STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455789	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Nursing and Rehabilitation Center	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)
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** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 1 of 7 residents (Residents #1) reviewed for care plans. The facility failed to update Resident #1's care plan to reflect that Resident #1 did not have a video monitoring device in her room. This failure could place residents at risk of not having their needs met and not receiving appropriate care. The findings included: Record review of Resident #1's admission record, dated 05/12/2026, reflected a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dementia (decline in cognitive functions (memory, reasoning, and thinking) which interferes with daily life) and lack of coordination. Record review of Resident #1's quarterly MDS assessment, dated 03/09/2026, reflected Resident #1 had a BIMS score of 0 out of 15, indicating severe cognitive impairment. Record review of Resident #1's care plan, undated, reflected focus of Video Monitoring. [Resident #1]'s family have chosen to install a video monitoring device in her room., initiated 11/06/2025. During an observation and attempted interview on 05/12/2026 at 10:54 AM, Resident #1 was sitting in her wheelchair and would not respond to any questions that were being asked. Observation of Resident #1's room revealed no video cameras were in her room. During an interview on 05/13/2026 at 09:51 AM, Resident #1's RP revealed she put a video camera in Resident #1's room to monitor Resident #1. She revealed she did not know what happened with the video camera or when it went missing but had not been able to follow up with the facility about this yet. During an interview on 05/13/2026 at 11:30 AM, LVN B revealed Resident #1 did not have a video camera in her room. She revealed the resident was in another hallway before being in her current room so she assumed that the video camera may have gotten lost while the resident was being transferred or the family took the video camera home. She revealed the resident's RP visited frequently and the RP had never voiced that Resident #1 was missing a video camera in her room. LVN B reviewed Resident #1's care plan and confirmed that the care plan reflected that Resident #1 was supposed to have a video camera in her room. During an interview on 05/13/2026 at 01:30 PM, the MDS nurse revealed that Resident #1 did not have video camera in her room, so she updated Resident #1's care plan to reflect Resident #1 did not have a video camera in her room. During an interview on 05/13/2026 at 02:28 PM, the DON revealed Resident #1's care plan was not updated to reflect that Resident #1 did not have video cameras in her room. She revealed the facility did not provide video cameras so they could not follow the care plan for Resident #1. The DON revealed Resident #1 did have a video camera in her room at one point and she was unsure when the video camera went missing. Record review of the facility's policy Care Plans, Comprehensive Person-Centered, revised December 2016, reflected .12. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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
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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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility with more than 120 beds failed to employ a qualified social worker on a full-time basis, for 1 of 1 social services staff reviewed for qualifications of Social Worker. The facility failed to employ a full-time social worker since April 15, 2026 when the facility was licensed for 170 beds. This failure could place residents at risk of social service and psychosocial needs not being met. The findings included:Record review of the Facility Summary Report, accessed on 05/11/2026, reflected the facility had 170 licensed beds. Record review of the facility's staff roster, undated, reflected there was no social worker employed at the facility. During an interview on 05/21/2026 at 08:50AM, ADON A revealed they did not have a social worker because this facility was a high turnover building when it came to staff. He revealed they had a part time social worker in the meantime. During an interview on 05/13/2026 at 11:45AM, the ADM revealed they did not have a full-time social worker, but they did have a part time social worker. He revealed on April 15th, 2026, the former social worker gave him a 30-day notice that he would no longer be working at the facility, but the former social worker ended up leaving on April 22nd, 2026. The ADM further revealed that the part time social worker and other staff like the MDS nurse were trying to catch up on work that was done by the social worker like resident assessments and addressing any concerns from the residents. Email communication on 05/13/2026 at 01:06 PM with the ADM revealed the facility hired a full-time social worker who would start on Monday May 18th, 2026. A policy about having a social worker was requested 05/13/2026 at 10:55 AM. The DON revealed the facility did not have the policy but followed the regulations.