

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/24/2026
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)		
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care for 1 of 12 residents (Resident #12) reviewed for behavioral health services. The facility failed to ensure Resident #12's physician orders for behavioral health services (psychological care services) were followed to ensure the resident was evaluated and treated for mental illness and behaviors. This failure could place residents at risk for diminished quality of life due to the lack of treatment and prevention to maintain resident safety. The findings were: Record review of Resident #12's face sheet dated 7/22/2026 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: wedge compression fracture of lumbar and thoracic vertebra subsequent encounter for fracture with routine healing dated 2/26/2026 (healing spinal compression fracture), generalized anxiety disorder (long term or persistent anxiety), restless and agitation, and schizoaffective disorder bipolar type (psychiatric disorder characterized by mood swings with psychosis or hallucinations). Record review of Resident #12's quarterly MDS assessment dated [DATE] revealed a BIMS score of 6, which indicated he was severely cognitively impaired. The assessment indicated Resident #12 had verbal behavioral symptoms directed towards others 1 to 3 days a week and had rejections of care 1 to 3 days a week. His functional assessment revealed the resident was totally reliant on staff for all ADL care and transfers, required maximal assistance for bed movement and was non-ambulatory. Record review of Resident #12's care plan initiated on 11/13/2025 revealed the resident had a behavior problem as evidenced by throwing his foley bag, oxygen tubing, call light and blankets on the floor. A care plan for behavior dated 12/03/2025 revealed the resident was resistive to care by refusing lab draws, medication and showers at times. Interventions included anticipate and meet the residents needs and encourage as much participation interaction by the staff as possible. The Care Plan also included mood problem related to schizoaffective disorder, bipolar type initiated 3/10/2026 with interventions which included behavioral health consult as needed. Record review of Resident #12's physician orders revealed he had an order for psych care to evaluate and treat dated 6/18/2026 related to schizoaffective disorder bipolar type. During an observation and interview on 7/22/2026 at 3:00 p.m. Resident #12 was observed awake and alert in his room. He stated he felt fine. When asked additional questions, he shook his head side to side in a no fashion and did not respond. During an observation on 7/23/2026 at 10:01 a.m. CNA B was observed providing care for Resident #12 in his bed. CNA B approached Resident #12 slowly, often waiting a minute or more between approaches before reapproaching in order to reposition the resident in bed. Resident #12 would say no and push the CNA's hand away before throwing his call light and attempting to pull on his indwelling catheter. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455789	Facility ID: 455789 If continuation sheet Page 1 of 10

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source for 1 of 3 residents (Resident #12) reviewed for transfers. The facility failed to assist Resident #12's family with coordination and planning of a transfer at their request to another facility. This deficient practice could place residents at risk for residents being isolated away from family and friends. The findings were: Record review of Resident #12's face sheet dated 7/22/2026 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: wedge compression fracture of lumbar and thoracic vertebra subsequent encounter for fracture with routine healing dated 2/26/2026 (healing spinal compression fracture), generalized anxiety disorder (long term or persistent anxiety), restless and agitation, and schizoaffective disorder bipolar type (psychiatric disorder characterized by mood swings with psychosis or hallucinations). Record review of Resident #12's quarterly MDS assessment dated [DATE] revealed a BIMS score of 6, which indicated he was severely cognitively impaired. The assessment indicated Resident #12 had verbal behavioral symptoms directed towards other 1 to 3 days a week and had rejections of care 1 to 3 days a week. His functional assessment revealed the resident was totally reliant on staff for all ADL care and transfers, required maximal assistance for bed movement and was non-ambulatory. Record review of Resident #12's care plan initiated on 12/06/2025 revealed there was no plan of care for discharges or transfers. Record review of Resident #12's progress notes dated 7/08/2026 revealed Resident's [family member] called and asked about update on resident's transfer to [another state]. She stated she spoke with the SW two days ago and gave her info (information) of the place where the resident was moving to. I did then follow up with SW and let her know about resident's [family member] inquiry. I also gave SW information about [facility name and phone number in another state]. During an interview on 7/21/2026 at 4:40 p.m., Resident #12's family member stated she wanted Resident #12 to move from the facility into a facility in her home state where she could visit him more often. She stated she was unable to easily travel to the resident's current location and she could not see him. She stated she felt like she was letting her family member down by not being able to have more contact. She stated she had been in touch with the SW about her desire to transfer the resident as soon as possible. She stated she had provided the facility with the name and contact information of the facility she wanted her family member to be transferred to. She stated the SW would only say that she could not arrange a transfer because he required a lot of care and the SW did not think he could handle the trip. The family member stated the SW also stated the state would not pay for his transportation. She stated she felt like she was getting mixed messages from staff. During an observation and interview on 7/22/2026 at 3:00 p.m. Resident #12 was observed awake and alert in his room. He stated he felt fine. When asked additional questions, he shook his head side to side in a no fashion and did not respond. During an interview on 7/22/2026 at 3:33 p.m., the SW stated she had been the SW at the facility for approximately two months. She stated her job included discharge planning. She stated discharge planning began on admission. The SW stated if a resident or family member was asking to transfer to another facility, the way it works was to check the BIMS score to see if the resident was cognitively intact to make the decision. She stated if their BIMS score was 12-13 or above, they were cognitively intact. She stated if the family member wanted a transfer to another facility, she would start the process. The (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW stated she would send clinical documents to the facility desired to see if they would accept the resident and then wait for their response. She stated the resident would have to be approved by the accepting facility both medically and financially. The SW stated Resident #12's family member wanted the resident transferred to the state where they resided. The SW stated the problem was the resident did not have the trunk strength to sit up or endure a transfer and he did not want to take his medications. The SW stated she did not think the resident could make the trip. She stated the doctor would have to make that decision, and the family would have to pay for a medical transport. The SW also stated Resident #12 had behavioral issues and did not think the family member could care for him. The SW stated she had talked to some of the nurses about Resident #12 and they had said, no, he can't make the trip. The SW stated she does not believe the family could afford to pay for a medical transport and the accepting facility would have to agree to pay for it because the resident's insurance would not pay for it. The SW stated she told the family member the facility was not paying for the transport. The SW stated the family member asked her to be creative with coming up with a way to get the transfer. The SW stated she had not notified the physician of the resident's family members desire to have him transferred and she had not worked on finding him an alternative placement or contacted the desired facility. She stated the administration had asked her to put her focus on another resident. The SW stated she said that because she believed the family members wish to have him transferred to another state was unrealistic due to both the family members and the resident's health conditions. During an interview on 7/23/2026 at 2:07 p.m., LVN A stated Resident #12's family member has expressed that she wants the resident in a facility closer to her. LVN A stated she relayed that information to the SW by telling her verbally and texting in a faculty group message. LVN A stated it was also documented in the daily communication notes available to all staff. She stated she was able to review the daily communication notes from the past week and saw it documented as on 7/17/2026 but believed it probably went back further than that. LVN A stated the SW was aware. During an interview on 7/23/2026 at 4:34 p.m., the Regional Compliance Nurse (former DON) stated when a family member requested a transfer, the facility would first inquire why, to see if it was a service issue and to find out where they wanted the resident transferred to. She stated once they have the information, they would reach out to the facility to see if the resident could be admitted. She stated the receiving facility who accepts the transfer comes to pick up the resident. The Regional Compliance Nurse stated she knew Resident #12's family member wanted him transferred out of state. She stated that was complex and the family would have to pay for it. She stated the facility did have a conversation with the family, and the SW brought it up in morning meetings. The Regional Compliance Nurse stated the family member did not want the resident transferred locally. She stated the family member knew it was her responsibility to arrange transportation and would let the facility know when she figured it out. She stated to her knowledge the family member never provided a specific facility. She stated there was no one person responsible for transfers at the facility, although the SW would reach out as needed. She stated she was unsure if the resident's physician or insurance company was contacted to find out what was possible. She stated that was something the SW or BOM would handle. She stated she herself did not call insurance or the accepting facility. During an interview on 7/24/2026 at 2:27 p.m., the BOM stated no one had ever come to her to ask her if Resident #12's insurance would cover transportation or to contact or coordinate with another facility to coordinate a transfer. During an interview on 7/24/2026 at 3:00 p.m. the DON stated she had been the DON for three weeks and one of those weeks she was in training and not in the building. She stated prior to surveyor entrance on 7/21/2026 she was not aware the Resident #12's family's desire to have the resident discharged. She stated the SW never discussed it during (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning meetings. The DON stated she was still learning the facility's ways and was not going to assume who was responsible for coordinating the transfer. She stated her expectations for staff was to discuss it as a team, and the transfer would need to be communicated by family to staff. The DON stated it was important to respond to family members request for transfer because it was a want and they have to try to see if they could meet the need. During an interview on 7/24/2026 at 3:20 p.m. the Regional Compliance Nurse stated the facility did not have a policy for transfers for discharges. She stated they utilized State Regulations for guidance. During an interview on 7/24/2026 at 3:24 p.m., the DON stated she did not have access and was not familiar with the company's procedures. She stated she was reliant on the Regional Compliance Nurse/former DON for policies and procedures.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instruction needed to provide effective and person-centered care of the resident that meets professional standard of quality of care within 48 hours of admission for 1 of 8 residents (Resident #7) whose medical records were reviewed for accuracy in that: The facility failed to develop a baseline care plan within 48 hours of Resident #7's admission to the facility. This failure could place residents at risk of not receiving needed care and treatment. The findings included: Record review of Resident #7's face sheet dated 07/21/2026 revealed an [AGE] year old male admitted on [DATE] with diagnoses which included: spondylolysis lumbar region (presence of crack in the bone connecting the joint of the low back bones), unspecified dementia, severe, with other behavioral disturbance (impaired ability to think, remember or make decisions due to brain cell damage) and major depressive disorder (mood disorder causing feelings of sadness and loss of interest). Record review of Resident #7's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 0 which indicated that the resident had severe cognitive impairment (meaning that he has severe difficulties with memory and thinking skills). The mood and behavioral assessments revealed no issues. Assessment of functional abilities detailed that Resident #7 required partial to moderate assistance with most of his ADLs. Record review of Resident #7's order summary report, dated 7/21/2026 revealed the following order: Admit - Resident/Resident representative has been informed of medical condition and plan of care. This was an active telephone order dated 05/09/2026. Record review of Resident #7's care plan conducted on 7/21/2026 at 2:45 p.m. revealed that there was no care plan present for the resident in the electronic health record. Record review of Resident #7's care plan conducted on 7/24/2026 at 1:12 p.m. and 4:09 p.m. revealed a care plan that appeared to have been initiated on 05/09/2026 but showed an actual initiation date of 07/24/2026 when viewed historically. There was one item listed on the care plan which was as follows: Focus. I chose to have FULL CODE. Date Initiated: 05/09/2026. Revision on: 07/24/2026. At the bottom of the care plan, it stated Date initiated: 07/24/2026. During an interview with MDS nurse on 07/24/2026 at 3:39 p.m., she stated that overall, the MDS staff is in charge of the care plans. She said the baseline care plan is done with the admitting nurse to cover the first 72 hours. She said that she accidentally hit delete earlier today which erased the existing baseline care plan but said that she was able to restore the previously documented care plan. She displayed a care plan in the electronic medical record for Resident #7 that showed an initiation date of 5/09/2026. She stated that if the care plan is not updated, then the electronic medical record is not up to date with the resident's care needs which could impact his care. During an interview with the ADON on 7/24/2026 at 2:20 p.m. he pulled up electronic medical record documentation of a care plan that appeared to be initiated on 5/09/2026. He revealed that the MDS nurse is in charge of the updates that are done to the care plan. He stated that within the first 24 hours the admitting nurse is to complete the baseline care plan with RN oversight. He stated that the care plan is necessary as it is what directs the residents care. During an interview with the DON #2 on 7/24/2026 at 3:40 p.m., she did not verify that there was a baseline care plan present for Resident #7. She stated that the staff uses the care plan as a guide to provide resident care so it should be present within 72 hours so that the staff knows how to care for the resident. Record review of the facility provided policy titled Care Plans - Baseline which was not dated, revealed the following: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.		

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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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 residents (Resident #7) reviewed for comprehensive care plans in that: The facility failed to ensure that there was a comprehensive care plan on file in the electronic health record for Resident #7 on 7/21/2026. These failures could place residents at risk of not having their individual care needs met and could result in a decreased quality of life. The findings included: Record review of Resident #7's face sheet dated 07/21/2026 revealed an [AGE] year old male admitted on [DATE] with diagnoses which included: spondylolysis lumbar region (presence of crack in the bone connecting the joint of the low back bones), unspecified dementia, severe, with other behavioral disturbance (impaired ability to think, remember or make decisions due to brain cell damage) and major depressive disorder (mood disorder causing feelings of sadness and loss of interest). Record review of Resident #7's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 0 which indicates that the resident has severe cognitive impairment (meaning that he has severe difficulties with memory and thinking skills). The mood and behavioral assessments revealed no issues. Assessment of functional abilities detailed that Resident #7 requires partial to moderate assistance with most of his ADL's. Record review of Resident #7's order summary report, dated 7/21/2026 revealed the following order: Admit - Resident/Resident representative has been informed of medical condition and plan of care. This was an active telephone order dated 05/09/2026. Record review of Resident #7's care plan conducted on 7/21/2026 at 2:45 p.m. revealed that there was no comprehensive care plan present for the resident in the electronic health record. Record review of Resident #7's care plan conducted on 7/24/2026 at 1:12 p.m. and 4:09 p.m. revealed a care plan that appeared to have been initiated on 7/24/2026. The care plan report printed 7/24/2026 documents a single focus as follows: I chose to have FULL CODE. Date initiated: 05/09/2026. Revision on: 07/24/2026. The goal reads: Status will be maintained through next review date. Date initiated: 07/24/2026. Target date: 08/07/2026. During an interview the ADON on 7/24/26 at 2:20 p.m., he stated that there was a comprehensive care plan present for Resident #7 dated 5/9/2026 and that the care plans get closed out every quarter and redone. He stated that the MDS nurse is more familiar with this process and she is in charge of updates to the comprehensive care plan. He stated that this care plan is necessary so that the residents receive the right care. During an interview with the MDS nurse on 7/24/2026 at 3:42pm, she displayed a care plan for Resident #7 with an initiation date of 5/09/2026. She stated that they try to keep up to date with the care plans as much as possible. She stated that she reviews the comprehensive care plans quarterly. She revealed that she had accidentally hit the delete button on Resident #7's care plan when working with it earlier today. She stated if the care plan is not updated, the electronic medical record will not be updated or accurate so the staff will not have pertinent information related to care of the resident. During an interview with DON #2 on 7/24/2026 at 3:45pm, she stated that there was a comprehensive care plan present for Resident #7 dated 5/9/2026 in the electronic medical record. She stated that the staff uses the comprehensive care plan as a guide to provide for resident care and to make needed updates to the existing care plan. She stated that the DON will also use the comprehensive care plan when conducting investigations of incidents in order to collaborate on any changes needed with the current interventions.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #5) out of 8 residents reviewed for medical records in that: Facility staff did not document details of a facility reported incident that reportedly occurred on 6/26/2026 at 5:00 p.m. in Resident #5's electronic health record. This failure could affect residents whose records were maintained by the facility and could place the residents at risk for errors in care and treatment. The findings included: Record review of Resident #5's face sheet dated 07/21/2026 revealed an [AGE] year old female admitted on [DATE] with diagnoses which included: Parkinsonism (group of brain conditions affecting movement), unspecified dementia (impaired ability to think, remember or make decisions due to brain cell damage), paranoid schizophrenia (mental health condition characterized by hallucinations, delusions and disordered thinking) and major depressive disorder (mood disorder causing feelings of sadness and loss of interest). Record review of Resident #5's comprehensive MDS dated [DATE] revealed that the resident had a BIMS score of 0 which meant that the resident had severe cognitive impairment, meaning that she had severe difficulties with memory and thinking skills. The behavioral assessment detailed that the resident had displayed physical behavioral symptoms directed towards others and rejection of care for 1-3 days during the look back period, verbal behavioral symptoms directed towards others for 4-6 days during the look back period and daily wandering activity. For functional abilities, Resident #5 required substantial/maximum assistance for performance of most tasks and was dependent on the staff for a few others. Record review of Resident #5's care plan, dated 6/03/2026 indicated focus of .is an elopement risk r/t previous attempts to leave the facility. Required placement in Memory Care Unit for safety. Date initiated: 10/06/25. Revision on: 10/06/25. Goals include: .safety will be maintained through the review date. Date initiated: 10/06/25. Revision on: 07/20/2026 and Target Date: 07/30/2026. Record review of Form 3613-A (Provider Investigation Report) faxed to complaint and incident intake department dated 07/02/2026 indicated that there was an incident involving Resident #5 and another resident 06/26/2026 at 17:00 p.m. (5:00 p.m.). The investigation documentation reviewed included a description of the incident, an assessment section that listed a description of the physical assessment performed at 17:05 p.m. (5:05 p.m.) which revealed a skin tear to Resident #5's right toe and scratch to right face of the other resident, provider response and immediate interventions provided. Record review of progress notes for Resident #5 from 06/26/2026 through 7/24/2026 did not reveal documentation in the electronic health record about the details of the facility reported incident that had occurred on 06/26/2026 at 5:00 p.m. During an interview with LVN B on 07/23/2026 at 6:30 p.m. she stated that incidents are usually documented in the incident reports, but LVN B was not able to find this report initially when she looked in the electronic medical record. She stated that there was a process to put late documentation into the electronic health record if needed, but she was not sure what the process was. About 10 minutes later, LVN B displayed documentation of the incident that had occurred on 6/26/2026 that was dated 6/26/2026 in the electronic medical record. LVN B stated that she was not sure why the documentation was not visible in the progress notes section of the electronic medical record. During an interview with ADON on 07/24/2026 at 2:20 p.m., he stated that incidents were to be documented in the chart by the staff. He looked in the electronic health record and reviewed the incident documentation for 6/26/2026. He informed me that this (continued on next page)		

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 07/24/2026
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)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation was listed in the risk management area of the electronic health record, which was only accessible to internal staff. He stated that the information should also be documented in the progress notes or some other area that was also visible to anyone viewing the record so that everyone had access to this resident's information if needed. During an interview with the prior DON #2 on 7/24/2026 at 3:50pm she stated that she was present during the time of this incident. She verified that there was an incident involving Resident #5 and another resident that had occurred on 06/26/2026 at 5:00 p.m. She attempted to locate documentation of the 06/26/2026 incident in the electronic health record then stated that it was not present where it could be viewed by those outside of the organization. She stated that she had forgotten to document the incident in the chart. She stated that the expectation is that staff document incidents in an incident report as well as the progress notes or else the record was not complete. She stated that the facility does not have a policy specifically addressing electronic health records.		