

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455789	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2024
NAME OF PROVIDER OR SUPPLIER  Oak Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7302 Oak Manor Dr San Antonio, TX 78229	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42402</p> <p>Based on interviews and record review, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for clinical records.</p> <p>The facility failed to ensure Resident #1's EMR reflected accurate wound care documentation on 10/24/2024, 10/26/2024,10/27/2024 and 10/31/2024.</p> <p>These deficient practices could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, computer dated 11/8/2024, revealed he was a [AGE] year old male with an initial admitted [DATE] and readmitted on [DATE] with diagnoses which included cerebral vascular accident(cva-medical term for a stroke. When blood flow to a part of the brain is stopped.), left side affected, Diabetes Mellitus 2( the body has a problem regulating sugar and the way it uses it.), hyperlipidemia(abnormally high levels of fat in the blood, it can cause blocked arteries and can lead to serious health conditions),anxiety(excessive,persistent and uncontrollable worry and fear about everyday situations),dementia(deterioration in mental status),arterial sclerotic heart disease(plaque buildup in the artery walls. can cause conditions such as heart attack and peripheral artery disease(disorder of blood vessels can affect the legs,feet,brain and other organs.).</p> <p>Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 13, which indicated cognitively intact.</p> <p>Record review of Resident #1's Care plan dated 9/6/2024 with revision 10/10/2024 revealed the resident had a diabetic ulcer of the right lateral foot related to diabetes pressure ulcer or potential for pressure ulcer development. 10/15/24-Stage 4 decubitus left heel.</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 0842</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 physician Order Summary Report dated 10/1/2024-10/31/2024 revealed the following wound treatment orders: Right foot diabetic ulcer proximal Phalanx of great toe: cleanse with normal saline, pat dry with 4 x 4 gauze, apply skin prep to peri wound apply santyl to wound bed, cover with calcium alginate and dry dressing every day shift. (start date 9/5/2024 dc date 11/3/2024). Wound care left heel deep tissue injury with open area: cleanse with normal saline and or wound cleanser, pat dry with 4 x 4 gauze, apply santyl nickel thick to wound bed, cover with calcium alginate and cover with bordered gauze dressing every day shift for wound healing. (start date 10/18/2024-10/31/24). (10/15-10/17/2024) Wound care left heel deep tissue injury with open area: cleanse with normal saline and or wound cleanser, pat dry with 4 x 4 gauze apply calcium alginate and cover with bordered gauze dressing every day shift for wound healing.</p> <p>Record review of Resident #1's TAR (treatment administration record) for October 2024 revealed there were blank spaces for Resident #1's treatment administration for the following days: 10/24/2024, 10/26/2024, 10/27/2024 and 10/31/2024.</p> <p>Record review of facility staffing sheet for October 2024 revealed LVN A worked on 10/24/24 and Treatment Nurse worked on 10/26, 10/27, 10/31.</p> <p>During an interview on 11/12/2024 at 10:15 am LVN A stated she worked on 10/24/2024 but forgot to sign (Resident #1's) TAR after doing Resident #1's treatment on his feet. She further revealed it was a very hectic day and she just did not go back and sign the sheet, but she did do his ordered treatments on his feet. She stated it was important to document when a treatment was done.</p> <p>During an interview on 11/12/2024 at 10:35 am Treatment Nurse stated he worked on 10/26/24, 10/27/24 and 10/31/2024 but forgot to sign (Resident #1's) TAR after doing Resident #1's treatment on his feet. He stated it was very important to document when a treatment was done so that it showed it was done.</p> <p>During an interview on 11/12/2024 at 2:00 p.m. facility DON confirmed LVN A and Treatment Nurse did not document on the wound administration record on 10/24/2024, 10/26/2024, 10/27/2024 and 10/31/2024 for Resident #1. The DON stated the treatments were most likely done but were not documented. Further interview with [NAME] revealed it was her expectation for staff to document in the electronic record of each resident whenever a treatment was done.</p> <p>Record review of the facility's policy titled Charting and Documentation dated 2001 revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response of care. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided and the name and title of the individual who provided the care.</p>		