| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455789 | A. Building<br>B. Wing | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oak Park Nursing and Rehabilitation Center | 7302 Oak Manor Dr<br>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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 4 residents (Resident #2 and #3) reviewed for MDS assessment accuracy.1. The Quarterly MDS Assessment for Resident #2 failed to accurately document the percentage of calories the resident received through the gastrostomy tube (a tube inserted into the stomach to administer medications and nutritional supplements; a feeding tube).2. The 5-Day MDS Assessment for Resident #3 failed to accurately document the resident had an indwelling urinary catheter.This failure could lead to residents not receiving the required care and decreased quality of life.The findings included:1. Record review of Resident #2's admission Record (Face Sheet), dated 5/29/26, revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included intracerebral hemorrhage (bleeding in the brain), protein calorie malnutrition (inadequate intake of calories or protein), aphasia (inability to speak), dysphagia (swallowing difficulties), hemiparesis (partial paralysis), and gastrostomy tube.Record review of Resident #2's MDS, a quarterly assessment dated [DATE], revealed her BIMS score was 0 out of 15, indication of severe cognitive impairment; and Section K was coded that Resident #2 had a feeding tube and received 51% or more of her total calories through the feeding tube.Record review of Resident #2's care plans revealed a care plan initiated on 09/28/2021 for being at risk for unplanned/unexpected weight loss with an intervention of administration of 1 can of Jevity 1.5 via gastrostomy tube if meal intake less than 50% and was revised on 05/21/2026.Record review of Resident #2's Physician's Order Summary Report, dated 05/31/2026, revealed an order for a pureed diet with nectar consistency liquids with a start date of 10/26/2025.Record review of Resident #2's Physician Order Summary Report, dated 05/31/2026, revealed an order to provide 1 can of Jevity 1.5 (a high calorie enteral nutritional supplement) via the gastrostomy tube if oral intake of meal was less than 50% as needed; and there were no further orders for enteral nutritional supplements to be administered via the gastrostomy tube.Record review of Resident #2's Task Sheet for Nutrition Amount Eaten from 05/17/2026 to 05/22/2026, revealed she consumed 75-100% of her meals.Record review of Resident #2's Skilled Administration Record for May 2026 revealed Resident #2 did not receive any bolus feeding (larger volume in a short period) of the enteral nutritional formula Jevity 1.5 through the gastrostomy tube from 05/17/2026 to 05/22/2026 and had not received any calories from the formula.In an interview on 05/31/2026 at 8:41 AM, LVN C said Resident #2 had a gastrostomy tube, but she also had an oral diet which she ate really good, and the nurse had not administered the Jevity 1.5 enteral nutrition formula.In a telephone interview on 05/31/2026 at 3:00 PM, MDS Nurse RN B said Resident #2 did not receive any bolus tube feeding of the Jevity 1.5 in May 2026 after she reviewed the resident's chart, and stated she should have checked on the MDS Section K that Resident #2 received 25% or less of her total calories from the feeding tube. 2. Record review of Resident #3's admission Record, dated 05/31/2026, revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included encephalopathy (a disease of the brain causing cognitive impairment) and neuromuscular dysfunction of the bladder (lack of bladder control due to nerve problems).Record review of Resident #3's MDS, a 5-day scheduled assessment (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 |
|---|---|---|

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dated [DATE], revealed a BIMS score of 0 out of 15, indication her cognitive skills were severely impaired; and under Section H it was checked the resident did not have an indwelling urinary catheter.Record review of Resident #3's care plans revealed a care plan initiated on 05/15/2026 for an indwelling urinary catheter.Record review of Resident #3's Order Summary Report, dated 05/31/2026, revealed an order for an indwelling urinary catheter and care to the catheter with a start date of 05/18/2026.Record review of Resident #3's May 2026 Skilled Administration Record revealed urinary catheter care was provided as ordered every shift from 05/18/2026 to 05/31/2026.Observation on 05/30/2026 at 11:18 AM of Resident #3 revealed she was lying in bed and had an indwelling urinary catheter.In a telephone interview on 05/31/2026 from 3:00 PM to 3:12 PM, MDS Nurse RN B said Resident #3 was recently readmitted to the facility with an indwelling urinary catheter and the MDS dated [DATE] should have been checked that the resident had an indwelling urinary catheter. MDS Nurse RN B stated she would look at the resident's physician's orders and the TARs when completing the MDS to ensure it was accurate.In an interview on 05/31/2026 from 3:20 PM to 3:48 PM, the DON said she would review quality measure reports and the CMS 802 Resident Matrix form to ensure residents' MDS assessments were completed accurately and could not think of any harm that could occur to a resident if the MDS was not accurate.In an interview on 05/31/2026 at 4:06 PM, the Administrator said daily meetings were held in the morning with the interdisciplinary team and assessments of residents would be reviewed at that time to ensure they were completed; and the MDS assessment needed to be reflect the residents' condition.Record review of CMS's RAI Version 3.0 Manual, Chapter 3: MDS Items Section K, page K16, revealed to 1. Review intake records within the last 7 days to determine actual intake through . tube feeding routes. 2. Calculate proportion of total calories received through these routes.Record review of CMS's RAI Version 3.0 Manual, Chapter 3: MDS Items Section H, page H1 to H3, revealed Steps for Assessment 1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary bowel appliances.Coding Instructions: Check next to each appliance that was used at any time in the past 7 days.Record review of the Resident Assessments policy, Revised 2019, revealed A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records on each resident that were complete and accurately documented for 1 of 4 residents (Residents #1) reviewed for consents for accurate medical records.The facility failed to ensure LVN A documented wound care was provided to Resident #1 on 05/24/2026.This failure could place residents at risk for inaccurate medical records.The findings included:Record review of Resident #1's admission Record (Face Sheet), dated 05/29/2026, revealed she was admitted on [DATE], and readmitted on [DATE] and was discharged on 05/27/2026; and diagnoses of anemia (low iron stores in the blood), atrial fibrillation (irregular heartbeat), dementia (impaired cognitive function that affects activities of daily living), atherosclerotic heart disease (plaque buildup in the blood vessels), and high blood pressure.Record review of Resident #1's MDS, an annual assessment dated [DATE], revealed a BIMS score of 1 out of 15, indication of severe cognitive impairment.Record review of Resident #1's care plan revealed a care plan initiated on 06/16/2021 for the potential for pressure ulcer development related to impaired mobility was revised on 04/10/2026.Record review of Resident #1's Weekly Skin/Wound Documentation, dated 05/22/20226, revealed an unstageable pressure ulcer (bed sore) was identified on her left plantar (bottom of the foot), the physician was notified and treatment orders were placed; and Resident #1's Responsible Party was notified.Record review of Resident #1's Order Summary Report, dated 05/30/2026, revealed an order dated 05/22/2026 to cleanse the wound to left plantar [bottom of the foot] with normal saline or wound cleanser, pat dry with gauze and apply skin prep, leave open to air daily on the day shift for 14 days with a start date of 05/23/2026.Record review of Resident #1's May 2022 TAR revealed on 05/24/2026 wound care to the left plantar was not checked that it was provided to the resident.Record review of Resident #1's nurses notes revealed a late entry note from LVN A for 05/24/2026, created on 05/30/2026 at 5:28 PM for documentation for the wound care provided to Resident #1's left plantar.In an interview on 05/31/2026 at 2:13 PM, LVN A stated she had provided wound care to Resident #1 on 05/24/2026 but did not check off as completed on the TAR.In an interview on 05/31/2026 from 3:20 PM to 3:48 PM, the DON said if wound care was not documented as completed it could give an inaccurate picture of what care was provided to the residents, and she ensures the clinical records are accurate through quality assurance audits conducted by the DON or the ADONs. The DON said LVN A wrote a late-entry nurses note on 05/30/2026 to document the wound care she provided to Resident #1 on 05/24/2026.In an interview on 05/31/2026 at 4:06 PM, the Administrator said the residents' clinical records were reviewed for accuracy by the interdisciplinary team and if clinical record was not accurate, it could have a negative effect on the resident.Record review of the Wound Care policy, revised October 2010, revealed under Documentation, The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The name and title of the individual performing the wound care.8. The signature and title of the person recording the data.Record review of the Charting and Documentation policy, revised July 2017, 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 to care. |