

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/04/2026
NAME OF PROVIDER OR SUPPLIER Stone Oak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Madison Oak Drive 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 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 observation, interview, and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for one (1) of six (6) residents (Resident #1) reviewed for medical records. The facility failed to include documentation to show Resident #1 and/or Resident #1's family member agreed to the resident residing in the locked unit. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included: Record review of Resident #1's admission Record, dated 06/02/2026, revealed an [AGE] year-old female. She was admitted on [DATE]. Resident #1 had three (3) listed contacts: an Attorney for her Emergency Contact #1, a family member as the Emergency Contact #1 (both contacts designated #1) and Resident Representative, and an APS agent. Record review of Resident #1's Medical Diagnosis tab in Resident #1's electronic medical record, undated and accessed 06/02/2026 at 02:06 p.m., revealed diagnoses included encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor, or stroke), panic disorder (a mental health condition characterized by recurrent, unexpected panic attacks and persistent worry about future attacks), neurocognitive disorder with Lewy bodies (also known as Lewy body dementia, a complex brain disorder characterized by the presence of abnormal deposits of a protein in the brain, called Lewy bodies, that affect chemicals in the brain and result in cognitive decline over time), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #1's Quarterly MDS Assessment, dated 05/05/2026, revealed the resident had a BIMS score of 07, indicating she was severely cognitively impaired. She was documented as having the presence of wandering behavior occurred one (1) to three (3) days. She did not use a mobility device and was independent with walking 10 feet to at least 150 feet. Resident #1 and her Significant Other were documented as having participated in Assessment and Goal Setting. Record review of Resident #1's Order Summary Report, dated 06/06/2026, revealed an order, Admit to Secure unit due to behaviors that may include but not limited to: wandering, exit seeking, rummaging, hoarding and disturbed sleep patterns., noted as Active, with an order date of 01/26/2026 and no end date. Record review of Resident #1's Nrsg: Exit Seeking Risk Tool, dated 01/28/2026, revealed under A. History/Behaviors, number six (6) was checked as appropriate, Verbalization: Resident verbalized the need and/or desire to go home or to another location and has the ability to act on that verbalization . and number twelve (12) was checked, Mobility: Resident is physically able to exit on foot or by wheelchair. The section titled Care Plan Decision, Yes was selected for Based on the above assessment, Does the resident display exit seeking behavior?. Record review of Resident #1's Resident and Community Care Agreement [Facility Name], documented as signed 01/29/2026, revealed, 1. Key Definitions in this Agreement.1.4 Community, we, our, and similar terms mean [Facility name]. 4. Consent to Treatment. You authorize us to provide Services to you that are reasonable and medically necessary for your (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675968	Facility ID: 675968 If continuation sheet Page 1 of 3

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 06/04/2026
NAME OF PROVIDER OR SUPPLIER Stone Oak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Madison Oak Drive 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	well-being, health, and safety as we determine in conjunction with you or Your Representative and your Attending Physician and other Authorized Providers., electronically signed by Resident #1 and the Care Navigator on 01/29/2026. The document included Exhibit B Statement of Resident Rights (26 Tex. Admin. Code 554.401 which included the Rights of the Elderly (Tex. Human Resource Code Section 102.003 and was electronically signed by Resident #1 on 01/29/2026 to acknowledge receipt of this Statement of Resident Rights and Rights of the Elderly. Record review of Resident #1's Progress Notes revealed:- dated 01/30/2026 by Psychiatric NP, .Patient seen on locked unit.Patient is .highly confused and anxious, highly repetitive. Was difficult to redirect because she was very forgetful at this visit. and under Assessment and Plan, At this time, patient is not deemed to be safe to join general population for programming due to significant risk for attempt to elope. Confusion levels are too significant for safe community participation.- dated 04/03/2026 by Psychiatric NP, .seen for routine psychiatric reassessment in skilled nursing facility where she resides on locked unit. She continues to need to be placed on locked unit due to severe risk for elopement. Attempt was made to program [trial] patient off of locked unit however she became agitated and did start to exit seek during that episode, so determined that for safety she continues to be needful of locked unit. Record review of Resident #1's IDT: Care Plan Conference & Advanced Care Planning Review, dated effective date and signed on 01/29/2026, revealed the reason for the care plan meeting was for the initial baseline 48-hour care plan. Resident #1's listed contact Attorney was documented as participated and reviewed the updated plan of care. Additional comments were noted to include .currently in memory care. The section titled Acknowledgements- At Risk Areas- Advanced Care Plan: Care Choices .1. Resident/Representative have been educated that, due to advanced age, medical conditions, and/or current medication regimen, the resident is at risk for the following areas: . *At Risk for wandering, elopement, or unsafe exit-seeking behaviors. were checked. Record review of Resident #1's IDT: Care Plan Conference & Advanced Care Planning Review, dated effective date 04/30/2026 and unsigned, revealed the reason for the care plan meeting was a routine care plan review (annual/quarterly/significant change). Resident #1's listed contact family member was documented as participated and reviewed the updated plan of care. The section titled, Acknowledgements- At Risk Areas- Advanced Care Plan: Care Choices . 1. Resident/Representative have been educated that, due to advanced age, medical conditions, and/or current medication regimen, the resident is at risk for the following areas: . *At Risk for wandering, elopement, or unsafe exit-seeking behaviors. were checked. Additional comments were noted to include, He [family member] shared that he still sees significant decline in her cognition and memory at times when he visits and feels she requires the support of memory care for ongoing LTC. Record review of Resident #1's Care Plan, undated and accessed 06/02/2026 at 02:11 p.m., revealed the focus At risk for elopement and/or wandering with unsafe boundaries r/t: cognitive impairment/judgement and safety awareness., date initiated and created on 01/28/2026 with intervention/task, Assess my continued need for residing on the memory care/secure unit as indicated., date initiated and created 02/12/2026. During an observation and interview on 06/02/2026 at 12:06 p.m., Resident #1 was observed in her room, located in the secured unit. During an interview, Resident #1 stated she was not senile (having or showing characteristics of old age, including a loss of mental capacity) but that she had a temper which was what got her here (at the nursing facility in the secured unit). Resident #1 stated she did not belong in the secured unit but also stated she wanted to go home and indicated she would leave the facility if given the opportunity. Resident #1 was observed during the interview to repeat the same stories or facts, which was focused on her family member and stating her family member turned her prior physician and the police against her. Resident #1 stated she was prescribed medication for dementia but would not take it (at home). Resident #1 did not answer when asked about consent for admission or when asked about the admission process and would return to her prior statements about her family member, turning everyone against her. During an attempted interview with Resident #1's APS contact on 06/02/2026 at 02:33 p.m. and on 06/03/2026 at 01:16 p.m., there (continued on next page)		

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 06/04/2026
NAME OF PROVIDER OR SUPPLIER Stone Oak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Madison Oak Drive 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no answer, message(s) were left with a return call not received. During an attempted interview with Resident #1's Attorney and Emergency Contact #1 on 06/03/2026 at 05:17 p.m. and 6/04/2026 01:47 p.m., there was no answer, message(s) were left with a return call not received. During an interview on 06/03/2026 at 03:33 p.m., the Care Navigator stated Resident #1 signed her own admission paperwork with Resident #1's attorney present over the phone for confirmation that Resident #1 was able to sign. During an interview on 06/04/2026 at 01:55 p.m., the ADMIN stated the physician's order was the consent for Resident #1 to be in the secured unit. She stated Resident #1 was admitted to the facility from a hospital with the hospital documentation noting that Resident #1 was exiting seeking and Resident #1's family member was unable to care for her. The ADMIN stated for placement in the secure unit, the facility procedure was for the IDT to meet and review the resident's clinical information, specifically exit seeking behaviors with a low BIMS or cognitive status, and the IDT will discuss the information with the resident and family, and then the physician. She stated residents in the secured unit had to meet criteria and in Resident #1's case, Resident #1 immediately went to the secured unit. The ADMIN stated that Resident #1 signed her admission documentation, referring to document Resident and Community Care Agreement [Facility Name], documented as signed 01/29/2026. During an interview on 06/04/2026 at 02:28 p.m., Resident #1's family member stated Resident #1's attorney assisted with Resident #1's admission to the nursing facility due to him having been in the hospital. Resident #1's family member stated the attorney acted with his permission for Resident #1. He stated he did not know if the attorney signed anything, but he was given paperwork today, 06/04/2026 for it (Resident #1's admission). He stated that the facility called him today, 06/04/2026 and asked if he wanted to keep Resident #1 in the secured unit and he replied yes. During an interview on 06/04/2026 at 05:22 p.m., the ADMIN stated Resident #1's baseline care plan, referring to document IDT: Care Plan Conference & Advanced Care Planning Review, dated 01/29/2026, showed Resident #1's secure unit placement was discussed with Resident #1's Attorney and the quarterly care plan, referring to document IDT: Care Plan Conference & Advanced Care Planning Review, dated 04/30/2026, showed Resident #1's secure unit placement was discussed with Resident #1's family member. Record review of facility policy titled, Criteria for Memory Support Unit, dated February 2017 and date revised January 2023, revealed: Guideline:Residing on the Memory Support Unit (MSU) should be the least restrictive course of action in that it allows the resident's free movement in a safe environment. The following criteria will serve as a guide for admission to and discharge from the memory care support unit (MSU).admission .- Family/RP accepts the admission, transfer, and discharge criteria of the community.		