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	01/28/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #4) reviewed for quality of care. The facility failed to notify the physician when Resident #4 gained 3 pounds over night between the dates of 1/19/2026 and 1/20/2026) per the orders and facility policy. This failure could place residents at risk of harm, not receiving necessary medical care, and hospitalization.The findings include: Record review of Resident #2's admission Record, printed on 1/27/2026, reflected a [AGE] year-old female who was originally admitted on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included heart failure (heart does not pump enough blood leading to fluid retention) and pneumonia (lung infection which may fill with fluid). Record review of Resident #2's Quarterly MDS Assessment, dated 12/19/2025, reflected the resident had a BIMS score of 8, which indicated she was moderately impaired. She had an active diagnosis of coronary artery disease (narrowing of the coronary arteries due to plaque build-up), heart failure, renal insufficiency (kidneys are not functioning properly to remove waste and maintain fluid balance) and pneumonia. Record review of Resident #2's Care Plan Report, dated as last care plan review initiated 12/10/2025, reflected the focus, Resident requests code status of DNR and intervention, Monitor for decrease in change of condition-report to MD and responsible party. The focus, The resident has altered cardiovascular status r/t CAD/HTN/Heart Failure and intervention, Weigh resident as order. Record review of Resident #2's Order Summary Report, printed on 1/28/2026 for Active Orders as of 1/28/2026, reflected Resident #4 had an order for Daily Weight one time a day related Heart Failure, Unspecified (150.9) Obtain weight every morning before breakfast. If the patient gains 3 lbs overnight or 5 lbs or more in one week, Notify the physician. Record review of Resident #2's Wts (Weights) Vitals tab in the EMR on 1/28/2026 at 19:28 (7:28 PM), reflected Resident #2 weighed 92.6 lbs. on 1/19/2026 and 96.6 lbs. on 1/20/2026 which resulted in a 4 lb. gain overnight. Record review of Resident #2's Progress Notes, dated 12/29/2026 to 1/29/2026 did not reveal a progress note related to the 3 lbs. or more weight gain overnight. A Nutrition Note with an effective date of 01/20/2026 at 13:21 (1:21 PM) reflected, Update-Weight and Wound. Current weight of 92.6# (01/19/2026). A Nursing-Skilled Note on 01/20/2026 at 14:02 (2:02 PM) stated . v/s (vitals) are wnl (within normal limits), no concerns noted at this time. During an observation and interview on 1/27/2026 at 4:15 PM, revealed Resident #4 was sitting in her wheelchair in front of the television with a bedside table in front of her. She was wearing clean clothes and appeared comfortable. Resident #4 stated the facility staff was able to care for her needs and did not really have any concerns about her stay. During an interview on 1/28/2026 at 6:00 PM, the DON stated Overall, the goal was for her to gain weight. We did not notify the MD when she had a 4 lb. gain. The congestive heart failure is the (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676353	A. Building B. Wing	01/28/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reason for the 3 lb. weight gain notification. She is going on hospice due to the weight loss she has experienced. Record review of the facility's Change of Condition Policy, with a date implemented of 10//2025, reflected: Policy:To identify and evaluate a change in condition and notify the Physician andResponsible Party when indicated.A significant change in Resident's status is any sign or symptom that is:Acute or sudden onsetA marked change (i.e., more severe) in relation to usual signs and symptomsNew or worsening symptomsExamples include but are not limited to the following: cardiovascular, respiratory,behavioral, fall with major injury, infection, dehydration, altered mental status,pressure injury and any other condition based on professional judgment.Procedure:When a change in condition occurs, the Licensed Nurse will:Evaluate the signs and symptoms the Resident is experiencing and collectpertinent information to report to the Physician on the Resident's status.A. Obtain vital signs, oxygen saturation and blood sugar, if indicated.B. Review recent labs, if indicated.C. Review Resident history and diagnosis, if indicated.D. Review list of medications the Resident has taken, if indicated.Notify the Physician of the change in condition and advanced directives.Document date, time Physician, Responsible Party was notified of findings from the evaluation and any new orders obtained.The Licensed Nurse will monitor and document the Resident's progress and response to orders given by Physician in the EMR.If it is determined that there is no improvement or resolution in the Resident's condition change, the nurse will notify the Physician for further guidance and document response in the EMR.If the Physician chooses to send the Resident to the hospital for further evaluation and treatment, the charge nurse will initiate the transfer process. Evaluation findings will be documented on the communication tool used to transition the Resident to the next level of care.The Resident's plan of care will be updated accordingly.

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	01/28/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 4 of 4 residents (Residents #1, #2, #3 and #4) reviewed for medical records. 1. The facility failed to ensure Resident #1's ADL-Bathing record recorded a bath or refusal for 1/19/2026, as noted on the electronic medical record. 2. The facility failed to ensure Resident #2's ADL-Bathing record recorded a bath or refusal for 1/2/2026 and 1/19/2026, as noted on the electronic medical record. 3. The facility failed to ensure Resident #3's ADL-Bathing record recorded a bath or refusal for 1/26/2026, as noted on the electronic medical record. 4. The facility failed to ensure Resident #4's ADL-Bathing record recorded a bath or refusal for 12/30/2026, 1/3/2026, 1/6/2026, 1/8/2026, 1/15/2026 and 1/24/2026, as noted on the electronic medical record. These failures could place residents at risk of not receiving necessary care and services to ensure a resident's abilities in ADLs did not deteriorate, promoted proper hygiene and a dignified existence.Findings include: 1. Record review of Resident #1's admission record, printed on 1/27/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's 30-day Task record for ADL-Bathing reflected a preference of Monday, Wednesday and Friday Evening. Based on an admission date of 1/15/2026, Resident #1 did not have a bath entry or refusal for a preferred date of 1/19/2026 (Monday). During an observation and interview on 1/27/2026 at 3:34 PM, Resident #1 was observed in her room laying on her bed. She revealed she was able to take showers on her scheduled days, which she did on her own and she had not missed any showers. 2. Record review of Resident #2's admission record, printed on 1/27/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #2's 30-day Task record for ADL-Bathing reflected a preference of Monday, Wednesday and Friday Evening. Based on an admissions date of 12/31/2026, Resident #2 did not have a bath entry or refusal for a preferred date of 1/2/2026 (Friday) and 1/19/2026 (Monday). During an observation and interview on 1/27/2026 at 4:30 PM, Resident #2 was observed in her room laying on her bed. She revealed she was able to take showers on her scheduled days and one staff member helped her. 3. Record review of Resident #3's admission record, printed on 1/27/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #3's 30-day Task record for ADL-Bathing reflected a preference of Monday, Wednesday, and Friday Days. Based on an admissions date of 1/21/2026, Resident #3 did not have a bath entry or refusal for a preferred date of Monday, 1/26/2026. During an observation and interview on 1/28/2026 at 3:25 PM, Resident #3 was observed in his room laying on the bed. His family member was also in the room. He and his family member revealed he had been at the facility for a short time. He originally stated he had not received a shower, but his family member corrected him stating he received a shower to which he agreed. He stated he was not sure if he had missed a shower. 4. Record review of Resident #4's admission record, printed on 1/27/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #4's 30-day Task record for ADL-Bathing reflected a preference of Tuesday. Thursday and Saturday Evening. Based on an admissions date of 12/10/2026, Resident #4 did not have a bath entry or refusal for a preferred date of Monday, 1/19/2026. During an observation and interview on 1/27/2026 at 4:15 PM, Resident #4 was observed in her room seated in a wheelchair watching television. She revealed she was able to take showers on her scheduled days and staff assisted her. She stated I pay for 3 times a week. I don't take bed baths, but I could. During an interview on 1/28/26 at 4:10 PM, CNA A revealed his (continued on next page)

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	01/28/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsibilities included assisting residents with showers and he was required to document showers on the POC chart. When a resident refused a shower, he revealed he would try to convince them but if they wouldn't, he would tell the nurse and document the refusal. During an interview on 1/28/26 at 3:55 PM, CNA B revealed her responsibilities included assisting residents with showers which she started after checking on every resident at the beginning of her shift. She revealed she was required to document showers and refusals. During an interview on 1/28/26 at 3:45 PM, CNA C revealed his responsibilities included providing residents with baths and she documented the task in EMR. When a resident refused a shower, she revealed she would document the refusal and tell the nurse after a number of refusals. During an interview on 1/28/26 at 4:30 PM, RN D revealed there should be a record for resident showers. She stated baths were documented in the POC, we have a schedule, and it should be documented. We try to accommodate PRN showers. During an interview on 1/28/26 at 4:20 PM, RN E revealed baths were documented every time. She stated, Families will sometimes ask if a resident looks un-showered or they are wearing the same clothes. Then we check EMR and if not documented, we have to ask the CNA. During an interview on 1/28/26 at 5:55 PM, the DON revealed reasons why a bath was not documented could be login issues, times of crisis like the recent freeze, and sometimes they didn't do it, but they should. During an interview on 1/28/26 at 5:45 PM, the ADMIN revealed 90% of entries that were not entered into the EMR were staff moving from task to task and losing track. He stated, in a perfect world, everything would be documented. Record review of the facility's Charting and Documentation policy reflected the following: Policy:Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Policy Explanation and Compliance Guidelines:1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.3. Documentation may be performed manually or as per the facility's specific electronic medical record software program.4. Principles of documentation include, but are not limited to:a. Documentation shall be factual, objective, and resident centered.i. False information shall not be documented.ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided.iii. Subjective information shall be recorded only as relevant, such as the resident's verbalizations, in quotation marks.b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.c. Documentation shall be timely and in chronological order.