

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  11/25/2024
NAME OF PROVIDER OR SUPPLIER  Coronado at Stone Oak		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</b></p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Residents #1) reviewed for medications and pharmacy services, in that:</p> <p>The facility failed to ensure Resident #1's eMAR reflected when she received oxycodone as follows: 10/14 at 12:00 PM, 10/15 08:00 AM, 10/17 12:07 AM, 10/20 03:00 AM, 10/21 at 11:25 AM, 10/22 10:45 AM, 10/23 01:50 PM, 10/23 05:00 PM, 10/26 04:21 AM, 10/27 06:10 PM, 10/29 08:00 PM, 10/30 07:30PM, 10/31 04:30 PM, 11/01 04:30 PM, 11/03/24 01:58 AM, 11/04 08:00 PM, 11/5 08:00 PM, 11/8 08:00 PM, 11/11 08:00 PM, 11/12 08:00 PM, 11/14 08:00 PM, 11/14 (time illegible), and 11/19 12:15 AM, resulting in the missed requirement to assess the effectiveness of this medication.</p> <p>This deficient practice could put residents at risk for pain and anxiety.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission record reflected a female admitted [DATE] with diagnoses to include major depressive disorder, encounter of other orthopedic aftercare, [left femur fracture], stage 2 pressure ulcer of sacral region.</p> <p>Record review of Resident #1's admission MDS, dated [DATE], reflected the resident had a BIMS score of 15 out of 15, indicating intact cognition.</p> <p>Record review of Resident #1's care plan, dated 11/22/24, reflected problem Nursing-Pain Management with interventions to include Assess and monitor pain medications are adequately managing pain and signs/symptoms of complications.</p> <p>Record review of Resident #1's doctor's orders, dated 11/22/24, reflected oxycodone-acetaminophen 5mg-325mg table (1) TABLET Oral for Pain 6-10 out of 10, as needed every four hours starting 10/14/24.</p> <p>Record review of Resident #1's eMAR, dated 11/22/24, reflected oxycodone-acetaminophen 5mg-325mg table (1) TABLET Oral As Needed Every Four Hours Starting 10/14/2024, Order Date: 10/14/2024 . FOR PAIN 6-10/10</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Controlled Drug Receipt/Record/Disposition Form, the DON verbally confirmed nursing staff did not enter pertinent data into Resident #1's eMAR when Resident #1 was taking medication oxycodone-acetaminophen tablet 5-325 MG. She revealed the dates the nursing staff documented oxycodone on her narcotics sheet but did not document in Resident #1' eMAR were: 10/14 at 12:00 PM, 10/15 08:00 AM, 10/17 12:07 AM, 10/20 03:00 AM, 10/21 at 11:25 AM, 10/22 10:45 AM, 10/23 01:50 PM, 10/23 05:00 PM, 10/26 04:21 AM, 10/27 06:10 PM, 10/29 08:00 PM, 10/30 07:30PM, 10/31 04:30 PM, 11/01 04:30 PM, 11/03/24 01:58 AM, 11/04 08:00 PM, 11/5 08:00 PM, 11/8 08:00 PM, 11/11 08:00 PM, 11/12 08:00 PM, 11/14 08:00 PM, 11/14 (time illegible), and 11/19 12:15 AM.</p> <p>During an interview on 11/22/24 at 03:27 PM, the DON revealed the nursing staff should be clicking on something in the electronic medical record, which would give the nursing staff an opportunity to assess for the effectiveness of Resident #1's oxycodone. She got Resident #1's controlled drug receipt/record/disposition form and revealed some nursing staff were not documenting the effectiveness of this medication because they were not filling out the eMAR appropriately. She revealed she oversaw this but had not noted this and the nursing staff were trained to document appropriately.</p> <p>During an interview on 11/22/24 at 04:27 PM, Resident #1 revealed she was given oxycodone when she needed it for pain. She revealed she did not always ask for this medication. She further revealed this medication helped her feel better and decreased the amount of pain she felt.</p> <p>During an interview on 11/25/24 at 11:41 AM, RN B revealed he did not give Resident #1 oxycodone on a regular basis. He revealed he documented the oxycodone appropriately in the eMAR and it was important in order to assess the effectiveness of this medication on Resident #1's pain. RN B further revealed Resident #1 would not ask for this pain medication unless she needed it and Resident #1 did not ask for it everyday.</p> <p>During an interview on 11/25/24 at 12:31 PM, LVN A revealed he failed to document in the eMAR when he administered [oxycodone-Acetaminophen tablet 5-325 MG] because he got busy. He said this was no excuse and he was trained on assessing residents for pain after giving this type of medication. He further revealed he signed it off in narcotics sheet and forgot to sign out in eMAR. He further revealed this was important to assess effectiveness. He revealed Resident #1 was alert and oriented, able to voice needs, and was always in pain. He further revealed Resident #1's pain seemed to improve, and she would ask for pain medication less as time passed.</p> <p>Record review of the facility policy, dated November 2017, titled [Corporate] PATIENT CARE MANAGEMENT SYSTEM 4. Medications, reflected, The details of administration of each PRN medication for a Patient/Resident, including the time of administration, must be noted along with the reason for giving the medication and the effectiveness of the medication.</p>		