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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframe's to meet a resident's medical and nursing needs including the services to be furnished to attain or maintain the resident's highest practicable physical well-being for 1 of 8 Residents (Resident #67) whose records were reviewed for care plans. Nursing staff failed to care plan Resident #67's skin conditions including autoimmune disease (Conditions where the immune system mistakenly attacks healthy body cells)-induced wound to left forearm, autoimmune disease-induced wound to left leg and autoimmune disease-induced wound to left forearm. This deficient practice could affect any resident and contribute to residents not receiving care and services as needed for skin conditions. The findings were: Review of Resident #67's quarterly MDS assessment, dated 2/26/23, revealed she was admitted to the facility on [DATE] with diagnoses including A-fib (an irregular and often very rapid heart rhythm), GERD (a digestive disorder that affects the ring of muscle between your esophagus and your stomach), anxiety and depression disorder. Further review revealed Resident #67's BIMS was 12 of 15 reflecting moderate cognitive impairment. There were also no noted skin conditions for pressure ulcers, other ulcers, wounds and skin problems. Review of Resident #67's Care Plan, revised 2/14/24, revealed she was at risk for pressure ulcer development; however, there was no documentation that she had other skin conditions. Review of Resident #67's wound assessment, dated 4/2/24, revealed she had an autoimmune disease-induced wound to left forearm, 6x4.5xNM (new measurement), moderate serosanguinous drainage (regular drainage of fluid from a wound or incision site after surgery), full thickness, 80% granulated (in the form of grains or particles) with 20% skin, oil emulsion with kerlix and tape, no change; no other skin conditions noted. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67's consolidated physician orders for April 2024 revealed an order read: Adaptic Dressing (non-medicated) Notes: Cleanse Lesion wound to Left forearm with Normal Saline or Skin Cleanser. Pat Dry. cover with Oil emulsion, Calcium alginate and bulky gauze and tape. Order Date: 4/2/2024. Observation and interview 04/02/24 at 11:41 AM with Resident #67 revealed she was lying in bed with with both side rails up. Call light was draped over bed. Noted Resident #67 with skin condition, bandage on left forearm, bilateral lower extremeties, open to air, oozing, significant blisters, scabs/dark black. Resident #67 stated she had an unusual skin condition. She stated she had a wound Dr. who said he never heard of it. She stated the wound Dr. saw her once a week and the wound nurse saw her twice weekly. Resident #67 stated her skin condition started with superficial cuts on her legs and upper left arm caused from being transferred in and out of the wheelchair. Interview on 4/3/24 at 12:30 PM with the DON revealed Resident #67 had a skin condition on her left upper arm and both legs but was not a pressure ulcer. She stated Resident #1 had it off and on for some time but had not healed because she refused to shower. She stated most recently Resident #67 agreed to shower at least once weekly but she only agreed if ADON E showered her. Interview on 4/5/24 at 4:05 PM with MDS Coordinator F and MDS Coordinator G revealed Resident #67 had an autoimmune skin-induced condition on her left upper forearm and on both lower legs that did not fit under any of the categories on the MDS assessment including foot problems, open lesion, other than ulcers, rashes, cuts, surgical wound, burns, skin tear and moisture associated skin damage which was why they did not include it in the assessment dated [DATE]. However, they stated it should be included in the Care Plan. MDS Coordinator G stated Resident #67's skin condition on her the left upper forearm was on the Care Plan related to antibiotic use from 2/13/24 to 3/26/24. She coded it as being resolved, it was closed and removed from the Care Plan. She stated she should have continued the skin condition including the new orders added on 4/2/24 but did not add it. MDS Coordinator F and MDS Coordinator G stated that Resident #67's skin condition on her legs also resolved on 3/26/24 but re-surfaced most recently. They stated the treatment nurse would assess and should add any acute changes per wound assessment but ultimately they were responsible for ensuring all identified new health conditions were added to the Care Plan including a goal and nursing interventions. They further stated all floor nursing staff had access to the Care Plan which served as an education tool about the needs and care the residents should receive. MDS Coordinator G stated the wound care Dr. also completed an assessment of Resident #67's skin condition and entered any new orders. She stated she had not read the wound Dr's assessment of Resident #67's skin and any new orders as of 4/2/24 but knew they were treating Resident #67's legs. MDS Coordinator G stated they were also responsible for including this data into the Care Plan as a new (re-surfaced) skin condition. She stated they had not added Resident #67's skin condition on her legs to the Care Plan either. Interview on 4/5/24 at 4:30 PM with MDS Coordinator F and MDS Coordinator G revealed they were asked to furnish a copy of the facility Care Plan policy. They did not provide a copy by exit on 4/5/24 at 8:15 PM. Interview on 4/5/24 at 5PM with the DON revealed the unit managers, ADON's, were responsible for ensuring the MDS Coordinators added all resident health conditions, behaviors, special circumstances that pertained to the resident to the Care Plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure each resident received assistance devices to prevent accidents for 1 of 1 Resident observed for mechanical lift transfer. CNA I failed to apply the brakes and widened the legs on the mechanical lift when raising Resident #8 into the air and transferring him from the bed to the wheelchair. CNA I also turned the mechanical lift towards the motorized wheelchair by pulling on the sling because there was not enough space for her to maneuver the lift around the foot of the bed and in between the metal shelving unit in front of the foot board. These deficient practices could affect residents who used a mechanical lift for transfers, could cause avoidable falls and residents could sustain serious injuries from a fall from a mechanical lift. The findings were: Review of Resident #8's quarterly MDS assessment, dated 3/22/24, revealed he was admitted to the facility on [DATE] with diagnoses including seizure (a sudden, uncontrolled burst of electrical activity in the brain) disorder, Schizophrenia (is a serious mental disorder in which people interpret reality abnormally), Congenital myopathies (any genetic muscle disorder that is typically noticed at birth and includes weakness and lack of muscle tone), Generalized idiopathic epilepsy and epileptic syndromes (juvenile myoclonic epilepsy (JME), juvenile absence epilepsy ([NAME]), childhood absence epilepsy (CAE), and generalized tonic-clonic seizures (formerly known as grand mal seizure, is defined as a seizure that has a tonic phase followed by clonic muscle contractions and unspecified lack of coordination). Further review revealed Resident #8 was moderately cognitively impaired, had functional limitation on both upper and lower extremities and Resident #8 was dependent for all ADLs including chair/bed-to-chair transfer. In addition, Resident #8's weight was noted as 254 pounds and he was 69 inches (6'9) tall. Review of Resident #8's Care Plan, effective 2/20/2023 - Present read: Transfers (to/from: bed chair wheelchair, standing position) - (Resident #8) is totally dependent on the staff. (Resident #8) will be out-of-bed daily (as tolerated); transfers will be completed by the staff (hoyer lift). Transfer using the transfer board/lift devices Hoyer lift, STATUS: Active (Current) Nursing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation during a mechanical lift transfer on 4/3/24 at 11:35 AM revealed Resident #8 was lying flat in bed with the sling positioned underneath him. CNA I operated the mechanical lift while CNA H guided Resident #8 in the sling. CNA H lifted the bed to accommodate the lift under the bed. CNA I pushed the lift underneath the bed, she did not widened the legs on the base. CNA H and CNA I attached the yellow and black openings to the swivel of the lift CNA I lifted Resident #8 into the air, while suspended Resident #8 was in a sitting position. CNA I did not lock the wheels on the mechanical lift before lifting Resident #8 into the air CNA I then started pulling the lift backwards away from the bed while CNA H guided Resident #8 in the sling. CNA I then started turning the base of the left to the left but was unable to completely turn it and pull the base out from underneath the bed because she did not have sufficient space between the foot of the bed and the metal shelving unit positioned on the wall across the foot of the bed. CNA I did not fit in the space and at this time started pulling the sling back while she held on to the center poll until she pulled the base of the mechanical lift completely out and away from the bed. CNA I turned the mechanical lift facing the motorized wheelchair and then widened the base of the lift and positioned the legs around the motorized wheelchair. Resident #8 was suspended over the motorized wheelchair. CNA H made sure the wheelchair was locked and CNA I lowered Resident #8 into the motorized wheelchair. She did not lock the wheels before she lowered Resident #8. Both CNA H and CNA I asked Resident #8 if he was ok and he stated yeah. They unhooked the sling from the swivel. Interview on 4/3/24 at 11:42 AM with CNA I revealed she had worked at the facility for about 1 year. She stated she had operated a mechanical lift between 18 months to 2 years but had not received training while employed at the facility. CNA I stated she believed the legs on the lift should be widened and should be in the locked position, but was not positive because had not received training. She stated she did not widened the legs on the lift until she positioned it around the motorized wheelchair. She stated she also did not lock the wheels when she lifted Resident #8 up from the bed and when she lowered Resident #8 into the motorized wheelchair. She stated it made sense to widened the legs which would provide stability while transferring the resident. Locking the wheels would prevent it from moving and both would prevent the lift from tilting over while transferring the resident. CNA I stated Resident #8 could be seriously hurt if the lift tilted and the Resident fell to the floor. CNA I stated she pulled on the sling to pull the base from under the bed so she could turn the lift around. She stated there was not enough room for her to maneuver the lift from between the foot of the bed and the shelving unit on the wall. CNA I stated she held on to the center poll to provide stability but was not sure if she should or should not pull on the sling to maneuver the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/5/24 at 10:38 AM with ADON J revealed she had worked at the facility for two years. She stated the legs on a mechanical lift should be widened when positioned under the bed and the wheels should be locked before lifting a resident into the air and before lowering the resident into the wheelchair. She stated widening the legs would provide stability and would keep the lift from tilting over especially with someone like Resident #8. She stated he was a big guy. She stated locking the wheels would prevent the mechanical lift from rolling. ADON J stated she understood CNA I did not widen the base or lock the wheels and had talked with her about to properly operate a mechanical lift. She stated she also understood CNA I pulled on the sling to pull the lift from underneath the bed because of the limited space between the foot board and the shelving unit in front of the bed. She stated should did not believe pulling on the sling to maneuver the lift was a safety hazard because CNA I was holding the center poll at the same time. She stated Resident #8's mother insisted on positioning the furniture in the room and insisted staff did not move it. ADON J stated that operating the mechanical lift in the manner that CNA I did was a safety hazard and could cause the lift to tilt and Resident #8 could have fallen. Review of a facility document titled, Full Mechanical Lift Safety Guidelines, undated, read: When transferring from/to a wheelchair, shower chair or bed, make sure that the wheels are in the locked position.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure the bed's dimensions are appropriate for the resident's size and weight for 1 of 8 Residents (Resident 8) whose records were reviewed for the use of side rails. The facility failed to ensure the size of the mattress was compatible with the bed frame resulting in a significant gap between the mattress and the side rails. This deficient practice could affect any resident using a side rail and could result in avoidable injury to the resident. The findings were: Review of Resident #8's quarterly MDS assessment, dated 3/22/24, revealed he was admitted to the facility on [DATE] with diagnoses including seizure (a sudden, uncontrolled burst of electrical activity in the brain) disorder, Schizophrenia (is a serious mental disorder in which people interpret reality abnormally), Congenital myopathies (any genetic muscle disorder that is typically noticed at birth and includes weakness and lack of muscle tone), Generalized idiopathic epilepsy and epileptic syndromes (juvenile myoclonic epilepsy (JME), juvenile absence epilepsy ([NAME]), childhood absence epilepsy (CAE), and generalized tonic-clonic seizures (formerly known as grand mal seizure, is defined as a seizure that has a tonic phase followed by clonic muscle contractions and unspecified lack of coordination). Further review revealed Resident #8 was moderately cognitively impaired, had functional limitation on both upper and lower extremities and Resident #8 was dependent for all ADLs including chair/bed-to-chair transfer. In addition, Resident #8's weight was noted as 254 pounds and he was 69 inches (6'9) tall. Review of Resident #8's Care Plan, effective 2/20/2023 - Present read: Transfers (to/from: bed chair wheelchair, standing position) - (Resident #8) is totally dependent on the staff. (Resident #8) will be out-of-bed daily (as tolerated); transfers will be completed by the staff (hoyer lift). Transfer using the transfer board/lift devices Hoyer lift, STATUS: Active (Current) Nursing. Assist Rail(s) - Quarter Rail(s) required as enabler in order to promote as much independence as possible. Observation of Resident #8's room on 04/02/24 at 11:57 AM revealed the bed was moved away from the wall. There was about a 14 x 14 inch cushion wedged between the mattress and the side rail on both sides. The side rails were both up. Interview on 4/3/24 at 11:06 AM with LVN K revealed the cushions between the side rails and the mattress on Resident #8's bed were used for comfort. He stated they did not keep Resident #8 from moving while in bed and was not a restraint. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/3/24 at 11:25 AM revealed Resident #8 was lying in bed with both side rails up. There was about a 14 x 14 inch cushion wedged between the mattress and the side rail on both sides. Resident #8 had his arms propped up on the cushions. During attempted interview, Resident #8 was not able to speak clearly and was not understood. Observation after a mechanical lift transfer on 4/3/24 at 11:35 AM revealed Resident #8's mattress was exposed. The pillows had been removed and the mattress did not have sheets. It was an air mattress and did not include bolsters. The mattress did not cover the interior bed f frame and the edging of the frame was visible. The spacing between the mattress and each side rail was significant and between 7 to 10 inches. Interview on 4/3/24 at 11:42 AM with CNA I revealed she had never noticed how small the mattress was considering Resident #8 was a big guy. She said she was not sure if it was one of their mattresses or if Resident #8's RP had brought it in. CNA I stated at one point the RP had a couple of mattresses stored in the bathroom. She looked in the bathroom and stated they were gone. CNA I further stated she had never noticed how big the gap was between the side rail and the mattress. She stated if she had to guess there was about a 7 -inch gap and could be a safety hazard. CNA I stated the gap was large enough for Resident #8 to get his head or limb stuck. Observation and interview on 4/3/24 at 11:50 AM revealed ADON J was walking down the hall with a mattress overlay with bolsters. Upon walking into Resident #8's room, ADON J stated the spacing between the mattress and the side rail was too much and she was going to apply the overlay to reduce the space between the mattress and side rails. ADON J stated Resident #8 was a big guy and didn't want him to get hurt. Interview on 4/3/24 at 2:29 PM with the MS revealed he had been employed for the facility since 2/26/24 and was not familiar with the requirements of using side rails. He stated he worked at 2 other nursing facilities but side rails were not used. Interview on 4/3/24 at 2:40 PM with the ADM revealed he was the MS' immediate supervisor. He stated he had oriented the MS to the layout of the facility and talked to him about the expectations for about one week and a master MS from another building provided the new MS some training for about 1 week. The ADM stated the MS was normally responsible for ensuring the dimensions of the mattress were appropriate for the bed frame used for each one of the residents; however the MS had been in his position less than a month. The ADM stated he was not familiar with the acceptable dimensions between a mattress and side rail that were considered to be safe. He stated he would have to confer with their management in the Corporate office. Interview on 4/3/24 at 4:15 PM with the ADM revealed he went to look at Resident 8's bed. He commented, I see what you mean about the mattress and the spacing between the rails. The mattress is really small and I don't think it's even one of our mattresses. He stated he replaced the mattress and threw the old one away. Surveyor alerted him that Surveyor had not taken measurements and needed to take measurements of the mattress. The ADM asked if he should retrieve the mattress and Surveyor responded yes, I need to take measurements. He stated he could also take a picture of the asset tag on the discarded mattress to look up the measurements. Surveyor stated I would prefer to take measurements of the mattress you threw away. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/5/24 at 9 AM with the ADM revealed he presented a manual for the bed frame and mattress used in the facility. He stated the width of the bed frame was 42 inches and the width of the mattress was 36 inches. The space between the mattress and side rail should not exceed 4 and 3/4 inches between the mattress and the side rail which were the measurements he took. He stated he replaced the mattress but the width was the same as the old mattress that was discarded. He commented, you can look at it yourself. Observation on 4/5/24 at 9:10 AM of Resident #8's bed revealed the mattress on the bed was a bigger and wider mattress with bolsters on both sides which occupied most of the space between the mattress and the side rails. The cushions which were wedged between the mattress and the side rails were no longer used. It was not the same mattress that was observed on 4/2/24 and 4/3/24. Interview on 4/5/24 at 10:38 AM with ADON J revealed she did not apply the overlay with the bolsters on Resident #8's bed because the ADM went in and replaced the old mattress with a bigger mattress that same day. ADON J stated she noted the difference in the spacing between the mattress and the side rails. She stated the new mattress fit closer to the side rail and the gap was not so wide.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47622 Based on observation, interviews, and record reviews, the facility failed to store, distribute, and serve food in accordance with professional standards for food service safety for 1of 2 (Willow Unit) nutrition rooms reviewed for storage: 1. The refrigerator on [NAME] Unit had a red sticky substance from spilled liquids on the shelves, on the door, and on the bottom shelf where nutritional supplements were stored for the residents. 2. The freezer on [NAME] Unit had food particles and stains from spilled liquids which had dried, a strand of hair on the floor of the freezer compartment where there were packages of food stored. 3. The ice machine on [NAME] Unit had a large amount of white hard water stains that had come from the vent of the ice maching and a black residue on the inside above the ice on the outlet where ice is dispensed into the unit. These failures could place 12 of 45 residents who receive snacks from the nutrition room at risk for food borne illness and contamination of food by airborne particles Findings included: During observation on 04/02/24 11:00 AM of the nutrition room on [NAME] Unit with the Dietary Manager, revealed the refrigerator had red sticky substance dried on the shelves, door and the bottom shelf of the refrigerator where nutritional supplements were stored for residents. Further observation revealed there were also small cartons of fruit punch and apple juice, puddings and sandwiches stored in the refrigerator. In the freezer there were stains fro spilled foods and a strand of hair on the floor of the freezer compartment where packages of food were stored. Inside the ice machine there was a black residue on the inside above the ice, and on the outside of the machine there were white-colored hard water stains down the side of the unit coming from the vent area. During an interview with the Dietary Manager on 04/02/24 at 11:00 AM , the Dietary Manger confirmed the refrigerator, freezer and the ice machine were not clean, and further stated he was not sure if it was the facility's dietary staff or the nurses that was responsible for cleaning the refrigerator, freezer, and ice machine in the nutrition room on [NAME] Unit. He stated it was important to keep the refrigerator and the freezer clean to avoid food contamination that could spread food borne illnesses to the residents. During an interview on 04/02/24 at 12:00 PM with the Administrator, he stated it was part dietary duty to keep the refrigerator and freezers clean in the nutrition rooms on the units. The Administrator stated the ice machine should be monitored by dietary but maintenance cleans the ice machine because of the technical components of cleaning the machine. The Administrator further stated the ice machine on [NAME] had issues he suspected it may be a seal issue. stated The Administrator stated the nurses should help to keep the refrigerator and the freezers clean in the nutrition rooms on the units as well. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy for food storage in refrigerators titled Nutrition Services Policy & Procedures Food Production & Food Safetydated March 2009; Rev 3/2019, revealed, All refrigerator units are kept clean and in good working condition at all times. Record review of the facility's policy for ice machines titled, Ice Machines and Ice Storage Chests dated (Revised January 2012) policy statement revealed ,Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice . 1. Ice-making machines, ice storage chests/containers, and ice can all become contaminated by: unsanitary manipulation by employees, residents, and visitors; waterborne microorganisms naturally occurring in the water source; colonization by microorganisms; and/or improper storage or handling of ice . 3. Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions.