

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675968 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/25/2025 |
| NAME OF PROVIDER OR SUPPLIER Stone Oak Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p> |

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675968 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/25/2025 |
| NAME OF PROVIDER OR SUPPLIER Stone Oak Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #1) of 5 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1 was coded on his Quarterly MDS assessment, signed as completed on 11/03/2025, for a fall without injury that occurred on 10/07/2025. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Record review of Resident #1's admission Record, dated 11/07/2025, reflected a [AGE] year-old male. He was admitted on [DATE]. Resident #1 was noted to be on hospice. Record review of Resident #1's Medical Diagnosis tab on the EMR, undated and accessed 11/07/2025 at 04:02 p.m., revealed diagnoses included malignant neoplasm (cancerous tumor) of unspecified kidney, muscle wasting and atrophy (shrinking of muscle or nerve tissue), and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder. Record review of facility Risk Management document, titled #5651 Fall, dated 10/07/2025 at 09:00 a.m., revealed LPN A completed the report. Resident #1 was noted to have had a fall in his room. LPN A described the incident as REACHED FOR A BLANKET ON THE FLOOR, AND ROLLED OUT OF THE BED. No injuries were observed at the time of the incident. Resident #1's pain was noted at a level of 3, no range noted, and he was noted as alert. No injuries were noted to have been observed post incident. The physician, the DON, and the responsible party were noted to have been notified on 10/07/2025 between 09:00 a.m. to 09:19 a.m. Under notes, intervention was noted as add bed Bolsters. Record review of Resident #1's Progress Notes, dated 11/07/2025 for date range 10/07/2025 to 10/10/2025, reflected:- a SNF Follow UP note, dated 10/07/2025 at 08:00 a.m. and signed 10/08/2025 at 10:14 a.m. by MD B, ***Chief Complaint*** Pain after fall from bed ***Hospital Course*** Patient experienced a fall from bed earlier this morning without head strike, now with leg and back pain. Nursing staff at bedside confirmed no head injury. Hospice nurse has been consulted and will adjust pain medications. Labs and vitals were reviewed. Plan is to continue current care. ***History of Present Illness*** [Resident #1], [AGE] years old male, was seen lying in bed, complaining of pain in his legs and back after he fell out of his bed earlier this morning. Discussion with the nurse at the bedside confirmed that the resident did not hit his head during the fall. During his last visit on 9/17/2025, he reported uncontrolled pain. ***Care Coordination*** Discussed fall and current symptoms with bedside nurse. Hospice nurse consulted to adjust pain medications. Labs and vitals reviewed; plan to continue current care.- a Nursing Progress Note, dated 10/07/2025 at 08:56 a.m. by LPN A, CALLED TO PT'S ROOM, HE IS ON THE FLOOR, SAID HE WAS REACHING FOR A BLANKET ON THE FLOOR AND ROLLED OUT OF THE BED ONTO THE FLOOR ON HIS LEFT SIDE, NO OBVIOUS INJURIES NOTED, .RESIDENT PLACED BACK IN THE BED, RESIDENT HAS CHRONIC MOSTLY UNDETERMINED PAIN, AND ANXIETY. Record review of Resident #1's MDS tab on the EMR, undated and accessed 11/07/2025 at 04:09 p.m., revealed Resident #1's last two MDS assessments were a quarterly MDS assessment on 09/15/2025 and 10/27/2025. Record review of Resident #1's Quarterly MDS Assessment, dated 10/27/2025 and signed as completed on 11/03/2025 by the RNAC, reflected assessment observation end date of 10/27/2025. Resident #1 had a BIMS score of 15 indicating he was cognitively intact. Under Any Falls Since Admission/Entry or Reentry or Prior Assessment, Resident #1 was coded as having not had a fall since admission/entry or reentry or the prior assessment. The section for fall history was noted to have been signed as completed by the RNAC. Record review of Resident #1's comprehensive care plan, dated as last care plan review completed 09/09/2025, reflected I am at risk for falls r/t: .10/7/25, date initiated and created 08/16/2025 and revised on 11/07/2025. Interventions included 10/7/25: Fall Risk: *Bolster / Scoop Mattress for safe boundaries to minimize risk for rolling out of bed., date initiated, created, and revised 10/07/2025. During an observation and interview on 11/07/2025 at 01:21 p.m., Resident #1 was observed lying on bed with an air mattress with bolsters and his call light in reach. Resident #1 stated he had a fall at the facility. He stated he slipped out of bed but did not get hurt. He stated he did not need to be sent out to the hospital. During an interview on 11/10/2025 at 02:59 p.m., the RNAC stated the procedure for her knowing if a resident had a fall was to attend the interdisciplinary team meetings in the morning and to review the risk management reports. She stated a resident having had a miscoded fall history on his MDS assessment would not impact his care if the fall was care-planned with appropriate interventions. She stated for Resident #1 she coded there was no falls, but he did have a fall according to a risk</p> | | |