because this direction was reflected on the EMR Dashboard, which nursing staff knew to review when they logged into the EMR. The ADM further revealed LVN A did not work at the facility anymore. They revealed they did not have hospital records for Resident #1 when she was at the hospital on [DATE]. Record review of the facility's policy Resident Safety: Prevention of Responding to Missing Person, and Exit Seeking, revised January 2025, reflected New Admits/Re-Admits should be assessed/re-assessed as clinically indicated by completing the elopement risk/exit seeking assessment UDA in[EMR]. And If assessment deems resident is at risk for elopement and placement on a special care unit or the use of an alert bracelet may be utilized to maintain the resident's personal safety and promote overall well-being. The Administrator was notified on 06/25/25 at 02:48 PM, a past non-compliance IJ situation had been identified due to the above failure. The facility implemented the following interventions. Record Review of Resident #1's care plan reflected a focus of At risk for elopement and/or wandering with unsafe boundaries r/t cognitive impairment/judgement and safety awareness, initiated 05/11/25, with intervention Safety Risk: Monitor resident regularly throughout shift to prevent wandering into other rooms, exit seeking and elopement. Distract & Assist quickly to prevent accidents/injury. Notify the nurse., initiated 05/11/25. Record Review of Resident #1 doctor's orders reflected as of 05/10/25 Admit to Secure unit due to behaviors that may include but not limited to: wandering, exit seeking ., dated 05/11/25, and Resident #1 was being monitored for wandering behavior. Resident #1 was placed on the secured unit on 05/11/25, when the resident came back to the facility. Record review of in-service training, starting on 05/10/25, reflected licensed nurses (to include LVN A, LVN B, and RN C) were educated on the importance of immediately completing the admission assessment/evaluation and exit seeking tool. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review reflected all staff (to include LVN A, LVN B, and RN C) were educated on 05/10/25 for Elopement Response & Exit Seeking Management and Resident Safety, exit seeking, abuse and neglect and Identifying and Responding to Triggers to Prevent. Record review reflected all staff (to include LVN A, LVN B, and RN C) were educated on 05/10/25 for Process for monitoring, identifying, and reporting resident with exit seeking behaviors or identified risks. Abuse and Neglect (~25% of staff were interviewed on in-servicing on elopements) Record review of facility Incidents and Accidents report for the last 6 months reflected that no other resident had eloped apart from the incident on 05/10/25. Record review of facility's monitoring tool for Elopement/Missing Person Response Drills, dated May and June 2025 dates, reflected the facility was monitored all shifts initially then random shifts, 2-4 times per month x1-2 months. Record review of 4 residents (to include Resident #1) reflected exit seeking tool was completed on 05/10/25. Interview on 06/24/25 at 03:11 PM, The ADM revealed there was not an official training or policy for letting visitors in and out of the building but she let the staff know how to tell the difference between a visitor and a resident so a resident would not be accidentally let out of the building. Interview on 06/25/25 at 10:48 AM, the DON revealed on 05/10/25 they re-assessed all residents with the exit seeking tool to ensure they were filled out properly. Interview on 06/24/25 at 10:58 AM, CNA K (typically worked 6AM-2PM, but worked other times as well) revealed he was trained on preventing elopements to include what residents were at high risk for elopements, responding to door alarms, checking on residents regularly, doing headcounts, and more. He revealed if a resident were to elope, he would follow the resident out and contact the ADM immediately. Interview on 06/24/25 at 11AM, LVN P (worked 6AM-6PM) revealed she was trained on elopements and would follow a resident who exited the building for safety. She revealed she would respond to any alarm to make sure residents were safe. She revealed they performed resident head count checks to make sure all the residents were in the building. She revealed she would report abuse, neglect, or elopements to ADM right away. Interview on 06/24/25 at 12:06 PM, RN C (worked 6AM-6PM) revealed after this incident she was trained on being able to identify who was a visitor and who was a resident. She revealed she would check in with the front desk, who oversaw letting people in and out of the building. She revealed visitors also had name tags to show they were visitors. She revealed she was trained on elopement to include checking on residents regularly and to respond to the wander guard alert if a resident were to get to the front door. She revealed for new admissions they assessed residents to include seeing how oriented they were in the facility. She revealed if a resident was confused, they would monitor resident to ensure they did not wander. She further revealed they would also have to assess if resident needed to be in the secured unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/24/25 at 12:25 PM, Receptionist O (worked 8AM-5PM) revealed anyone who leaves the building needed to check out with her. She revealed when anyone enters the building, they also checked in with her. She revealed if she did not know if a resident was supposed to leave for the day, she would check with the nursing staff before letting them out because they needed to sign something first. Interview on 06/24/25 at 02:26 PM, the Admissions Coordinator (worked 8AM-5PM) revealed she was trained on how to tell the difference between a resident and a visitor to include asking specific questions. She revealed she was trained on preventing elopements like redirecting residents who were trying to exit the building. She revealed if a resident were to exit the building, she would follow them. She revealed their wander guard alarm system would alarm if a resident with a wander guard was trying to exit the front door. She revealed she made sure that staff had wander guard as needed if a resident assessment showed a resident needed a wander guard. Interview on 06/25/25 at 08:37 AM, CNA E (worked 10PM-6AM) revealed she was trained on preventing elopements. She revealed for Wander alarms, if the alarm went off, they would run to stop the resident, redirecting them away from the exit. She revealed she would follow the resident if they did happen to exit and kept eyes on her residents. She revealed she would report to ADM immediately. She revealed that PCC had a front page for pertinent alerts. She further revealed she was trained to tell the difference between visitors and residents. She revealed the visitors had visitor badges, so the staff knew to look out for this. Interview on 06/25/25 at 08:52 AM, CNA F (worked 10PM-6AM) revealed she was trained on elopement. She revealed she checked on residents in their rooms frequently. She revealed if a resident was not in their room, she would check their restroom, her hallway, speak to the nurse, and contact ADM immediately. She revealed if the door alarm went off, she would redirect resident to the middle of the building and alert the nurse. She revealed if a resident eloped, she would not leave any resident alone due to resident safety. She revealed she was trained on abuse and neglect and reported this along with elopements to the ADM immediately. She revealed visitors had name tags or she would look at the visitor logbook to verify visitors. She revealed she used the home page in the PCC for alerts to include resident pictures for warnings such as if a resident was a wanderer. Interview on 06/25/25 at 08:58 AM, LVN G (worked 6PM-6AM) revealed she was trained on what to do when a resident eloped. She revealed if a resident had a wander guard, the alarm went off and they would respond immediately to get the resident. She revealed she would call ADM and DON immediately if there was a missing resident, and they would search the building to see if resident were hiding somewhere first. She revealed if the doors alarmed, they would go outside right away to search for resident. She revealed she was trained on how to tell the difference between a visitor and resident. She revealed visitors had name tags and she would ask more questions to the visitor or resident to determine who they were. She revealed if a visitor did not sign in, she would ask questions. She revealed she used the PCC Dashboard for pertinent alerts for residents. Interview on 06/25/25 at 09:10A, Receptionist O revealed if a resident were to exit the building, she would stay with them the whole time and call for help. She revealed if any alarm went off (to include the wander alarm or door alarm), she would go to the direction of the alarm, redirect resident, and contact nursing staff. She revealed if someone were to leave, she would contact ADM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/25/25 at 09:15 AM, Dietary [NAME] Q, Dietary Aide R and Dietary Aide S revealed they were trained on elopement. They revealed if they heard any alarm, they would go towards the alarm and make sure the resident was redirected from exiting. They revealed they knew to help locating a missing resident if the whole building needed to find a resident, but they have not been asked to do so yet. They revealed if they saw abuse, neglect, or an elopement, they would contact the ADM as soon as possible. They revealed they knew visitors should have name tags, but they revealed they knew they had to speak with the nursing staff before letting anyone out of the building to ensure it was a visitor. They revealed if they saw a resident exiting the building, they would make sure to follow them, so the resident remained safe. Interview on 06/25/25 at 09:20 AM, CNA J (worked 6AM-2PM) and LVN U (worked 6AM-2PM) revealed they were trained on elopements and had a quick reference attached to their badges. They revealed if they heard an alarm go off in the building, they would go to it right away and make sure the resident would not elope. They revealed they would count residents and go outside if they were not able to locate the resident inside the building. They revealed they do visual checks on residents frequently and were aware of what residents wandered or were exit seeking. They revealed they knew visitors had name tags to identify themselves, but if they questioned if someone was a visitor, they would ask questions or look in EMR to see if they were a resident. They revealed they could also check with the receptionist to identify visitors before letting them out of the building. They revealed they were trained on abuse, neglect, and elopements and would report to the ADM and DON right away. LVN U revealed he was detailed in his assessments and even documented in progress notes if a resident was a wanderer or elopement risk. He revealed if the resident was not capable of contributing to an interview, he would call family, previous nurses, administration, or the previous facility. They revealed they knew to look at the EMR dashboard for pertinent alerts to include if a resident was a wanderer. Interviews on 06/25/25 at 09:26 AM, CNA V (worked 6AM-2PM), CNA K (worked 6AM-2PM), Agency Nurse T (worked 6AM-6PM) revealed they were trained on abuse, neglect, and elopement and to report to ADM and DON immediately. They revealed they checked on their residents frequently and if they had a missing resident, they would search the building and let all nursing staff know. They revealed they would search outside if they could not find the resident inside. They revealed visitors had name tags and they would double check with the nurses before letting someone out of the building. They revealed they used EMR dashboard for any alerts for their residents. Agency nurse revealed that she was detailed in her assessments of residents to include their physical assessment, physical ability, and if a resident were a wanderer or needed monitoring. Interview on 06/25/25 at 10:08 AM, LVN W (worked 2PM-10PM) revealed he was trained on elopements. He revealed he would respond to alarms right away for wander guards or doors. He revealed if they did not find the resident inside the building, they would have to go outside to find the resident. He revealed he would report to ADM immediately. He revealed if resident exited the building, he would follow the resident out. He revealed the visitors had a badge to identify themselves. He revealed EMR had an alert page to know about anything new going on with the residents. He revealed he checked on his residents regularly and if someone was missing, they would have to search for the resident and alert ADM immediately. He also revealed he contacted the ADM immediately if there was any abuse or neglect. He revealed the number one priority was resident safety. He further revealed he recorded detailed information if resident had incident or history of elopement. He revealed they would document any observations or potential triggers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675968	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Oak Care Center	505 Madison Oak Dr San Antonio, TX 78258

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/25/25 at 11:15 AM, CNA X (worked 10PM to 6AM and 2PM-10PM sometimes) revealed she was trained on abuse, neglect, and elopements. She revealed she would report to nurse and ADM immediately. She revealed if any doors or wander guard alarmed, she would do a head count, check doors, and check wander guards. She revealed she redirected residents from going outside. She revealed if they made it outside, she would stay with the resident. She revealed she used the EMR dashboard for alerts. She revealed visitors had name tags and she knew to not let residents out of the building. She revealed she checked residents frequently. She revealed if she had a missing resident, she would let nurses know, do a head count, search for resident, and report to ADM immediately. Interview on 06/27/25 at 01:03 PM, COTA Y revealed she had been trained on preventing elopements. She revealed she would respond to any door alarms or wander guard alarms. She revealed she would help out with searching for any missing residents or any resident that had eloped. She revealed if she saw a resident elope, she would follow the resident for resident safety. She revealed she knew to report abuse, neglect, and elopements to the ADM immediately. Observation on 06/24/25 at 09:06 AM revealed that upon entrance, this surveyor had to be let into the facility by Receptionist, check in via a computer, and get a name tag to identify as a visitor. This observation continued throughout investigation. Observation on 06/26/25 at 06:45PM revealed the front door was locked and needing a staff member to verify this surveyor was a visitor before opening the front door. The noncompliance was identified as PNC. The IJ began on 05/10/25 and ended on 05/11/25. The facility had corrected the noncompliance before the investigation began.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 2 of 5 residents (Residents #4 and #5) reviewed for consents for accurate medical records. 1. The facility failed to document a discharge summary in Resident #4's electronic medical record on 01/24/25, when Resident #4 discharged . 2. The facility failed to document shower/bath for Resident #5 appropriately on 06/02/25. These failures could place residents at risk for inaccurate and unorganized medical records. The findings included: 1. Record review of Resident #4's admission record reflected Resident #4 was a [AGE] year-old male admitted on [DATE] with diagnoses to include senile degeneration of brain and major depressive disorder. It further revealed Resident #4 had an RP and was discharged on 01/24/25. Record review of Resident #4's quarterly MDS assessment, dated 01/12/25, reflected Resident #29 had a BIMS score of 03 out of 15, indicating severe cognitive impairment. It revealed Resident #4 was not a part of active discharge planning to return to the community. It further revealed Resident #4 did not want to be asked about returning to the community until comprehensive assessments. Record review of Resident #4's assessments tab in the electronic medical record (EMR), accessed on 06/25/25, reflected IDT Discharge Summary-Planning/Instructions/Recapitulation was dated 08/31/24. It revealed there were no discharge summaries dated 01/24/25. Record review of Resident #4's assessments tab EMR accessed on 06/27/25, reflected IDT Discharge Summary-Planning/Instructions/Recapitulation was dated 01/24/25 but had a status that reflected Errors and not Complete. Interview on 06/27/25 at 11:22 AM, SW confirmed the assessment IDT Discharge Summary had errors and was not marked complete. She revealed if there were errors for an assessment that meant it may not be locked (the assessment still had items to address like unanswered questions). The SW revealed anyone in the disciplinary team can lock the assessment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/27/25 at 11:47 AM, the DON and Director of Clinical Operations revealed the expectation for the discharge summary should be complete with a signature and date. They revealed it should also be locked with no errors. They revealed resident's family did receive orientation and discharge information to include where Resident #4 was going. Interview on 06/27/25 at 01:40 PM, Director of Clinical Operations and Director of Clinical Reimbursement revealed Resident #4's discharge summary was complete even though it had errors. Director of Clinical Operations revealed it did not need to be dated or have a signature, and Resident #4 and family did receive a discharge summary. They revealed it was complete, it just was not locked in the EMR. Interview on 06/27/25 at 02:13 PM, Director of Clinical Operations revealed Resident #4's discharge summary was complete. She revealed if the errors mentioned there was an answer missing from a prompt in the discharge summary, then it was important to answer. She revealed even though it was not answered, it was summarized in the Additional Summary Comments. 2. Record review of Resident #5's admission record reflected Resident #5 was an [AGE] year-old female admitted on [DATE] with diagnoses to include cognitive communication deficit and major depressive disorder. Record review of Resident #5's admission MDS assessment, dated 04/02/25, reflected Resident #5 had a BIMS score of 02 out of 15, indicating severe cognitive impairment. It further revealed Resident #5 was dependent for shower/bathe self, which meant helper does ALL of the effort. Record review of Resident #5's EMR bathing in the last 30 days, accessed on 06/25/25, reflected from 06/01/25 to 06/07/25 Resident #5 had only 1 shower/bath on 06/06/25. Record review of Resident #5's EMR bathing in the last 30 days, accessed on 06/27/25, reflected from 06/01/25 to 06/07/25 Resident #5 had 2 showers/baths on 06/04/25 (added by CNA K) and 06/06/25. Interview on 06/27/25 at 11:47 AM, the DON revealed she told nursing staff while surveyors were on site to documented complete showers in kiosk, if and forgot to document. Director of Clinical Operations revealed CNA K documented a bath/shower on 06/02/25 which meant he showered Resident #5 on that day but forgot to document; she stated staff do not document unless the task was done. Interview on 06/27/25 at 11:53 AM, CNA K revealed he documented the shower on 06/02/25 after he was told to in order to keep up with his documentation. He revealed he did give Resident #5 a shower or 06/02/25 but forgot to record it. He revealed it was important to document showers in kiosk so resident care was maintained. Interview on 06/27/25 at 01:46 PM, the ADM revealed that CNAs were allowed to change documentation for 90 days in the EMR and nurses for 30 days. She revealed the EMR was supposed to be a compliant system so this should mean it was compliant with regulations. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Medical Records, revised January 2023, reflected, A medical record is maintained for every person admitted to a community in accordance with accepted professional standards of practices . The medical record consists of but not limited to the following: . a record of the resident's assessments, the plan of care and services provided .