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	12/03/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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 0726 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 have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 of 1 nurse (LVN A) reviewed for competent nursing care.The facility failed to ensure the LVN A practiced nursing within her scope of practice when she conducted an initial admission assessment, initiated a baseline care plane and initiated the comprehensive care plan for Resident #1. This deficient practice affects residents who depend on nursing care and could place residents at risk for incomplete or inaccurate assessment and care plans. The findings included:Record review of Resident #1's face sheet dated 12/02/2025 revealed an admission date of 11/28/2025 with diagnosis which included: acute on chronic combines systolic congestive and diastolic heart failure (heart failure where both sides of the heart are compromised), type 2 diabetes mellitus without complications and primary open-angle glaucoma bilateral stage unspecified (symptomless vision loss due to elevated eye pressure when then eye drainage system fails). Record review of Resident #1's MDS assessments revealed she did not have a comprehensive assessment due to new admission status. Record review of Resident #1's assessment and baseline care plan dated 11/28/2025 revealed as assessment review all body systems was completed including a physical a head-to-toe assessment, vital signs and completion of the baseline care plan signed by LVN B. There was a black check box at the bottom of the form to indicate an RN had reviewed the document that was not marked off as reviewed. Record review of Resident #1's comprehensive care plan initiated on 11/28/2025 included plans of care for: -diabetes, risk for nutritional deficits and/or dehydration, risk for falls, actual or risk for skin impairment, advanced directives/full code status, risk for oral care issues all initiated by LVN B. An RN reviewed and updated the comprehensive care plan on 12/01/2025. During an interview on 12/02/2025 at 4:02 p.m., LVN B stated she was the admitting nurse and completed a head-to-toe assessment and initiated the baseline care plan. She stated she based her assessment on what she can see and what the residents and the family tell her. She stated she can do the baseline care plan as a LVN, but an RN was required to do the comprehensive care plan. LVN B stated Resident #1 was a new admission on [DATE] at approx. 2:00 p.m. She stated she was not prepared for the admission. She stated she did not receive a report, and the resident did not have any paperwork with her. LVN B stated the admission Coordinator told her she was getting a new admission approximately one hour prior to Resident #1 arriving. LVN B stated she was told Resident #1 was a respite hospice patient. She stated the Admissions Coordinator told her the hospice nurse would come to the facility to do her admission. LVN B stated she was aware of the LVN scope of practice. She stated she was able to complete assessments including an initial baseline assessment base on her five senses.what she can see, smell, hear, etc. LVN B stated she had never been told an initial or baseline assessment and care plan must be reviewed or completed by an RN. She stated it is always done by the admitting nurse, and she was that person. LVN B stated Resident #1's admission occurred during day shift on regular weekdays. She stated there was an RN in the building when the admission occurred. During an interview on 12/03/2025 at 1:11 p. m. the DNS (Director of Nursing Services on facility records) that had been promoted but was still in the process of transitioning. She stated she was still providing oversite to the facility in an interim manner for a few more days. She stated her last day as DON was officially 11/21/2025 however she was remaining in the facility as interim DON until the new DON had completed training. She stated she was not sure when that would be. The DNS stated either a licensed or registered nurse was able to complete a new admission. She stated LVN B did conduct the initial assessment which included the baseline care plan for Resident #1. She stated an RN should go behind the LVN within 48 hours and review the assessment and baseline care plan and document the review. She stated on the last page of the baseline care plan and initial assessment there was a place to document the RN review. The DNS stated she did not consider a complete head-to-toe assessment to be a comprehensive assessment, rather each section was considered a focus assessment. The DNS stated there was a part of the initial baseline assessment/care plan that should only be done by an RN and that the care plan interventions. After reviewing Resident #1 care plan she stated acknowledgement that LVN B had completed the baseline care plan interventions, and the document was not signed as reviewed by an RN. The DNS stated the facility had an interdisciplinary team M-F, with a RN on staff should review it and make sure everything was covered. She stated she was not sure why Resident #1's was

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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 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	Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident and determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 4 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1's Lantus (insulin glargine- a long-acting insulin) was administered on 11/28/2025. This failure could place the residents at risk of hyperglycemia (elevated blood glucose levels) and poorly controlled diabetes. The findings included: Record review of Resident #1's face sheet dated 12/02/2025 revealed an admission date of 11/28/2025 with diagnosis which included: acute on chronic combines systolic congestive and diastolic heart failure (heart failure where both sides of the heart are compromised), type 2 diabetes mellitus without complications and primary open-angle glaucoma bilateral stage unspecified (symptomless vision loss due to elevated eye pressure when then eye drainage system fails). Record review of Resident #1's MDS assessments revealed she did not have a comprehensive assessment due to new admission status. Record review of Resident #1's baseline care plan dated 11/28/2025 revealed she had diabetes with an intervention to administer medications as recommended by her doctor. Record review of Resident #1's Order Summary Report revealed a physician order dated 11/28/2025 for Lantus Solostar subcutaneous (under skin into fat) solution pen-injector 100 unit/m. (insulin glargine), inject 35 units subcutaneously at bedtime for hyperglycemia (elevated blood sugar), hold if blood sugar under 60. Record review of Resident #1's November 2025 MAR revealed Lantus Solostar subcutaneous solution pen-injector 100/unit/ml (insulin glargine), inject 35 units subcutaneously at bedtime for hyperglycemia was documented as given by LVN A at bedtime on 11/28/2025. During an observation and interview on 12/02/2025 at 3:05 p.m. Resident #1 was observed in her room and was aware, alert and conversational. She stated she had been in the facility a few days. She stated she had a few rough days but things had started to improve. She stated she had diabetes that was controlled with shots she took before bed each night. She stated she did not think she got her insulin the first night she was at the facility although she had gotten it every night sense them. She stated she had no noticeable effects from not receiving her medication and had not felt ill. She stated she did tell staff, but she was not sure who she told or when. During an interview on 12/02/2025 at 4:42 p.m., LVN A stated she did not give Resident #1 Lantus subcutaneous injection on 11/28/2025 because the resident was a new admission and she assumed the medication had not yet arrived from the pharmacy. She stated she did provide an accuchecks that was documented. She stated she documented administration of Lantus inadvertently when she only meant to document that she had completed the accuchecks. LVN A stated Lantus (insulin glargine) was available in the facility emergency medication e-kit. She stated she did not access the e-kit to give the Lantus. She stated she did not know why. During an interview on 12/03/2025 at 1:11 p.m. the DNS (Director of Nursing Services on facility records) that had been promoted but was still in the process of transitioning. She stated she was still providing oversite to the facility in an interim manner for a few more days. She stated her last day as DON was officially 11/21/2025 however she was remaining in the facility as interim DON until the new DON had completed training. She stated she was not sure when that would be. The DNS stated Lantus was available in the facility e-kit. She stated the e-kit was a large metal medication cart with a computerized log in and password. She stated the nurse had to type in the resident's name, choose the medication listed to have access to the medication in the e-kit. She stated this was based on the physician order for the medication that had been entered into PCC based upon admission. The DNS stated Resident #1 was a hospice respite admission from home. She stated the resident brought her home medication but was unsure what had happened. She stated on 12/02/2025 she discovered the Lantus had not been given as ordered on 11/28/2025 and spoke with LVN A who informed her she was not aware the family had brought the Lantus to the facility. The DNS stated LVN A should have accessed the e-kit if the Lantus was missing and administered the insulin to Resident #1. The DNS stated to administer insulin as ordered because the resident could have developed hyperglycemia. Record Review of the facilities policy titled Medication Administration dated January 2024 revealed: Resident medications are administered in an accurate, safe, timely, and sanity manner.6. Administer medication as ordered by the physician.

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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. Based on interview and record review the facility failed to ensure medical records were maintained in accordance with accepted professional standards and practices for each resident, that were complete and accurately documented for 1 of 4 residents (Residents #1) reviewed for accuracy of medical records. The facility failed to ensure Resident #1's progress notes were documented accurately and according to professional standards of practice when LVN A documented she administered Lantus (insulin glargine-a long-acting insulin) on 11/28/2025 when she did not. This deficient practice could place residents at risk for errors in care and treatment and inaccuracies in documentation. The findings include:Record review of Resident #1's face sheet dated 12/02/2025 revealed an admission date of 11/28/2025 with diagnosis which included: acute on chronic combines systolic congestive and diastolic heart failure (heart failure where both sides of the heart are compromised), type 2 diabetes mellitus without complications and primary open-angle glaucoma bilateral stage unspecified (symptomless vision loss due to elevated eye pressure when then eye drainage system fails). Record review of Resident #1's MDS assessments revealed she did not have a comprehensive assessment due to new admission status. Record review of Resident #1's baseline care plan dated 11/28/2025 revealed she had diabetes with an intervention to administer medications as recommended by her doctor. Record review of Resident #1's Order Summary Report revealed a physician order dated 11/28/2025 for Lantus Solostar subcutaneous (under skin into fat) solution pen-injector 100 unit/m. (insulin glargine), inject 35 units subcutaneously at bedtime for hyperglycemia (elevated blood sugar), hold if blood sugar under 60. Record review of Resident #1's November 2025 MAR revealed Lantus Solostar subcutaneous solution pen-injector 100/unit/ml (insulin glargine), inject 35 units subcutaneously at bedtime for hyperglycemia was documented as given by LVN A at bedtime on 11/28/2025. During an observation and interview on 12/02/2025 at 3:05 p.m. Resident #1 was observed in her room and was aware, alert and conversational. She stated she had been in the facility a few days. She stated she had a few rough days, but things had started to improve. She stated she had diabetes that was controlled with shots she took before bed each night. She stated she did not think she got her insulin the first night she was at the facility although she had gotten it every night sense them. She stated she had no noticeable effects from not receiving her medication and had not felt ill. She stated she did tell staff, but she was not sure who she told or when. During an interview on 12/02/2025 at 4:42 p.m., LVN A stated she did not give Resident #1 Lantus subcutaneous injection on 11/28/2025 because the resident was a new admission and she assumed the medication had not yet arrived from the pharmacy. She stated she did provide an accuchecks that was documented. She stated she documented administration of Lantus inadvertently when she only meant to document that she had completed the accuchecks. LVN A stated Lantus (insulin glargine) was available in the facility emergency medication e-kit. She stated she did not access the e-kit to give the Lantus. She stated she did not know why. During an interview on 12/03/2025 at 1:11 p.m., the DNS stated she was interim DON until the new DON finished training and orientation. She stated LVN A had informed her on 12/02/2025 she made an error in documentation and on 11/28/2025. She stated LVN A informed her she did not give Lantus to Resident #1 as documented. The DNS stated she it was important for staff to follow physician orders. She stated inaccurate documentation could lead others to believe that the medication had been administered when it was not. She stated documenting a med was given when it was not, did not meet the facilities expectations. Record review of a handwritten facility document (undated) indicated the facility did not have a policy for documentation or accuracy of documentation. Record Review of the facilities policy titled Medication Administration dated January 2024 revealed: Resident medications are administered in an accurate, safe, timely, and sanity manner. The policy did not address documentation of medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 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 collaborate with hospice representatives through effective communication for 1 of 2 residents (Resident #1) reviewed for hospice services.The facility failed to collaborate with hospice upon Resident #1 admission on [DATE] to ensure the resident received three glaucoma medications she was taking at home and were detailed on her preadmission home health pre-admission paperwork.This deficient practice could place residents who receive hospice services at risk of receiving inadequate care due to a lack coordination of care, and communication of resident needs and could lead in complications of eyesight. The Findings included: Record review of Resident #1's face sheet dated 12/02/2025 revealed an admission date of 11/28/2025 with diagnosis which included: acute on chronic combines systolic congestive and diastolic heart failure (heart failure where both sides of the heart are compromised), type 2 diabetes mellitus without complications and primary open-angle glaucoma bilateral stage unspecified (symptomless vision loss due to elevated eye pressure when then eye drainage system fails). Record review of Resident #1's MDS assessments revealed she did not have a comprehensive assessment due to new admission status. Record review of Resident #1's baseline care plan dated 11/28/2025 revealed the resident was a hospice respite patient. The section of the checklist care plan for vision impairment was not marked and was blank. Record review of Resident #1's Home Health Care IDG Meeting Review notes uploaded into the resident's medical record prior to her admission by the Admissions Coordinator and dated 11/18/2025 revealed a medication reconciliation list which included:1.Lantanoprost (PF) o.005% eye drops, I drop both eyes at hour of sleep for glaucoma effective 9/29/20252. brimonidine 0. 2% eye drops, one drops both eyes two times daily for glaucoma effective 9/29/2025.3. Cospoft (PF) 2%-0. 5% eye drops 2 drops two times daily in both eyes for glaucoma effective 9/29/2025. Record review of Resident #1's handwritten hospice orders dated 11/28/2025 (date of facility admission) did not include any of the three glaucoma eye drops. The order was signed by the hospice RN and an unknown facility staff member. Record review of Resident #1's Order Summary Report dated 12/02/2025 revealed: 1. Cospopt PF ophthalmic solution 2-0.5%, instill one drop in both eyes two times a day for glaucoma had an order and start date of 12/01/2025. 2. Brimonidine Tartrate ophthalmic solution 0.2%, instill one drop in both eyes, two times a day for glaucoma had an order and start date of 12/01/2025. 3. Latanoprost PF ophthalmic solution 0. 005%, instill one drop in both eyes at bedtime for glaucoma had an order and start date of 12/01/2025. Record review of Resident #1's November 2025 MAR's revealed she did not receive any of the three-glaucoma eye drop medications on 11/28/2025, 11/29/20205, or 11/30/2025. Record review of Resident #1's December 2025 MAR revealed she received her first dose of all three-glaucoma eye drops on 12/01/2025 in the morning. During an observation and interview on 12/02/2025 at 3:05 p.m., Resident #2 was observed in bed, with her walker nearby. She was awake, alert, and conversational. She stated she had been in the facility for several days. She stated she had a rough start. She stated she had glaucoma and took three different medications to treat it. She stated she had the medications in her purse since arrival at the facility and had told the staff about it. She stated yesterday in the evening, she told a male nurse (unknown) and he took the medications from her and said he needed to talk to her doctor about them. She stated she thought she would get the medications that night, but she did not. She stated she did receive them yesterday. Resident #1 stated she did not notice any change in her vision from not receiving her eye drops. She stated she was able to get up by herself and use her walker to without assistance. During an interview on 12/02/2025 at 4:02 p.m., LVN B stated Resident #1 was a new admission on [DATE] at approx. 2:00 p.m. She stated she was not prepared for the admission. She stated she did not receive a report, and the resident did not have any paperwork with her. She stated Resident #1 came with medications in a little bag, some were over the counter and some were prescriptions. LVN B stated the admission Coordinator told her she was getting a new admission approximately one hour prior to Resident #1 arriving. LVN B stated she was told Resident #1 was a respite hospice patient. She stated the Admissions Coordinator told her the hospice nurse would come to the facility to do her admission. LVN B stated the hospice nurse did not arrive until near the end of the shift at approximately 4 pm. LVN B stated the hospice nurse wrote orders for medications from the hospice physician. LVN B stated she then called the facility NP just to notify them that the patient had arrived but not to reconcile medications. She stated she informed the NP that the hospice nurse wrote orders for medications, and she told her it was okay to accept those orders. LVN B stated she