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	11/20/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ased on interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated for 2 of 8 residents (Resident # 2 and Resident # 6) reviewed for abuse and neglect.The facility did not provide evidence of a thorough investigation, including interviews with residents in the unit where Resident #2 resided, following a family member's allegation of neglect to the Admin on 8/7/2025. The facility did not provide evidence of a thorough investigation, including interviews with residents in the unit where Resident #6 resided, following a family member's allegation of abuse to the Admin. on 8/1/2025. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm.The findings included:1. Record review of Resident # 2's face sheet, dated 10/02/25, revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: Major depressive disorder (is a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed), Chronic heart failure (a condition in which the heart does not pump blood as well as it should), and Kidney disease (when the kidneys are damaged and cant filter, waste, fluids and toxins from the body). Record review of Resident #2's admission MDS assessment, dated 07/24/2025, revealed the resident's BIMS score was 01, which indicated severe cognitive impairment.Record review of the facility investigation file titled [Resident #2] revealed a document titled Provider Investigation Report (Form 3613-A) dated 8/07/2025. The 3613-A reflected Resident #2's family member alleged Resident #2 had been neglected by the facility because the family member observed the resident wearing a brief soiled with urine when she would visit. The Form 3613-A described the investigation of the allegation did not include a physical assessment of Resident #2 due to discharged status, but included team member and resident interviews, and a record review. The form also reflected the following:After a thorough investigation, findings were unfounded. Resident with no new skin issues noted. Questionnaires revealed no negative findings.Further record review of the facility investigation file reflected 16 questionnaires dated 8/07/2025. The questionnaires included questions regarding abuse and neglect asked of residents performed on the 300 and 400 resident halls. In an interview with the Admin. on 10/3/2025 at 9:50 AM, she stated Resident #2 resided on 500 hall immediately prior to discharge. She said the facility's investigation of the abuse allegation included resident and staff safe surveys. She said that the facility received multiple allegations of abuse/neglect within several days, so the resident surveys on the 300 and 400 halls were used to determine safety of all residents within the facility. She said residents on the 500 hall were not surveyed during the investigation of the allegation of neglect of Resident #2. She said the determination of unit safety was also made through daily, routine angel care rounds performed by staff every morning. 2. Record review of Resident #6's face sheet dated 9/30/2025 revealed an [AGE] year-old male admitted to the facility on [DATE] and discharged on 8/07/2025. Relevant diagnoses included cognitive communication deficit and unspecified dementia (a progressive neurological disorder that affects cognition and memory). Record review of Resident #6's quarterly MDS reflected a BIMS score of 02, which indicated severely impaired cognition. Record review of the facility investigation file titled [Resident #6] revealed a document titled Provider Investigation Report (Form 3613-A) dated 8/1/2025. The 3613-A reflected Resident #6's family member alleged Resident #6 had been physically assaulted by a shoe, resulting in a facial injury. The Form 3613-A described the investigation of the allegation included a physical assessment of Resident #6, resident and team member abuse and neglect questionnaires, and of review of video footage. Further record review of the facility investigation file reflected 16 questionnaires dated 8/07/2025. The questionnaires included questions regarding abuse and neglect asked of residents performed on the 300 and 400 resident halls. In an interview with the Admin. on 10/3/2025 at 9:50 AM, she stated Resident #6 resided on the memory care/600 hall during his admission. She said the facility's investigation of the abuse allegation included a physical assessment of Resident #6, resident and staff safe surveys, and an interview with the resident and his family member. She said the investigation did not include abuse/neglect surveys on residents of the memory care unit because she felt they could not participate in the surveys due to cognitive decline, and the residents would not be able to respond. She said physical assessments in place of verbal surveys were not performed as part of the investigation. She said her interviews of the staff did not reveal findings that any residents on the memory care unit were exhibiting behaviors that deviated from their baseline status, so she felt that was sufficient evidence that all residents

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of 1 of 5 residents (Resident #4) reviewed for pharmacy services. The facility failed to ensure Resident #4's PRN Tramadol (a pain medication) orders included the necessary indications for administration. These failures could lead to mismanagement of a resident's pain or unintended sedation. Findings included:Record review of Resident #4's face sheet dated 9/30/2025 revealed a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included dementia (a progressive disorder affecting memory and cognition) and muscle weakness. Record review of Resident #4's admission MDS submitted 9/12/2025 reflected a BIMS score of 04, indicating severely impaired cognition. Record review of Resident #4's Order Summary Report dated 9/30/2025 revealed the following:Tramadol HCl tablet 50mg, give 1 tablet by mouth every 6 hours as needed for pain (order date 9/05/2025)Tramadol HCl tablet 50mg, give 2 tablet [sic] by mouth every 6 hours as needed for pain (order date 9/05/2025)Record review of Resident #4's Care Plan Report printed 9/30/2025 revealed the following:[Focus] Baseline / Initial Care Plan: I may be at risk for: self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress {sic} [Intervention] PAIN RISK: Monitoring on-going for pain or discomfort. Provide nonpharmacological interventions to relieve pain/discomfort such as repositioning, back rub, relaxation and [etcetera]. Administer pain medications as indicated. Report pain concerns to [the provider] as indicated. (date initiated 9/17/2025)Record review of Resident #4's September 2025 MAR revealed the following:Tramadol HCl tablet 50mg, give 1 tablet by mouth every 6 hours as needed for pain (order date 9/05/2025)10/11/2025 at 6:44 PM for pain level 410/12/2025 at 2:47 PM for pain level 410/17/2025 at 12:01 PM for pain level 410/17/2025 at 7:22 PM, no documented pain level10/20/2025 at 10:35 AM for pain level 610/26/2025 at 7:01 PM for pain level 510/27/2025 at 8:33 PM for pain level 5Tramadol HCl tablet 50mg, give 2 tablet [sic] by mouth every 6 hours as needed for pain (order date 9/05/2025)Not administeredResident #4 was unable to participate in an attempted interview on 9/30/2025 at 2:08 PM due to cognitive decline and confusion. In an interview on 10/1/2025 at 10:00 AM, LVN D said she administered Tramadol 50mg 1 tablet when Resident #4 complained of pain. She said she would then reassess him in an hour and if the pain had not resolved or was worse, she would administer another tablet of Tramadol 50mg after calling the provider to obtain a one-time order. She was unsure under which circumstances she would administer Tramadol 50mg 2 tablets to Resident #4. She said she had seen other residents' PRN pain medications contained specific parameters for administration, but she was not sure why Resident #4's orders did not. LVN D said the potential harm to a resident receiving PRN pain medications without specific parameters was intoxication or sedation. In an interview on 10/1/2025 at 10:00 AM, the DON said that nursing staff were taught by the facility to administer a lower dose of PRN pain medication for mild pain and a higher dose of medication for severe pain. She said the medication order should clarify which dosage of the medication to administer for the level of pain. In an interview on 10/2/2025 at 10:34 AM, the RPh said the inclusion of a pain scale parameter on the two PRN Tramadol orders would be considered best practice and appropriate to ensure management of Resident #4's pain. He said it was unlikely Resident #4 would receive too much Tramadol because nurses are trained to question duplicate administration of medications. He said he had audited Resident #4's medication regimen in September 2025, but he had not focused on the PRN pain medication. In an interview on 10/2/2025 at 10:40 AM, the MD clarified the order should have been transcribed to include pain level of 1-4 out of 10 for 1 tablet of Tramadol 50mg, and pain level of 5-10 for 2 tablets of Tramadol 50mg. He reported no concerns with the care provided to the resident by the facility. Record review of the facility policy titled Pain Management revised 1/2025, revealed the following: The Licensed Nurse, when administering; scheduled, routine, or PRN pain medications, should monitor the effectiveness of the intervention i.e. pain medication, post administration and if not effective follow physician's orders and/or notify the prescriber.

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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 interview and record review, the facility failed to maintain clinical records on each resident, in accordance with accepted professional health information management standards and practices, that are: complete, and accurately documented for 1 (Resident #3) of 15 residents reviewed for clinical records, in that:Resident #3's clinical record contained inaccurate information.This deficient practice could cause miscommunication among the resident's caregivers and result in improper care.The findings were: Record review of Resident #3's facesheet, dated 10/03/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Muscle Wasting and Atrophy, Essential Primary Hypertension, and Cerebral Infarction. Record review of Resident #3's comprehensive MDS, dated [DATE], revealed a BIMS score of 2 which indicated severe cognitive impairment. Record review of Resident #3's clinical progress notes revealed a provider note, dated 08/15/2025, .eyes did appear to be mildly red, no discharge noted. He was started on erythromycin 3 times a day for 5 days. Apply warm compresses as needed. Further review revealed a provider note, dated 08/22/2025, .mild redness in both eyes. Further review revealed a provider note, dated 08/26/2025, . treated for bilateral conjunctivitis with erythromycin showing improvement.Review of Resident #3's list of medical diagnoses, as of 10/03/2025, revealed conjunctivitis was not listed and review of Resident #3's physician orders and medication administration record revealed the medication erythromycin was never ordered nor administered to the resident. During an interview on 10/03/2025 at 10:50 a.m. with the DON and the NP, both stated they did not recall Resident #3 ever experiencing redness in his eyes. The NP stated she recalled the resident very well and that the documentation regarding conjunctivitis was entered into Resident #3 clinical record in error.Record review of the facility policy, Medical Records, revised January 2023, revealed, A medical record is maintained for every person admitted to a community in accordance with accepted professional standards and practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #4) reviewed for infection control. The facility failed to properly implement enhanced barrier precautions for Resident #4. This failure could result in the spread of infection or illness.Findings included:Record review of Resident #4's face sheet dated 9/30/2025 revealed a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included dementia (a progressive disorder affecting memory and cognition) and muscle weakness. Record review of Resident #4's admission MDS submitted 9/12/2025 reflected a BIMS score of 04, indicating severely impaired cognition. Record review of Resident #4's Order Summary Report dated 9/30/2025 revealed the following:EBP (Enhanced barrier precautions): Practice EBP as indicated: every shift (order date 9/17/2025)WC: Cleanse with normal saline and pat dry with gauze. Apply Bacitracin ointment to sutures and cover with dry dressing day and prn, as needed for if soiled or missing [sic] (order date 9/17/2025)Record review of Resident #4's Care Plan Report printed 9/30/2025 revealed the following:[Focus] At risk for infection or recurrent/chronic infection r/t compromised medical condition [intervention] Enhanced Barrier Precautions practices as clinically indicated [sic] (date initiated 9/17/2025)Record review of Resident #4's September 2025 TAR revealed the following:EBP (Enhanced Barrier Precautions): Practice EBP as indicated: every shift (start date 9/17/2025 [6:00 PM])Resident #4's September 2025 TAR was signed as completed for all shifts beginning 9/17/2025 night. Record review of Resident #4's October 2025 TAR, printed 10/1/2025, revealed the same order and was signed as completed on 10/1/2025 day by LVN D. No sign indicating EBP status or PPE cart were observed on the following dates/times:9/30/2025 at 2:08 PM10/1/2025 at 9:13 AMResident #4 was unable to participate in an attempted interview on 9/30/2025 at 2:08 PM due to cognitive decline and confusion. He was observed to have a wound on his forehead with multiple sutures. The wound did not have a dressing. In an interview on 9/30/2025 at 2:59 PM, CNA stated Resident #4 was not on any isolation precautions, including EBP. He said he would know if a resident required isolation precautions based on the electronic medical record or the signage on residents' doors. He said he was new to the facility but had training about infection prevention from the facility upon hire. In an interview on 10/1/2025 at 10:00 AM, LVN D said she did not think that Resident #4 required EBP. She said her initials as completed on a TAR order for EBP indicated the EBP precautions were implemented, including sign and PPE cart), and that she understood the resident was on EBP. She did not recall signing Resident #4's TAR for EBP on 10/1/2025. She was unsure why Resident #4 was on EBP. She said the potential harm to a resident of not having ordered isolation precautions implemented was the spread of infection. In an interview on 10/1/2025 at 10:00 AM, the DON said she did not think Resident #4 required EBP, but she would research the issue for clarity. In a subsequent interview on 10/3/2025 at 10:45 AM, the DON said Resident #4 should not have had an order for EBP because the wound did not have a dressing and was not severe enough to require EBP. She was unsure why the nursing staff had signed the TAR indicating Resident #4 was on EBP. She said she was acting as the interim infection preventionist, and she reviewed admission orders frequently to audit the initiation and discontinuation of isolation precautions. She said the potential harm to a resident who did not have proper isolation precautions implemented was infection. Record review of the facility policy titled Infection Prevention and Control revised 4/2024, revealed the following:Residents/patients with the following clinical indication should be under EBP open wounds requiring a dressing; excluding simple skin breaks or tears that are covered with an adhesive bandage (e.g., Band-aid) or similar dressing.