

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 06/21/2024
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46677</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 resident (Resident #55) of 24 residents reviewed for MDS assessments.</p> <p>The facility failed to ensure Resident #55's quarterly MDS, dated [DATE], accurately reflected she does not have a feeding tube.</p> <p>This deficient practice could place residents at [NAME] of inadequate care.</p> <p>The findings included:</p> <p>Record review of Resident #55's face sheet on 06/19/2024 revealed resident to be a [AGE] year-old female originally admitted to the facility on [DATE]. Resident's diagnoses included Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure) and, feeding difficulties.</p> <p>Record review of Resident #55's care plan, dated 06/05/2024, did not identify Resident #55 as having a feeding tube.</p> <p>Record review of Resident #55's MDS (Minimum Data Set) assessment, dated 05/01/24, revealed the resident had a BIMS score of 4, indicating severe cognitive impairment and was coded as having a feeding tube.</p> <p>Observation of Resident #55 on 06/18/2024 at 12:17 PM revealed resident to be eating lunch by mouth.</p> <p>Interview with the ADON on 06/21/24 at 9:35 AM revealed Resident #55 did not have a feeding tube. The ADON stated Resident #55 eats meals and snacks by mouth. The ADON stated that Resident #55 had not had a feeding tube while ADON had worked at the facility. The ADON also stated to her knowledge Resident #55 has never had a feeding tube while at the facility. When asked, the ADON stated resident might not receive meals or snacks as ordered if she was identified as having a feeding tube causing malnutrition.</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
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the MDS Coordinator on 06/21/24 at 9:41 AM, revealed Resident #55 did not have a feeding tube. The MDS Coordinator stated there were only two residents in the facility with feeding tubes and Resident #55 was not one of them. The MDS Coordinator stated feeding tube must have been checked accidentally during the last assessment. The MDS Coordinator stated resident could be at risk for not receiving appropriate care by being incorrectly identified as having a feeding tube.</p> <p>Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, October 2023 reflected The RAI process has multiple regulatory requirements (1) the assessment accurately reflects the resident's status.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619</p> <p>Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #16, and #58) of 24 residents reviewed for care plans.</p> <p>1. Facility failed to develop and implement a person-centered care plan for Resident #16 to reflect she took an anticonvulsant medication daily.</p> <p>2. Facility failed to develop and implement a person-centered care plan for Resident #16 to accurately reflect she was not on oxygen therapy.</p> <p>These deficient practices could places residents at risk of not receiving required specific care, services and interventions.</p> <p>The findings included:</p> <p>1. Record review of Resident #16's electronic face sheet dated 06/18/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: cerebral atherosclerosis (a disease that occurs when the arteries in the brain become hard and blood flow is decreased), refractory anemia (a genetic condition that is characterized by a low red blood cell count) and unspecified convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking).</p> <p>Record review of Resident #16's significant change MDS assessment dated [DATE] reflected she scored a 7 out of 15 on her BIMS which signified she was moderately cognitively impaired. She could usually be understood and was able to understand. She was dependent on staff for most of her ADL's and she had seizure disorder listed under Active Diagnoses.</p> <p>Record review of Resident #16's comprehensive person-centered care plan revised 06/17/2024 failed to reflect she was on an anticonvulsant medication for seizures.</p> <p>Record review of Resident #16's Active Orders as of: 06/17/2024 reflected Keppra Tablet 250mg, give 1 tablet by mouth two times a day r/t unspecified convulsion, start dated 12/28/2022.</p> <p>Record review of Resident #16's MAR dated 06-01-2024 - 06/30/2024 reflected she received Keppra twice a day for unspecified convulsions.</p> <p>During an interview on 06/21/2024 at 09:00 AM with Resident #16, she stated she was on medication for seizures.</p> <p>Interview on 06/21/2024 at 10:29 AM with the DCR revealed Resident #16's care plan needed to reflect her Keppra because it was a daily part of her care. She stated if the care plan was inaccurate staff could miss important care information and the resident could miss required care.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/21/2024 at 10:47 AM with the DON revealed Resident #16's care plan needed to be accurate for staff to know what type of care the resident required, and it could be missed if the care plan was inaccurate.</p> <p>2. Record review of Resident #58's electronic face sheet dated 06/18/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: dysphagia (swallowing difficulties), atherosclerotic heart disease (hardening of the arteries which results in lack of blood flow) and gastrostomy status (an opening into the stomach from the abdominal wall and a tube is inserted to allow air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food to the patient).</p> <p>Record review of Resident #58's quarterly MDS assessment with an ARD of 05/20/2024 reflected she scored a 9 out of 15 on her BIMS which signified she was moderately cognitively impaired. She could usually be understood and could usually understand. She was dependent on staff for most of her ADL's. She was not on any respiratory treatments.</p> <p>Record review of Resident #58's comprehensive person-centered care plan dated 04/04/2024 reflected Focus, oxygen therapy r/t ineffective gas exchange.</p> <p>Observations on 06/18/2024 at 09:00 a.m., 06/19/2024 at 09:30 a.m. and 06/20/2024 at 1:00 p.m. of Resident #58 revealed she was not on oxygen therapy.</p> <p>Record review of Resident #58's Active Orders as of: 06/20/2024 reflected she had no physician orders for oxygen therapy.</p> <p>During an interview on 06/19/2024 at 10:00 a.m. with Resident #58, she stated she was not recently on oxygen therapy.</p> <p>Interview on 06/21/2024 at 10:29 AM with the DCR revealed Resident #58's care plan should not have reflected she was on oxygen therapy because it was not presently part of her care. She stated if the care plan was inaccurate staff could miss important care information and the resident could receive inappropriate care.</p> <p>Interview on 06/21/2024 at 10:47 AM, the DON revealed Resident #58's care plan needed to be accurate for staff to know what type of care the resident required, and it could be missed if the care plan was inaccurate.</p> <p>Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, October 2023 reflected the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time limits and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 (Resident #58) of 2 residents observed for gastrostomy tube (tube surgically placed through the abdomen to the stomach for feeding and medications) feeding and medication administration via the tube.</p> <p>The facility failed to ensure Resident #58's enteral feeding tube rate was set at 65cc's per hour as the physician ordered and medication flushes were not provided between medication administration as ordered.</p> <p>This deficient practice places residents with gastrostomy tubes for enteral feedings and medication administration at risk for malfunctioning of the tube, pain, and medication adverse reactions.</p> <p>The findings included:</p> <p>Record review of Resident #58's electronic face sheet dated 06/18/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: dysphagia (swallowing difficulties), atherosclerotic heart disease (hardening of the arteries which results in lack of blood flow) and gastrostomy status (an opening into the stomach from the abdominal wall and a tube is inserted to allow air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food to the patient).</p> <p>Record review of Resident #58's quarterly MDS assessment with an ARD of 05/20/2024 reflected she scored a 9 out of 15 on her BIMS which signified she was moderately cognitively impaired. She could usually be understood and could usually understand. She was dependent on staff to help her with ADL's. She had a feeding tube for Nutritional Approaches.</p> <p>Record review of Resident #58's comprehensive person-centered care plan dated 05/04/2024 reflected Focus, receive my formula and medications via G-tube (Gastrostomy tube).</p> <p>Observation on 06/18/2024 at 09:00 a.m., revealed Resident #58's enteral feeding pump infused at 60cc's per hour.</p> <p>Record review of Resident #58's Active Orders as of: 06/14/2024 reflected Enteral Feed Order every shift every shift Formula: Jevity 1.5 at 65cc/hr. x 22h (1320cc/24h formula and (2640kcal/24h) via peg tube by programed pump. H2O</p> <p>flush 200cc q 4h (1290cc/H2O flush/24h) via peg tube by programed pump. Active 06/12/2024</p> <p>Enteral Feed Order every shift Flush Gastric Tube with _30_ CC H2O before and after meds and flush with 5-10CC H2O between each medication administration Active 05/28/2024.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/18/2024 at 10:00 a.m., RN A who was an agency nurse who was assigned to Resident #58, stated she did not really notice what the feeding pump was set at and assumed it was at the right rate. She stated it was important for the feeding to be provided at the right rate because of the calories and nutrition the feeding was calculated to provide to the resident and she could lose weight or not receive the appropriate amount of nutrients. She stated she was trained to provide enteral feedings.</p> <p>Interview on 06/21/2024 at 10:47 AM with the DON, she stated Resident #58's enteral feeding needed to be at the prescribed rate or she could lose weight or valuable nutrients that could result in malnutrition.</p> <p>Upon request by the surveyor on 06/21/2024 at 11:00 PM for a policy or procedure on G-tube management, the Administrator stated there was none.</p> <p>34788</p> <p>Observation on 06/20/24 at 8:58 a.m., revealed while preparing medications for enteral administration for Resident #58, LVN C did not administer the premedication flush of 30 CC of water and did not flush with water between medications.</p> <p>During an interview with LVN C on 06/20/24 at 9:40 a.m., LVN C denied not flushing prior to medications administration and between medication.</p> <p>During an interview with LVN D on 06/20/24 at 9:41 a.m., LVN D, who was also in the room at the time of administration, confirmed LVN C had not done the flushes. LVN C confirmed there was an order for flush before and after and in between medications.</p> <p>During an interview with the DON on 06/21/24 at 10:00 a.m., the DON confirmed flushes must be done, if ordered, prior to administration and in between medications. The DON revealed flushing was important to prevent clogging or blockage of the tubing.</p> <p>Record review of Facility's policy, titled medication administration via enteral tube, dated January 2023, revealed May instill 10-30 ml of water into tube through syringe for patency check. [.] on the medication or treatment sheet record [.] amount of fluid instilled to flush tubing.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive care plan, the resident's goals and preferences for 1 (Resident #16) of 3 residents observed on oxygen therapy.</p> <p>The facility failed to ensure Resident #16's oxygen was set at 2L/min as prescribed</p> <p>This deficient practice affects residents on oxygen therapy and could place them at risk for respiratory distress.</p> <p>The findings were:</p> <p>Record review of Resident #16's electronic face sheet dated 06/18/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: cerebral atherosclerosis (a disease that occurs when the arteries in the brain become hard and blood flow is decreased), refractory anemia (a genetic condition that is characterized by a low red blood cell count) and unspecified convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking).</p> <p>Record review of Resident #16's significant change MDS assessment dated [DATE] reflected she scored a 7 out of 15 on her BIMS which signified she was moderately cognitively impaired. She could usually be understood and was able to understand.</p> <p>Record review of Resident #16's Active Orders as of: 06/17/2024 reflected Continuous Oxygen 2 Liters per N/C every shift for dyspnea (Shortness of breath), start date 05/22/2024.</p> <p>Record review of Resident #16's Licensed Nurse Administration record dated 06-01-2024 - 06/30/2024 reflected she received continuous oxygen at 2L/min and RN A had initialed off for 06/18/2024 day shift.</p> <p>Observations on 06/18/2024 at 10:00 AM, 06/18/2024 at 11:22 AM and 06/18/24 at 2:00 PM. Revealed Resident #16's oxygen concentrator was infusing at 3L/min.</p> <p>During an interview on 06/18/2024 at 10:00 a.m., RN A who was an agency nurse who was assigned to Resident #16, stated she did not really notice what the oxygen concentrator was set at and assumed it was at the right rate. She stated it was for the oxygen rate to be as prescribed because if it was not, a resident could have respiratory distress. She stated she was trained to provide oxygen therapy.</p> <p>Interview on 06/21/2024 at 10:47 AM with the DON revealed Resident #16's oxygen rate needed to be as prescribed or respiratory distress could happen.</p> <p>Upon request by the surveyor on 06/21/2024 at 11:00 PM for a policy or procedure on oxygen therapy or management, the Administrator stated there was none.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</p> <p>Based on observations, interviews and record reviews the facility failed to ensure that nurses were able to demonstrate competency in skills and techniques to provide nursing and related services for 1 of 2 residents (Resident #58) by 1 of 2 nurses (LVN C) reviewed for competent staff, in that:</p> <p>LVN C failed to provide G-tube flushes before medications administration and between medication administration as ordered for Resident #58.</p> <p>These failures could place residents at risk for not receiving nursing services by adequately trained and licensed nurses and could result in a decline in health.</p> <p>The findings included:</p> <p>Record review of Resident #58's electronic face sheet dated 06/18/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Dysphagia (swallowing difficulties), atherosclerotic heart disease (hardening of the arteries which results in lack of blood flow) and gastrostomy status (an opening into the stomach from the abdominal wall and a tube is inserted to allow air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food to the patient).</p> <p>Record review of Resident #58's quarterly MDS assessment with an ARD of 05/20/2024 reflected she scored a 9 out of 15 on her BIMS which signified she was moderately cognitively impaired. She could usually be understood and could usually understand. She was dependent on staff to help her with ADL's. She had a feeding tube for Nutritional Approaches.</p> <p>Record review of Resident #58's comprehensive person-centered care plan dated 05/04/2024 reflected Focus, receive my formula and medications via G-tube (Gastrostomy tube).</p> <p>Record review of Resident #58's Active Orders as of: 06/14/2024 reflected Enteral Feed Order every shift Flush Gastric Tube with _30_ CC H2O before and after meds and flush with 5-10CC H2O between each medication administration Active 05/28/2024.</p> <p>Observation on 06/20/24 at 8:58 a.m. revealed while preparing medications for enteral administration for Resident #58, LVN C did not administer the premedication water flush of 30 CC and did not flush with water between medications.</p> <p>During an interview with LVN C on 06/20/24 at 9:40 a.m., LVN C denied not flushing prior to medications administration and between medication. LVN C confirmed there was an order for flush before and after and in between medications.</p> <p>During an interview with LVN D on 06/20/24 at 9:41 a.m., LVN D who was also in the room at the time of administration, confirmed LVN C had not done the flushes.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 06/21/24 at 10 a.m., the DON confirmed flushes must be done, if ordered, prior to administration and in between medications. The DON revealed flushing was important to prevent clogging or blockage of the tubing.</p> <p>Record review of LVN C's licensed nurse competencies checklist revealed LVN C passed competency for tubing and Medications on 06/18/2024</p> <p>Record review of Facility's policy, titled medication administration via enteral tube, dated January 2023, revealed May instill 10-30 ml of water into tube through syringe for patency check. [.] on the medication or treatment sheet record [.] amount of fluid instilled to flush tubing.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>28619</p> <p>Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>CNA B picked up a resident's roll that had fallen off his tray onto the table with her bare hands and placed the roll onto the resident's dish at lunchtime.</p> <p>This deficient practice could affect residents who dine in the dining room and place them at risk for contamination of food.</p> <p>The findings included:</p> <p>Observation on 06/18/2024 at 12:30 PM during dining observations, CNA B dropped a roll from a resident's tray onto the table. She picked the roll up with her bare hand and placed it onto the resident's plate.</p> <p>Interview on 06/18/2024 at 12:32 PM with CNA B, she stated she should get the resident another rolls because she touched the roll with her hands and that was not sanitary. She did not get the resident at that time another roll, and he continued to eat. CNA B later returned with a roll.</p> <p>Interview on 06/21/2024 at 10:47 AM with the DON, she stated staff were trained to not touch resident's food with their bare hands. She stated staff could contaminate a resident's food and they could become ill.</p> <p>Record review of the facility policy and procedure titled Food Preparation and Handling revised June 1, 2019, reflected Do not allow bare hands to touch food directly.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</p> <p>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 disease and infection for 2 of 8 residents (Residents #41 and #58) reviewed for infection control, in that:</p> <ol style="list-style-type: none"> 1. CNA B did not change gloves and sanitize or wash her hands before touching Resident #41's clean brief during incontinent care. 2. LVN C did not wear gloves to touch Resident #58's medication. <p>These failures could place residents at-risk for infection due to improper care practices.</p> <p>The findings include:</p> <p>Record review of Resident #41's face sheet, dated 06/20/2024, revealed an admitted [DATE], and a readmitted [DATE], with diagnoses which included: Anemia (Blood has a reduced ability to carry oxygen), Mixed irritable bowel syndrome (Functional gastrointestinal disorder causing pain, bloating and loose stool) , Hypertension (High blood pressure), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Hypothyroidism (under active thyroid), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Anxiety (A group of mental illnesses that cause constant fear and worry), Hemiplegia(Paralysis of one side of the body) , Type 2 diabetes mellitus (high level of sugar in the blood), Chronic kidney disease (gradual loss of kidney function).</p> <p>Record review of Resident #41's 5 days MDS assessment, dated 05/05/2024, revealed the resident had a BIMS score of 12 indicating moderate impairment. Resident #41 required extensive assistance to total care, had an indwelling catheter and was always incontinent of bladder and bowel.</p> <p>Review of Resident #41's care plan, dated 05/03/2024, revealed a problem of I require a catheter due to NEUROMUSCULAR DYSFUNCTION OF BLADDER and a goal of I will not experience any complications associated with my catheter to include trauma, infection or pain, dignity concerns through my next review date.</p> <p>Observation on 06/20/24 at 02:51 p.m. revealed while providing incontinent care for Resident #41, CNA B, after cleaning Resident #41's buttocks, touched Resident #41's clean brief without changing her gloves and sanitizing or washing her hands. The resident had bowel movement.</p> <p>During an interview on 06/20/2024 at 3:10 p.m., CNA B verbally confirmed she did not change her gloves and sanitize her hands after cleaning Resident #41's buttocks. She verbally confirmed she received training in infection control and incontinent care.</p> <p>(continued on next page)</p>

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 06/21/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 06/21/24 at 10:00 a.m., the DON verbally confirmed staff should change gloves and sanitize or wash their hands after cleaning a resident and before touching clean briefs. The DON revealed the staff received training on infection control and incontinent care at least annually. The staff skills were check yearly. The ADON spot check the staff while they provided care for infection control and quality of care.</p> <p>Review of facility policy, titled Handwashing/Hand hygiene, dated January 2023, revealed Use an alcohol based hand rub [.] before moving from a contaminated/soiled to clean care or procedures.</p> <p>2. Record review of Resident #58's electronic face sheet dated 06/18/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Dysphagia (swallowing difficulties), atherosclerotic heart disease (hardening of the arteries which results in lack of blood flow) and gastrostomy status (an opening into the stomach from the abdominal wall and a tube is inserted to allow air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food to the patient).</p> <p>Record review of Resident #58's quarterly MDS assessment with an ARD of 05/20/2024 reflected she scored a 9 out of 15 on her BIMS which signified she was moderately cognitively impaired. She could usually be understood and could usually understand. She was dependent on staff to help her with ADL's. She had a feeding tube for Nutritional Approaches.</p> <p>Record review of Resident #58's comprehensive person-centered care plan dated 05/04/2024 reflected Focus, receive my formula and medications via G-tube (Gastrostomy tube).</p> <p>Observation on 06/20/24 at 8:58 a.m., while preparing medications for enteral administration for Resident # 58, LVN C touched one of the capsules to open it with her bare hands.</p> <p>During an interview with LVN C, on 06/20/24 at 9:23 a.m., LVN C confirmed she should have worn gloves to touch the capsule. She confirmed receiving infection control training within the year.</p> <p>During an interview with the DON, on 06/21/24 at 10 a.m., the DON confirmed the nurse should have worn gloves to touch the capsule and open it to prevent cross contamination and infection to the resident. The DON confirmed staff received infection control training within a year and staff's skills were observed and assessed annually.</p> <p>Record review of the facility's policy, titled Medication Administration, dated January 2024, revealed Follow save and sanitary practices [.] use sanitary technique to place medications into a souffle or medication cup{ .] do not touch oral medication, topical ointments, or cream.</p>		