STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676353	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado at Stone Oak	19638 Stone Oak Parkway 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse of residents for 1 of 8 Residents (Resident #1) whose records were reviewed for abuse. The ADM failed to report an allegation of resident abuse within 2 hours after learning about the allegation per facility policy. This deficient practice could affect any resident and contribute to further resident abuse. The findings were: Review of Resident #1' face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of Encounter for orthopedic aftercare following surgical amputation. Review of Resident #1's EHR revealed an initial MDS assessment was not completed. Review of Provider Investigation Report dated 3/19/24 revealed on 3/13/24 at 12 PM LVN A overheard Resident #1 making an allegation of resident abuse about CNA C. Further review revealed the allegation was reported to HHSC on 3/13/24 at 6 PM. Review of LVN A's statement of events dated 3/13/24 read: Today around 1230-PM, medications were due for Resident in room [room number], Resident #1, this nurse pulled medications from cart and took the medications down towards the room, upon knocking to enter the open room, this nurse overheard Resident #1, stating someone that she intended to notify someone about the abuse she is receiving and that the Federal laws are being broken. Upon entering the room, the [name of insurance] Case manager was in the room. Resident #1 proceeded to wrap up the conversation by telling him that it needs to be reported and it's the law. He acknowledged and retreated out of the room and told Resident #1 that he would make notes and report the incidents to the administrator. [Name of CNA] entered room, placed tray on bedside table and uncovered meal. CNA C began tidying up room and picked a blanket off the floor folding it to place it on the dresser to the left of Resident #1. Resident #1 at that point told CNA C I don't appreciate how you wake me up early and frightened me, then you toss me around from side to side , and roll me up to be changed. It's not right and it is abuse. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Coronado at Stone Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 19638 Stone Oak Parkway San Antonio, TX 78258	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Employee Coaching and Counseling Record dated 3/13/24 revealed CNA C was suspended pending investigation due to patient allegation of verbal abuse. Dated of violation was noted as 3/13/24 and time of violation was noted as 1:30 PM. Interview on 4/3/24 at 1:30 PM with CNA C revealed about 1 week ago Resident #1 alleged she was abusing her. CNA C stated Resident #1 complained of pain during pericare (involves cleaning the private areas of a resident). CNA C stated she told Resident #1 she could stop but Resident #1 told her to go ahead. CNA C stated Resident #1 was not assisting when rolling her from side to side. CNA C stated Resident #1 told her she was being abusive and threatened to call the police. She stated the ADM asked to speak with her and suspended her, prior to the end of her shift, about 1:30 PM pending an investigation of alleged abuse. CNA C stated she returned to work the following day. Interview on 4/3/24 at 1:54 PM with LVN A revealed Resident #1 made an allegation of abuse about one week after her admission to the facility. LVN A stated Resident #1 was alert and oriented and able to make her needs known. Resident #1 alleged CNA C was abusive during pericare. LVN A reiterated the details provided in her statement dated 3/13/24. LVN A stated she told ADON D about the allegation of abuse and then they both went to tell the ADM right away. LVN A stated the ADM met with CNA C, sent her home and she wrote her statement. LVN A stated no other residents had complained about CNA C and on the contrary had complimented CNA C regarding her care. LVN A stated CNA C was caring and hard working. Interview on 4/5/24 at 7:15 PM with the ADM revealed he was the Abuse Coordinator. He stated an allegation of abuse was reported to HHSC within 24 hours and within 2 hours if the resident in question sustained serious bodily injuries according to provider letter sent out during 2019. The ADM stated he learned about the allegation of abuse involving Resident #1after he interviewed Resident #1 on 3/13/24. He stated Resident #1 reported CNA C was abusive during pericare and at this point he submitted a report to HHSC at 4 PM. In reviewing the Provider Investigation Report with the ADM, he documented the incident took place at 12 PM. He documented LVN A reported she over heard Resident #1 making an allegation of abuse involving CNA C. He then stated LVN A reported Resident #1 made a suspected allegation of abuse and he did not confirm it until after talking with Resident #1. Review of facility policy Abuse Prohibition Protocol, dated April 2019 read: 2. Our Facility will not condone Patient abuse, neglect, mistreatment or misappropriation of patient property and exploitation (collectively Patient Abuse) by anyone, including staff members, other Patients, consultants, volunteers, staff of other agencies serving the Patient, family members, legal guardians, friends, or other individuals. 10. The Abuse Prevention Coordinator will: a. Immediately (within 2 hours) report to the Department of Aging and Disability Services (DADS) and other appropriate authorities incidents of Patient Abuse as required under applicable regulations and regulatory guidance.

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 27520

Based on interview and record review the facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse for 1 of 8 Residents (Resident #1) whose records were reviewed for abuse.

The ADM failed to report an allegation of resident abuse within 2 hours after learning about the allegation per facility policy.

This deficient practice could affect any resident and contribute to resident abuse.

The findings were:

Review of facility policy Abuse Prohibition Protocol, dated April 2019 read: 2. Our Facility will not condone Patient abuse, neglect, mistreatment or misappropriation of patient property and exploitation (collectively Patient Abuse) by anyone, including staff members, other Patients, consultants, volunteers, staff of other agencies serving the Patient, family members, legal guardians, friends, or other individuals. 10. The Abuse Prevention Coordinator will: a. Immediately (within 2 hours) report to the Department of Aging and Disability Services (DADS) and other appropriate authorities incidents of Patient Abuse as required under applicable regulations and regulatory guidance.

Review of Resident #1' face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of Encounter for orthopedic aftercare following surgical amputation.

Review of Resident #1's EHR revealed an initial MDS assessment was not completed.

Review of Provider Investigation Report dated 3/19/24 revealed on 3/13/24 at 12 PM LVN A overheard Resident #1 making an allegation of resident abuse about CNA C. Further review revealed the allegation was reported on 3/13/24 at 6 PM.

Review of LVN A's statement of events dated 3/13/24 read: Today around 1230-PM, medications were due for Resident in room [room number], Resident #1, this nurse pulled medications from cart and took the medications down towards the room, upon knocking to enter the open room, this nurse overheard Resident #1, stating someone that she intended to notify someone about the abuse she is receiving and that the Federal laws are being broken. Upon entering the room, the [name of insurance] Case manager was in the room. Resident #1 proceeded to wrap up the conversation by telling him that it needs to be reported and it's the law. He acknowledged and retreated out of the room and told Resident #1 that he would make notes and report the incidents to the administrator. [Name of CNA] entered room, placed tray on bedside table and uncovered meal. CNA C began tidying up room and picked a blanket off the floor folding it to place it on the dresser to the left of Resident #1. Resident #1 at that point told CNA C I don't appreciate how you wake me up early and frightened me, then you toss me around from side to side , and roll me up to be changed. It's not right and it is abuse.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Employee Coaching and Counseling Record dated 3/13/24 revealed CNA C was suspended pending investigation due to patient allegation of verbal abuse. Dated of violation was noted as 3/13/24 and time of violation was noted as 1:30 PM. Interview on 4/3/24 at 1:30 PM with CNA C revealed about 1 week ago Resident #1 alleged she was abusing her. CNA C stated Resident #1 complained of pain during pericare (involves cleaning the private areas of a resident). CNA C stated she told Resident #1 she could stop but Resident #1 told her to go ahead. CNA C stated Resident #1 was not assisting when rolling her from side to side. CNA C stated Resident #1 told her she was being abusive and threatened to call the police. She stated the ADM asked to speak with her and suspended her, prior to the end of her shift, about 1:30 PM pending an investigation of alleged abuse. CNA C stated she returned to work the following day. Interview on 4/3/24 at 1:54 PM with LVN A revealed Resident #1 made an allegation of abuse about one week after her admission to the facility. LVN A stated Resident #1 was alert and oriented and able to make her needs known. Resident #1 alleged CNA C was abusive during pericare. LVN A reiterated the details provided in her statement dated 3/13/24. LVN A stated she told ADON D about the allegation of abuse and then they both went to tell the ADM right away. LVN A stated the ADM met with CNA C, sent her home and she wrote her statement. LVN A stated no other residents had complained about CNA C and on the contrary had complimented CNA C regarding her care. LVN A stated CNA C was caring and hard working. Interview on 4/5/24 at 7:15 PM with the ADM revealed he was the Abuse Coordinator. He stated an allegation of abuse was reported to HHSC within 24 hours and within 2 hours if the resident in question sustained serious bodily injuries according to provider letter sent out during 2019. The ADM stated he learned about the allegation of abuse involving Resident #1after he interviewed Resident #1 on 3/13/24. He stated Resident #1 reported CNA C was abusive during pericare and at this point he submitted a report to HHSC at 4 PM. In reviewing the Provider Investigation Report with the ADM, he documented the incident took place at 12 PM. He documented LVN A reported she over heard Resident #1 making an allegation of abuse involving CNA C. He then stated LVN A reported Resident #1 made a suspected allegation of abuse and he did not confirm it until after talking with Resident #1.