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	03/13/2026

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 4 of 5 residents (Residents #16, #35, #68 and #94) reviewed for abuse.The facility failed to ensure a resident-to-resident altercation on 2/2/2026 between Residents #16 and #35 was reported to the SSA. The facility failed to ensure Resident #68's allegation of exploitation was reported to the SSA. The facility failed to report an incident where Resident #94 was hospitalized for suicidal ideation on 12/15/2025. These findings could result in a lack of oversight of residents. 2. Record review of Resident #68's admission record, dated 03/13/2026, reflected Resident #68 was a [AGE] year-old male who admitted [DATE], with diagnoses to include major depressive disorder (persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities) and anxiety disorder (excessive fear or worry). Record review of Resident #68's quarterly MDS assessment, dated 01/30/2026, reflected Resident #68 had a BIMS score of 14 out of 15, indicating intact cognition. The MDS reflected Resident #68 did not have delusions or hallucinations. Record review of Resident #68's care plan, undated, reflected [Resident #68] has a behavior problem r/t making false allegations against staff and facility., initiated 12/09/2025. Record review of Grievance Form about Resident #68, dated 02/03/2026 and authored by the SW, reflected they keep taking my money. I think they may be doing this to me on purpose, I am supposed to be getting about $70.00 every month. I only received $35.00. Record review of Grievance Form about Resident #68, dated 02/09/2026 and authored by the SW, reflected the money lady is personally taking my social security money. Interview on 03/10/2026 at 12:18 PM Resident #68 revealed he had not seen his checks. He revealed he was supposed to be getting $75 per month, but the facility was taking his money. He revealed the BOM was ignoring him, and the ADM did not have time to help him. Interview on 03/13/2026 at 12:45 PM, the SW revealed Resident #68 claimed the BOM was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	specifically targeting him and taking his money. He revealed Resident #68 presented with confusion and he had 3 to 4 attempts to discuss social security. The SW further revealed Resident #68 said he was being exploited. The SW stated, He uses some powerful words. The SW was reviewing his notes and mentioned psych said Resident #68 presented with logical thought processes and his judgment was fair. The SW revealed he may have brought this up in the morning meetings and the ADM may know about this situation. He revealed he investigated this situation and thought Resident #68 was confused so he did not think it needed to be reported to the ADM. He revealed he was unsure if he had to report to the ADM when he heard Resident #68 mention exploitation. Interview on 03/13/2026 at 01:44PM, the BOM revealed she was aware that Resident #68 accused the facility of stealing his money. She revealed she explained how his social security checks worked and he seemed fine, but then he would bring up the same concern again. She revealed she did not know if Resident #68 was just not remembering their conversations. She revealed she told the former ADM that Resident #68 thought she was stealing his money. She revealed she was not aware the resident was using the word exploitation otherwise this should have been reported right away. Record review of facility's policy Grievances/Complaints, Filing, revised April 2017, reflected 9. The grievance officer will coordinate actions with appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines of reporting abuse, neglect and misappropriation of property, as per state law. 3. Record review of Resident #94's admission record, dated 03/10/2026, reflected Resident #94 was a [AGE] year-old female who initially admitted on [DATE] and re-admitted [DATE], with diagnoses to include major depressive disorder (persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities), anxiety disorder (excessive fear or worry), bipolar disorder (mental health condition that causes extreme mood swings), schizoaffective disorder (mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, along with symptoms of mood disorder, such as mania (period of abnormally elevated, extreme changes in mood or emotions, energy level or activity level) and depression). Record review of Resident #94's quarterly MDS assessment, dated 11/27/2025 (before 12/15/2025 incident), reflected Resident #94 had a BIMS score of 14 out of 15, indicating intact cognition. The MDS reflected Resident #94 did not have delusions or hallucinations, did not feel down, depressed, or hopeless, and did not feel little interest or pleasure in doing things. Record review of Resident #94's quarterly MDS assessment, dated 02/27/2026, reflected Resident #94 had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. The MDS reflected Resident #94 did not have delusions or hallucinations, did not feel down, depressed, or hopeless, and did not feel little interest or pleasure in doing things. Record review of Resident #94's care plan, undated, reflected [Resident #94] has a potential behavior problem by inflicting self-harm r/t poor impulse control d/t schizophrenia, bipolar disorder., initiated 12/16/2025, with intervention Intervene as necessary to protect the rights and safety of others. Record review of the Resident #94's order summary report, dated 03/10/2026, reflected Senior (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Psychological to eval and treat, with order date 12/18/2025. Record review of incident report for Resident #94, authored by RN E and dated 12/15/2025 at 01:15 PM, reflected The resident came to the nurse's station with a sharp object and said she was going to end her own life and put a sharp object to her throat, while nurse retrieved object from [Resident #94] for her safety. [Resident #94] expressed, 'I can't take it anymore. The nurse attempted to calm her down reminding her that her daughter and family need her. [Resident #94] was placed on a one to one until EMS arrived. Management, DON, ADONs, Administrator, RP, MD, and head of psych MD notified. It further reflected that Resident #94 had an abrasion on her chest. Record review of Resident #94's hospital documentation, dated 12/15/2025, reflected chief complaint Suicidal. ([Resident #94] from a nursing facility here because she had scissors to her neck and told the nursing staff, she was going to kill herself. Per officer, nursing staff took the scissors a way but [Resident #94] was able to scratch herself with her fingernails. [Resident #94] does have several abrasions to right side of her neck. [Resident #94] states 'I try to kill myself, but I need to be home by 10pm today' Interview on 03/11/2026 at 08:10 AM, Resident #94 revealed she could not recall a time when she was hospitalized for suicidal ideation and said since she had been to this facility she did not have a moment when she was depressed. Resident #94 would not answer any further questions about this incident. Interview on 03/12/26 at 09:38AM, RN E revealed Resident #94 was typically happy and her behavior on 12/15/2025 was not her normal behavior. She revealed Resident #94 was upset because another resident did not want to talk to her. She revealed Resident #94 had child-safe scissors and said she was going to kill herself. RN E revealed she took the scissors from the resident, kept Resident #94 in her line of sight until someone was able to follow the resident until EMS arrived at the facility, and let the appropriate parties know what happened. Interview on 03/12/2026 at 05:23 PM, the DON revealed Resident #94 did not actually hurt herself so she would not have reported this incident. She revealed the provider letter (Long-Term Care Regulation Provider Letter) did not mention self-harm so there was no guidance for reporting this incident. Interview on 03/13/2026 at 01:55PM, the ADM revealed he reviewed the grievances and was aware of Resident #68's claims of his money being taken. He revealed he investigated this grievance, met with the BOM and the SW, and found that Resident #68 appeared confused and forgetful. The ADM revealed the BOM would explain how his social security checks worked but he did not want to accept her explanation. He further revealed that he did not know if he would have reported Resident #94's incident because he did not know all the facts. Record review of the Long-Term Care Regulation Provider Letter, dated 08/29/2024, reflected A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: abuse, neglect, exploitation. Record review of TULIP, dated 03/10/2026 at 03:45 PM, reflected no self-reports of Resident #68's allegations of exploitation or Resident #94's hospitalization for suicidal ideation on 12/15/2025. Record review of Resident #16's admission Record dated 3/12/2026 reflected a [AGE] year-old male (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE]. Relevant diagnoses included unspecified dementia (a progress condition affecting memory and reasoning). Record review of Resident #16's annual MDS submitted 1/30/2026 reflected a BIMS score of 0, which indicated severely impaired cognition. Section E0200 of the MDS reflected Resident #16 exhibited physical and verbal behavioral symptoms towards other for 1-3 days of the assessment period. Record review of Resident #16's Care Plan Report printed 3/12/2026 revealed the following: Behavior [Resident #16] has a behavior problem r/t RESISTIVE TO CARE [sic] Potential to be verbally and physically aggressive. d/t Dementia dx noted to have a verbal altercation on 1/3/26 with another resident. Seen by [psychiatry provider] Date Initiated: 10/16/2025 Revision on: 03/10/2026 verbally agressive [sic] r/t Dementia, Poor impulse control 2/2/26 resident allegedly was involved in a physical aggression altercation where resident was the initiator. Date Initiated: 03/10/2026 Revision on: 03/10/2026 Record review of Resident #16's progress notes revealed an entry dated 2/2/2026 at 4:30 PM by LVN G: Another resident informed staff that this resident walked into his room, was told this was not his room, he slapped the other resident in the face. Resident states he does not remember hitting anyone. Pt. teaching to ask staff for assistance if he forgets where his room is. Placed call informed [DON] of incident, [MD] here in facility informed him of incident, informed [Administrator], informed [psychiatry provider] and [legal guardian], [hospice provider] also notified. Resident placed on q 15 minute checks to monitor behavior. Record review of Resident #35's admission Record dated 3/12/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included unspecified developmental delays. Record review of Resident #35's quarterly MDS submitted 1/15/2026 reflected a BIMS score of 03, which indicated severely impaired cognition. Section E0200 of the MDS revealed Resident #35 exhibited physical and verbal behavioral symptoms towards other for 4 to 6 days of the assessment period. Record review of Resident #35's Care Plan Report printed 3/13/2025 revealed the following: [Resident #35] has potential to be physically aggressive r/t Dementia Potential [sic] to be verbally aggressive at times. Date Initiated: 08/14/2025 Record review of Resident #35's progress notes revealed an entry dated 2/2/2026 at 4:30 PM by LVN G: Resident told [CNA D] that another resident was in his room he told him this is not your room and the other resident slapped him on his left side of face resident had helmet on at the time, no injury noted. Informed [DON], [Administrator], and [MD]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 3/12/2026 at 10:41 AM of the facility's self-reported incidents on TULIP did not reveal a submission related to the incident between Residents #16 and #35 on 2/2/2026. In an interview on 3/13/2026 at 8:25 AM, Resident #35 said another resident had slapped him in the face, but he was unsure when or where the incident occurred. He was unsure which resident had slapped him. He said the slap was painful. In an interview with the DON on 3/13/2026 at 10:55 AM, she said she was aware of the incident between Residents #16 and #35. She said she interviewed both residents immediately after the incident was reported to her by LVN G, and Resident #35 denied he had been slapped. She said Resident #35 also denied hitting anyone. She said her investigation of the incident included obtaining laboratory specimens from both residents to determine if the alleged behaviors had underlying medical causes and both residents were evaluated by the psychiatry provider. She said the incident was not reported to the SSA because she felt it did not meet the reporting criteria based on the cognitive impairments of both residents. She said the verbiage of the provider letter that clarifies intent causes confusion when applying the standards to cognitively impaired residents. Record review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 revealed the following: 9. Investigate and report any allegations within timeframes required by federal requirements.

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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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. The facility failed to discard a pan of chicken pot pie with discard date 03/04/2026.The facility failed to ensure boxes of food products were stored properly on the top shelf in the walk-in freezer. These failures could place residents at risk for food borne illness.The findings included: The findings included:Observation on 03/10/2026 at 09:15 AM revealed there was a pan of chicken pot pie with discard date 03/04/2026 in the walk-in refrigerator.Observation on 03/10/2026 at 09:15 AM revealed there were 3 boxes of food products stored on the top shelf in the walk-in freezer that appeared too close to the ceiling (exact distance unknown).During an interview and observation on 03/12/2026 at 02:40 PM, the Dietary Manager revealed the boxes of frozen food products in the walk-in freezer were too close to the ceiling and could interfere with the sprinkler system if the sprinkler system went off. It was important so that it did not block the water from the fire sprinkler from getting to something around these boxes, in case of an emergency. She revealed everyone in the kitchen oversaw throwing out foods that passed the discard date and the pan of chicken pot pie should have been thrown away. [NAME] F revealed she was trained on throwing out food products once it passed discard dates. [NAME] F revealed she would have to throw it out because the food was not good for the residents to eat.During an interview on 03/12/2026 at 06:50 PM, the RD revealed the boxes of food products needed to be 18 inches away from the ceiling for food storage, but she was unsure why. That's a problem if it was less because it can be too close to the ceiling. Record review of the FDA Food Code 2022 reflected, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: . (2) At 5 C (41 F) or less. Record review of the FDA Food Code 2022 reflected, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and. Record review of the facility's policy Refrigerators and Freezers, revised November 2022, reflected 1. Refrigerators and/or freezers are maintained in good working condition. Refrigerators keep foods at or below 41 degrees Fahrenheit.9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates. Record review of the facility's policy Foods Brought by Family/Visitors, revised March 2022, reflected, Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The nursing and/or food service staff will discard any foods prepared for the resident that show any signs of potential foodborne danger. Record review of the facility's policy Food Receiving and Storage, revised November 2022, Refrigerated/Frozen Storage. 3. Refrigerated foods are stored in such a way that promotes adequate air circulation around food storage containers. 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. The facility failed to ensure Resident #82's personal refrigerator was less than 41 degrees Fahrenheit.The facility failed to ensure Resident #106's personal refrigerator was cleaned and did not have 2 Styrofoam containers with no date or label. The facility failed to ensure Resident #85's personal refrigerator's freezer was properly functioning and not iced. These failures could place residents at risk for food borne illness.The findings included:3. Record review of Resident #82?s admission record, dated 03/10/2026, reflected Resident #82 was a [AGE] year-old male who initially admitted [DATE] and re-admitted [DATE], with diagnoses to include type 2 diabetes (chronic condition causing high blood sugar)Record review of Resident #82's quarterly MDS assessment, dated 01/29/2026, reflected Resident #82 had a BIMS score of 15 out of 15, indicating intact cognition.In interview and observation on 03/10/2026 at 01:21 PM revealed a thermometer in Resident #82's personal refrigerator read 48 degrees Fahrenheit. There were only cans of soda in his refrigerator, but Resident #82 revealed that he used his refrigerator to store food. He further revealed he could not store ice cream in his freezer because it never got cold enough. It was observed that there was no thermometer in Resident #82's freezer. He further revealed he did not know what temperature his refrigerator should be at, and he was not sure if the facility staff was checking his refrigerator for the appropriate temperature. He revealed he wanted his refrigerator to be at the right temperature so he could store food.In an interview and record review on 03/12/2026 at 06:02 PM, ADON A revealed he oversaw temperature logs for residents' personal refrigerators. He showed a temperature log sheet that nursing staff used which had the parameters that the residents' refrigerators could be up to 46 degrees Fahrenheit. ADON A revealed Resident #82's refrigerator was above 41 degrees Fahrenheit, and he was not aware that refrigerators needed to be below 41 degrees Fahrenheit.In an interview on 03/12/2026 at 06:37 PM, ADON B revealed he oversaw infection surveillance, and there were no gastrointestinal issues (GI) or spread of GI issues in the facility in the last 3 months. He further revealed the temperature log the nursing staff used to track temperatures of residents' personal refrigerators had a temperature range of 36 to 46 degrees Fahrenheit of what the residents' personal refrigerator thermometers should read.In an interview on 03/12/2026 at 06:50 PM, the RD revealed the nursing staff oversaw the residents' refrigerators and the expectation would be that the refrigerators were below 40 degrees Fahrenheit. In an interview on 03/13/2026 at 10:18 AM, the DON revealed she was not aware of what the temperature range needed to be for refrigerators. She revealed the sheet that nursing staff used to write temperatures for the residents' refrigerators reflected the refrigerator temperature could be up to 46 degrees Fahrenheit. She revealed the nursing staff oversaw that 4.Record review of Resident #106's admission Record dated 03/13/2026 was documented she was admitted on [DATE], re-admitted on [DATE].Record review of Resident #106's Annual MDS dated [DATE] was documented a BIMS score of 15/15 (cognitive intact).Record review of Resident #106's care plan dated 03/13/2026 was documented for eating she required set-up or clean up.Record review of Resident #106's personal effects inventory dated 11/20/206 was documented she had an electric wheelchair, pair of glasses and a refrigerator.Observation and interview on 03/11/2026 at 04:32 PM, revealed Resident #106 had a personal refrigerator in her room. It was dirty, had a Styrofoam container not labeled, Styrofoam container unknown foods and was not labeled. Resident #106 stated the refrigerator was hers, and she was not willing to say when the refrigerator was cleaned or how long the Styrofoam containers were in the refrigerator. 5. Record review of Resident #85's admission Record dated 03/13/2026 he was admitted on [DATE], re-admitted on [DATE] with diagnoses of type 2 diabetes.Record review of Resident #85's Quarterly MDS dated [DATE] was documented his BIMs score was 15/15 (cognitive intact), and was (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	independent with eating with no weight loss, and current weight was 274 pounds. Record review of Resident #85's care plan dated 09/23/2025 was documented for eating was set up or clean up assistance. Adjust diet to accommodate chewing, swallowing or eating issues in order to maximize independence and nutritional intake. Record review of Resident #85's personal effects inventory dated 05/31/2025 revealed he had a personal refrigerator. Observation and interview on 03/10/2026 at 10:44 AM in Resident #85's room revealed he had a personal refrigerator; the freezer was iced over. It looked like a ball of ice was in it. Resident #85 revealed the freezer was iced over, for a while. In an interview on 03/13/2026 at 03:00 PM with the Maintenance Director revealed he was responsible for the residents' personal refrigerators. Maintenance stated he was not aware that Resident #106 and #85's personal refrigerators had issues and would get to it right away. Maintenance stated the staff/residents usually verbally told him or puts it in a computer log for maintenance to fix. Maintenance stated the nurse on the night shift looked at and wrote resident personal refrigerator temperatures. Record review of the FDA Food Code 2022 reflected, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and. Record review of the facility's policy Refrigerators and Freezers, revised November 2022, reflected 1. Refrigerators and/or freezers are maintained in good working condition. Refrigerators keep foods at or below 41 degrees Fahrenheit.9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates. Record review of the facility's policy Foods Brought by Family/Visitors, revised March 2022, reflected, Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The nursing and/or food service staff will discard any foods prepared for the resident that show any signs of potential foodborne danger. Record review of the facility's policy Food Receiving and Storage, revised November 2022, Refrigerated/Frozen Storage. 3. Refrigerated foods are stored in such a way that promotes adequate air circulation around food storage containers. 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the resident had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 1 (Resident #4) of 8 residents reviewed for resident rights. The facility failed to obtain informed consent for the use of Ziprasidone HCL (an antipsychotic medication) for Resident #4. This failure could place residents who receive psychotropic medications at risk of receiving medications without consent, knowledge of possible side effects of the medications, or other treatment options.Findings included:Record review of Resident #4's admission record dated 3/13/2026, reflected that she was [AGE] years old, initial admission on [DATE] and re-admitted on [DATE]. The resident was diagnosed with diabetes mellitus (condition that occurs when the body cannot properly use blood sugar), anxiety (a feeling of worry, nervousness, or unease), and intermittent explosive disorder (mental health condition characterized by sudden, intense outbursts of anger or aggression that are disproportionate to the situation).Record review of Resident #4's Quarterly MDS dated [DATE] reflected resident had clear speech, had the ability to understand others, clear comprehension, BIMS score indicated moderately impaired cognition, Section D: Mood severity score of 4, indicating that she had been observed with a mood disorder, Section E: Behaviors indicated the resident had no behaviors.Section GG: Functional Status reflected the resident was dependent on staff for substantial/maximal assistance for ADLs and required the use of a wheelchair. Section J: Health Conditions reflected the resident had pain occasional interference with day-to-day activities and was at risk of SOB. Section K Swallowing/Nutritional Status reflected Resident #4 had complaints of difficulty or pain with swallowing. Section M skin: reflected the resident was at risk of PU. Resident #4 required the use of a Pressure reducing mattress, and application of ointments. Section N: Medications reflected the resident took an antipsychotic, antidepressant, opioid, and hypoglycemic.Record review of Resident #4's Care Plan dated 8/28/2025 and revised 11/06/2025 reflected she had an ADL self-careperformance deficit related to disease process, used psychotropic/antipsychotic medications (Ziprasidone HCl) related to intermittent explosive disorder (characterized by sudden episodes of unwarranted anger and violent outbursts) and antidepressant medication (Sertraline and Trazodone) related to Depression/Insomnia and resident had a psychosocial well-being problem related to anxiety, Dependent behavior, Disease Process, worsening condition, nursing home placement. Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability.During an observation and interview on 3/11/2026 at 11:22 a.m., Resident #4 was in the hallway heading towards her room ambulating in her manual wheelchair, she was dressed well, groomed appropriately, no odor. She was upset and said an employee stole her money from her bank and she reported it to the ADM and SW. She said the staff who stole her money is hiding in the restroom and constantly laughs at her. Resident #4's memory and events were difficult to understand, she was unable to keep a clear conversation, and she would lose her train of thought. She said the theft was reported to the management team, they filed a report and are investigating it. She was unable to recall when this event occurred and could not provide information about the date or the staff member.Record review of Resident #4's MAR from 2/01/2026 to 2/28/2026 reflected the resident received her Ziprasidone HCl Oral Capsule 60 MG via PEG-Tube two times a day every day (28) for the month of February at 9:00 a.m. and 8 p.m. for schizophrenia.Record review of Resident #4's Physician Progress Note dated 1/14/2026 reflected the resident had a Mental Illness (MI), schizophrenia.physician ordered ziprasidone. Record review of Resident #4's physician's orders, dated 11/06/2025, reflected the resident had the order of Ziprasidone HCl Oral Capsule 60 MG (continued on next page)

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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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Ziprasidone HCl) Give 60 mg via PEG-Tube two times a day for Schizophrenia. Record review of Resident #4's hospital Discharge summary dated [DATE], reflected the resident diagnosis list included: Undifferentiated schizophrenia as of 8/5/2023. medications listed Ziprasidone, 60 mg. During an interview on 3/13/2026 at 1:44 p.m., the DON said there was consent in Resident #4's medical record regarding Ziprasidone, but that she was not sure which form was in her medical record and that she would speak with ADON A to investigate this further.During an interview on 3/13/2026 at 2:18 p.m., ADON A said psychotropic medication required consent to administer medications and without one psychotropic medication should not be administered. He said not having the proper psychotropic consent forms in resident's medical record could harm the resident and the care they receive. ADON A said Resident #4's medical record contained the proper psychotropic consent forms. He said Resident #4's psychotropic medication, Ziprasidone did not require the completion of Form 3713, Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment and the facility's standard Psychoactive Consent form in Resident #4's medical record was sufficient for this medication. He said he reached out to the psychiatrist and was informed that Ziprasidone did not require Form 3713.Record review of the facility document titled, Statement of Resident Rights, undated, reflected: (23) Receive Information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee, to have psychoactive medications prescribed and administered In a responsible manner, as mandated by the Health and Safety CODE, 242.505, andto refuse to consent to the prescription of psychoactive medications.Record review of the facility's document titled, Care Plans, Comprehensive Person-Centered dated December 2016 reflected: 5. The resident will be informed of his or her right to participate in his or her treatment.Record review of the facility's document titled, SELF DETERMINATION ACT Resident Policy and Resident Statement undated, reflected: 1. [Facility] recognizes the dignity and value of each resident's life and the right of each resident to make decisions regarding his or her care.Record review of the facility's document titled, Acknowledgement/ Receipt of Privacy Practices undated reflected: [Facility] and my physicians will create and keep a written record of my care. The record will Include my health history, diagnosis, evaluations and test results, medications, treatments, care plan and objectives, and advance directives, If any. The record Is for use in documenting care and treatment provided, planning care, communication among care givers, a source of Information for billing and collection of health care services provided and for assessing the quality of care and services provided.Record review of the facility's document titled, Pharmacy Services Overview dated April 2019 reflected: 9. The consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services, including (but not limited to): (4) facility staff roles and responsibilities during the receipt and storage of medication. documentation of processes, as applicable.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 13 residents (Resident #5) reviewed for assessments. The facility failed to ensure Resident #5's quarterly MDS submitted 2/24/2026 accurately reflected that she does not use a restraint device. This failure could result in residents receiving inappropriate care.Findings include: Record review of Resident #5's admission Record dated 3/10/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included other reduced mobility.Record review of Resident #5's quarterly MDS submitted 2/24/2026 reflected a BIMS score of 12, which indicated moderately impaired cognition. Section P0100 reflected Resident #5 used a trunk [torso] restraint on a less than daily basis. Record review of Resident #5's Order Summary Report dated 3/10/2026 did not reveal a physician's order for a restraint device. Record review of Resident #5's Care Plan Report printed 3/10/2026 did not reveal care planning for a restraint device. In an observation on 3/11/2026 at 9:15 AM, Resident #5 was observed in her wheelchair without a trunk restraint. In a subsequent observation and interview on 3/11/2026 at 2:52 PM, Resident #5 was again observed in her wheelchair without a trunk restraint. Resident #5 was unsure if her wheelchair had a seatbelt or other restraining device. In an interview with ADON B on 3/11/2026 at 3:00 PM, he said there were no residents at the facility who used seatbelts or other trunk restraints on their wheelchairs. He said the facility was a restraint-free facility. In an interview with MDS on 3/12/2026 at 1:41 PM, she said Resident #5 does not use any type of restraint, and the information was entered in error. She said she would submit a correction for the submission. A facility policy regarding MDS assessments and/or accuracy of assessments was requested on 3/13/2026 at 10:19 AM but not provided prior to survey exit.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's care planning for 1 of 8 residents (Resident #100) reviewed for PASARR services.The facility failed to ensure Resident #100's PASRR Level 1 Screening was completed accurately with mental illness diagnosis to secure a Level 2 Evaluation by the Local Authority.This deficient practice could place residents at risk of not receiving services identified by the local authority.The findings included:Record review of Resident #100's admission record dated 3/13/2026, reflected that he was [AGE] years old admitted on [DATE]. The resident was diagnosed with schizoaffective disorder, bipolar type (mental health condition that combines symptoms of schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves) with manic episodes (period of abnormally elevated, expansive or irritable mood accompanied by increased energy and activity)) bipolar disorder (psychological condition that causes dramatic changes in a person's mood, ability to think clearly, and energy), unspecified (significant, abnormal mood elevations), seizures (sudden surge of abnormal electrical activity in the brain that can affect behavior, movements, sensations, and consciousness), and chronic obstructive pulmonary disease, unspecified (chronic obstructive pulmonary disease, unspecified).Record review of Resident #100's Quarterly MDS dated [DATE], reflected resident had clear speech, had the ability to understand others, BIMS score indicated moderately impaired cognition, Section D: Mood severity score of 0, indicating he had not been observed with a mood disorder, Section E: Behaviors indicated the resident had no behaviors.Section GG: Functional Status reflected the resident was dependent on staff for all ADLs and required 2 person assistance to complete activity. Section I: Active Diagnoses reflected the resident had active diagnoses of bipolar disorder and schizophrenia. Section M skin: reflected the resident was at risk of PU. Resident #100 required the use of a Pressure reducing mattress. Section N: Medications reflected the resident took an antipsychotic and anticonvulsant.Record review of Resident #100's Care Plan dated 8/06/2022 reflected he had impaired thought processes related to schizophrenia [revised 11/11/2025), used antipsychotic medications Risperdal related to schizoaffective disorder, bipolar type [revised 8/06/2022] and resident had a psychosocial well-being mood problem related to schizoaffective disorder, bipolar type [revised 8/06/2022].Record review of Resident #100's Psychiatry Visit Note dated 2/26/2026 reflected the resident had a Mental Illness (MI), schizoaffective disorder and PA ordered Risperdal.During an observation on 3/11/2026 at 11:40 a.m., Resident #100 was not interested in interviewing with surveyor and did not communicate. Resident #100 was observed lying in bed falling asleep, no odor, smell, clean environment. Resident #100's eyes were open, and he turned his head and stared at surveyor and then went back to sleep.During an interview on 3/13/2026 at 4:00 p.m., the MDS Coordinator said Resident #100's PASRR Level 1 Screening did not identify resident as having a PASRR condition and PASRR Level 2 Evaluation was not required. The MDS Coordinator and surveyor completed record review together and MDS said Resident #100 had schizophrenia and bipolar diagnoses and PASRR Level 1 Screening should have triggered positive prompting a Level 2 Evaluation to be performed by the Local Authority (LA). She said she had been auditing files after she was hired on four months back, but there are so many residents to review that she had yet to get to Resident #100's medical record to make changes but would be making changes today and submitting Form 1012 (used in nursing facilities to evaluate residents for mental illness and dementia) to request a PASRR 2 evaluation.Record review of the facility document titled, Rights and Obligations of the Resident undated reflected: MDS Privacy Act Notification, Facility is required by Medicare and Medicaid regulations to conduct comprehensive, (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurate, standardized, and reproducible assessments of each resident's functional capacity and health status.Record review of the facility's document titled, Acknowledgement/ Receipt of Privacy Practices undated reflected: [Facility] and my physicians will create and keep a written record of my care. The record will Include my health history, diagnosis, evaluations and test results, medications, treatments, care plan and objectives, and advance directives, If any. The record Is for use in documentingcare and treatment provided, planning care, communication among care givers, a source of Information for billing and collection of health care services provided and for assessing the quality of care and services provided.

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 13 residents (Resident #81) reviewed for care planning. The facility failed to ensure Resident #81's comprehensive care plan accurately reflected the required safety interventions for smoking.This failure could result in residents not receiving the level of intended care. Findings included:Record review of Resident #81's admission Record reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included schizoaffective disorder (a disorder in which a person has difficulty distinguishing reality from hallucinations or delusions). Record review of Resident #81's annual MDS submitted 12/12/2025 reflected a BIMS of 00, which indicated severely impaired cognition. Record review of Resident #81's Smoking Safety Screen dated 2/19/2026 reflected the following:1. notes on safety from IDTC (i.e. resources required to support resident, other resident safety, potential injury, capabilities): Resident require [sic] monitoring while smokingRecord review of Resident #81's Care Plan Report printed 3/10/2026 reflected the following:[Resident #81] is a smoker. Unsafe to smoke. May smoke WITH SUPERVISON [sic] and smoking apron in place. Has been educated on facility smoking policy. Date Initiated: 12/05/202The resident requires a smoking apron while smoking. Date Initiated: 02/18/2026The resident requires SUPERVISION [sic] while smoking. Date Initiated: 02/18/2026In an observation on 3/10/2026 at 3:11 PM, Resident #81 was observed in the designated smoking area of the memory care unit without a smoking apron. In an interview on 3/12/2026 at 10:26 AM, CNA D said that Resident #81 was the only resident who smoked in the male memory care unit, and he did not require a smoking apron. In an interview with ADON A on 3/12/2026 at 1:30 PM, he said Resident #81 did not require a smoking apron. He said Resident #81 had never required a smoking apron, and he was unaware Resident #81's care plan contained the intervention for an apron. He said the care plan should contain accurate interventions to ensure residents receive the intended care.In an interview with MDS on 3/12/2026 at 1:41 PM, she said she was responsible for the care planning related to smoking safety. She was unsure why Resident #81's care plan contained a smoking apron because she said he had never required one. She said the care plan should be accurate to provide care. Record review of the facility policy titled Care Plans, Comprehensive Person-Centered revised December 2016 reflected the following:9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the resident has a right to be treated with respect and dignity for 1 of 8 (Resident #74) residents reviewed for grooming in that: Resident #74 had facial hair on upper lip and chin. This failure could place residents with unwanted facial hair at risk of low self-esteem. The Findings:Record review of Resident #74's admission Record dated 3/13/2026 revealed she was admitted on [DATE], age of 58, and was diagnosed with nicotine dependence, lack of coordination, auditory hallucinations and major depressive disorder. Record review of Resident #74's admission MDS dated [DATE] was documented as impaired vision, usually understood, had a BIMs score of 7/15 (severely cognitively impaired), had hallucinations, she mobilized with a manual wheelchair, and required partial/moderate assistance with personal hygiene (the ability to maintain personal hygiene, including shaving). Record review of Resident #74's care plan dated 1/20/2026 revealed she required personal hygiene, the resident requires assistance by 1 staff with personal hygiene. Observation on 3/10/2026 at 3:57 PM and 3/11/2026 at 3:50 PM with Resident #74 revealed she was outside, sitting in wheelchair and had facial hair on upper lip and on her chin. Observation on 3/11/2026 at 3:50 PM with Resident #74 revealed she was outside, sitting in wheelchair and had facial hair on upper lip and on her chin. Observation on 3/12/2026 at 3:50 PM, ADON B was in Resident #74's room and observed facial hair on the upper lip and chin area. Interview on 3/11/2026 at 3:51 PM, Resident #74 stated she was embarrassed and felt like other resident's stared at her, because of her facial hair. Resident #74 stated she has had facial hair for about 2 weeks. Resident #74 stated the aides do the showers and do the grooming. Resident #74 stated she was not aware of the facial hair and did not ask staff about it. Interview on 3/12/2026 at 4 PM, ADON B stated he was not aware of Resident #74 having facial hair. ADON B stated residents are usually groomed during their showers. ADON B stated he will get the aide to care for Resident #74. Interview on 3/12/2026 at 4:27 PM, CNA G stated she cares for Resident #74's showers/grooming and did not see her facial hair and did not ask if she wanted it to shave off. Interview on 3/13/2026 at 1:30 PM, CNA H stated she did care for Resident #74 and did not notice her facial hair and did not ask her if she wanted to shave. Interview on 3/13/2026 at 2:30 PM, LVN I stated he did care for Resident #74 and had not noticed facial hair on her. Interview on 3/13/2026 at 5:51 PM, the DON stated she was not aware of Resident #74 having facial hair. The DON stated it would cause Resident #74 to be sad, and she might not want to come out of her room. Record review of Policy titled, Dignity dated February 2021 documented, Each resident shall be cared for in a manner that promotes and enhances his of her sense of well-being, level of satisfaction with life, and feelings of self- worth and self-esteem. 1. Residents are treated with dignity and respect at all time. 5. When assisting with care, residents are supported in exercising their rights. For example, residents area. groomed as they with to be groomed (facial hair).

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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** Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 of 13 residents (Resident #81) reviewed for accidents and hazards. The facility failed to ensure Resident #81 was supervised while smoking on 3/10/2026. This failure could result in injury. Findings included: Record review of Resident #81's admission Record reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included schizoaffective disorder (a disorder in which a person has difficulty distinguishing reality from hallucinations or delusions). Record review of Resident #81's annual MDS assessment submitted 12/12/2025 reflected a BIMS of 00, which indicated severely impaired cognition. Record review of Resident #81's Care Plan Report printed 3/10/2026 reflected the following:[Resident #81] is a smoker. Unsafe to smoke. May smoke WITH SUPERVISON [sic] and smoking apron in place. Has been educated on facility smoking policy. Date Initiated: 12/05/202The resident requires a smoking apron while smoking. Date Initiated: 02/18/2026The resident requires SUPERVISION [sic] while smoking. Date Initiated: 02/18/2026 Record review of Resident #81's Smoking Safety Screen dated 2/19/2026 reflected the following:1. notes on safety from IDTC (i.e. resources required to support resident, other resident safety, potential injury, capabilities): Resident require [sic] monitoring while smoking In an observation on 3/10/2026 at 3:11 PM, Resident #81 was observed in the designated smoking area of the memory care unit without staff supervision. The door to the designated smoking area leading into the memory care unit was observed to be propped open at 3:17 PM, and no staff were within eyesight of Resident #81, who was still outside smoking. In an observation and interview at 3:18 PM, CNA D emerged from a closed door and said he was the staff member responsible for supervising Resident #81, but he stepped away to obtain a trash bag from a supply closet. He said Resident #81 finished smoking at the time of the interview, so it was okay to leave him unsupervised. In an interview with ADON A on 3/12/2026 at 1:30 PM, he said Resident #81 requires supervision while smoking. He said staff supervising smokers should be outside directly supervising residents who require supervision while smoking, and the staff should not leave them unattended. Record review of the facility policy titled Smoking/ Vaping/ Electronic Cigarette Policy- Residents revised July 2017 reflected the following: .11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 8 residents (Resident #4) reviewed for medically related social services. The facility failed to ensure Resident #4 was assisted in obtaining psychology/psychiatry consultation as ordered by physician on 1/29/2026 and developing interventions that are targeted and meaningful to the resident.This failure could place residents who have a mental illness diagnoses at risk of not receiving needed mental and psychosocial counseling services.Findings included: Record review of Resident #4's admission record dated 3/13/2026, reflected that she was [AGE] years old, initial admission was on 8/27/2025 and she re-admitted on [DATE]. The resident was diagnosed with diabetes mellitus (condition that occurs when the body cannot properly use blood sugar), anxiety (a feeling of worry, nervousness, or unease), and intermittent explosive disorder (mental health condition characterized by sudden, intense outbursts of anger or aggression that are disproportionate to the situation).Record review of Resident #4's Quarterly MDS assessment dated [DATE] reflected the resident had clear speech, had the ability to understand others, clear comprehension, BIMS score of 12 indicated moderately impaired cognition, Section D: Mood severity score of 4, indicating that she had been observed with a mood disorder, Section E: Behaviors indicated the resident had no behaviors.Section GG: Functional Status reflected the resident was dependent on staff for substantial/maximal assistance for ADLs and required the use of a wheelchair. Section J: Health Conditions reflected the resident had occasional pain interference with day-to-day activities and was at risk of SOB. Section K Swallowing/Nutritional Status reflected Resident #4 had complaints of difficulty or pain with swallowing. Section M skin: reflected the resident was at risk of PU. Resident #4 required the use of a pressure reducing mattress, and application of ointments. Section N: Medications reflected the resident took an antipsychotic, antidepressant, opioid, and hypoglycemic.Record review of Resident #4's Care Plan dated 8/28/2025 and revised 11/06/2025 reflected she had an ADL self-care performance deficit related to disease process, used psychotropic/antipsychotic medications (Ziprasidone HCl) related to intermittent explosive disorder and antidepressant medication (Sertraline and Trazodone) related to Depression/Insomnia and resident had a psychosocial well-being problem related to anxiety, Dependent behavior, Disease Process, worsening condition, nursing home placement. Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability.Record review of Resident #4's physician orders dated 11/06/2025 Ziprasidone HCl Give 60 mg via PEG-Tube two times a day for Schizophrenia.Sertraline HCl Oral Tablet 100 MG Give 1 tablet via PEG-Tube in the morning for antidepressant.Monitoring -ANTIDEPRESSANTS.physician orders dated 12/13/2025 Behavior Monitoring -ANTIDEPRESSANTS. Behavior Monitoring -ANTIPSYCHOTIC.physician orders dated 1/29/2026 Behavior Monitoring -SEDATIVE/HYPNOTICS. physician orders dated 3/10/2026 Behavior Monitoring -ANTIANXIETY. Side Effect Monitoring -ANTIANXIETY.Record review of Resident #4's Psychoactive Consent dated 3/04/2026 reflected that she was prescribed psychoactive medication: Geodon 60 mg BID, antipsychotic to target behaviors: delusions, paranoia, hallucinations for diagnosis of intermittent explosive disorder.Record review of Resident #4's Consent for Antipsychotic or Neuroleptic Medication Treatment 3713 Form dated 8/27/2025 reflected her diagnosis was based on the following diagnostic criteria and assessment findings exhibited: psychotic behavior and the course of therapy with antipsychotic or neuroleptic medication is proposed with the following medication, dosage, and frequency: Risperidone 60 mg BID.Record review of Resident #4's Progress Note dated 1/29/2026 reflected the NP's ASSESSMENT/PLAN: Encourage (continued on next page)

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	455789	A. Building B. Wing	03/13/2026

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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alternative medications, nursing and psychology techniques for anxiety and sleep management. - Consider psychology/psychiatry consult as needed.Record review of Resident #4's Physician Progress Note dated 1/14/2026 reflected the resident had a Mental Illness (MI), schizophrenia.physician ordered ziprasidone. Record review of Resident #4's hospital Discharge summary dated [DATE] reflected diagnosis list included: Undifferentiated schizophrenia as of 8/5/2023. medications listed Ziprasidone, 60 mg, Oral, BID with meals.During an observation and interview on 3/11/2026 at 11:22 a.m. of Resident #4, was observed in the hallway heading towards her room ambulating in her manual wheelchair. She was dressed well, groomed appropriately, and had no odors. She was upset and said an employee stole her money from her bank and she reported it to the ADM and SW. She said the staff who stole her money was hiding in the restroom and constantly laughed at her. It was difficult to understand and keep up with Resident #4's memory and events. She was unable to keep a clear conversation, and she would lose her train of thought. She said the theft was reported to the management team, they filed a report and are investigating it. She stated she was unable to recall when the theft occurred, and she could not provide information about the date or the staff member.During an interview and record review on 3/13/2026 at 2:47 p.m. with the MDS Coordinator, she said she had been employed for four months at the facility and training on entering diagnoses for new admissions, MDS assessments, PASRR screenings, PASRR evaluations, and care plan revisions were provided by the regional staff and from online self-pace webinars. She said inaccuracy of medical records could be a problem for residents and the care they receive. She said Resident #4 did not have a MI or related condition at the time of admission and her Level I screening was negative. However, a referral was made to the appropriate state-designated authority for a Level II PASARR evaluation, and the determination of no services needed. The MDS Coordinator reviewed Resident #4's initial facility admission records, hospital discharge summary, diagnosis list, and psychiatric medication orders she admitted with, and said Resident #4 did not have a valid diagnosis of schizophrenia as she was trained that unless the supporting documentation was coming from a psychiatrist, it could not be used as a diagnosis. MDS Coordinator and surveyor reviewed Resident #4's hospital Discharge summary dated [DATE] listing Undifferentiated schizophrenia diagnosis as of 8/5/2023 and medication ordered for treatment, Ziprasidone 60 mg, and physician orders dated 11/06/2025 for Ziprasidone HCl Give 60 mg via PEG-Tube two times a day for Schizophrenia, the MDS Coordinator said after reviewing all these documents together, she believed an error in Resident #4's medical diagnosis was made. She said Resident #4's diagnoses at admission should have included MI diagnosis, schizophrenia, and should have been listed on the resident's assessment and care plan.During an interview on 3/13/2026 at 3:18 p.m., the DON said she did not know Resident #4 had a MI diagnosis of schizophrenia. She said she would need to check with psych services as to why an evaluation and follow up had not been completed for Resident #4 as ordered by the physician.During an interview on 3/13/2026 at 4:23 p.m., the DON said physician order to evaluate and treat for psych services was written, and the nursing staff is responsible for writing referrals for psych evaluation and the SW sends the referral over to the psych agency. She said SW had been employed for less than a month and believed the referral may have been lost and it was not sent over to the psych agency. She said the referral was sent over to psych services on 3/13/2026. She said the MDS Coordinator is responsible for reviewing resident electronic medical record for medical history and inputting an accurate diagnosis. After reviewing the initial admission record for Resident #4, the DON said the medical record sources documenting diagnoses and mediation orders treating schizophrenia would have been sufficient to list diagnoses in Resident #4's medical record. She said the medical record sources do not need to come from a psychiatrist. She said this error would cause the resident's assessment and care plan to not include a significant diagnosis, which could cause the resident to not receive the necessary services. During an interview on 3/13/2026 at 6:47 p.m., the SW said he had been employed with the facility for less than one month. He said he had not been given the responsibility of submitting psych referrals and was not given a psych referral for Resident #4. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility document titled, Care Plans, Comprehensive Person-Centered dated December 2016 reflected: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1 The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive assessment. 8. The comprehensive, person-centered care plan will: b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; m. aid in preventing or reducing decline in the resident's functional status and/or functional levels; o. reflect currently recognized standards of practice for problem areas and conditions. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. b. The resident's physician (or primary healthcare provider) is integral to this process.Record review of the facility's undated document titled, Rights and Obligations of the Resident reflected: MDS Privacy Act Notification, Facility is required by Medicare and Medicaid regulations to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity and health status.Record review of the facility's undated document titled, Acknowledgement/ Receipt of Privacy Practices reflected: [Facility] and my physicians will create and keep a written record of my care. The record will Include my health history, diagnosis, evaluations and test results, medications, treatments, care plan and objectives, and advance directives, If any. The record Is for use in documenting care and treatment provided, planning care, communication among care givers, a source of Information for billing and collection of health care services provided and for assessing the quality of care and services provided.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental services to meet the needs of 1 of 8 (Resident #12) residents reviewed for dental services. The facility failed to ensure Resident #12 received dental services when she had a broken tooth that caused her discomfort. This failure could place residents at risk of not receiving needed dental care and a decreased quality of life.The findings included: Record review of Resident #12?s admission record, dated 03/10/2026, reflected Resident #12 was an [AGE] year-old female who initially admitted [DATE] and re-admitted [DATE], with diagnoses to include dementia (the loss of cognitive functioning that interferes with daily life and activities), major depressive disorder, and dysphagia (difficulty in swallowing). Record review of Resident #12's quarterly MDS assessment, dated 01/24/2026, reflected Resident #12 had a BIMS score of 15 out of 15, indicating intact cognition. The MDS reflected Resident #12 required supervision or touching assistance with oral hygiene that included ability to use suitable items to clean teeth. The MDS reflected Resident #12 had a mechanically altered diet, no swallowing disorder, no significant weight loss in the last 6 months, and had no broken or loosely fitting full or partial denture or mouth or facial pain, discomfort, or difficulty with chewing. Record review of Resident #12's care plan, undated, did not address any dental issues. Record review of Resident #12's order summary report, dated 03/13/2026, reflected Dental Care PRN, order date 10/14/2025. During an interview and observation on 03/11/2026 at 09:45 AM, Resident #12 had no teeth, except for 2 tiny teeth fragments on the bottom, front center that appeared black. She revealed she had not been seen by a dentist. She revealed everything was fine with her teeth, she had not had any weight loss, and she was able to eat the food she got served at the facility. During an interview on 03/13/2026 at 12:45 PM, the SW revealed he had been at the facility for about 6 weeks and he had not assessed Resident #12 for dental services yet. He revealed he had been slowly assessing residents at the facility to include a resident's need for dental services. He reviewed the last 2 care conference meeting notes for Resident #12 and there were no notes about dental services for this resident so he revealed he could not answer when the last time Resident #12 was seen by a dentist. During an interview and observation on 03/13/2026 at 03:35 PM, RN E revealed Resident #12 was missing teeth. RN E was not aware of how Resident #12 lost her teeth. RN E asked Resident #12 about her teeth and Resident #12 revealed that her teeth had fallen out and she experienced pain from time to time but was currently not feeling any pain. Resident #12 let RN E know that she wanted to see a dentist and RN E stated she was going to work on this for her. RN E revealed if a resident complained about their teeth, they told the social worker, and the social worker would find a service to help the residents. Interview on 03/13/2026 at 06:54 PM, the ADM revealed he was not aware of how the dental services worked for this building. He asked the DON and she was not aware. He revealed he expected to receive a contract to sign so the facility could provide dental services. He revealed dental services were important because it was a service that the facility offered. Record review of facility's policy Dental Services, revised December 2016, reflected Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 1. Routine and 24-hour emergency dental services are provided to our residents through: a. a contract agreement with a licensed dentist that comes to the facility monthly.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 of 21 meals on the Week 4 menu reviewed food and nutrition services. This facility failed to ensure the residents , who consumed this meal, received a balanced dinner meal that included a protein, in accordance with established national guidelines, on Tuesday 03/10/2026 (Day 24 of the Week 4 menu). This failure could place residents at risk for a decline in health status due to inadequate or inappropriate nutritional intake, weakness, and weight loss. The findings include:Record review of the facility's Dinner on Tuesday (Day 24 of the Week 4 menu) reflected: homemade vegetable soup, house salad with dressing, crackers, and chocolate chip cookie. 1.Record review of Resident #7's admission Record dated 03/13/2026 was documented she was admitted on [DATE] with diagnoses of anemia and severe protein calorie malnutrition. Record review of Resident #7's admission MDS assessment dated [DATE] revealed her BIMS score was 12/15 (cognitively intact), she required substantial/max assistance with eating, her height was 36 and weight was 61, with no weight loss, and had mechanically altered diet. Record review of Resident #7's consolidated orders for March 2026 revealed she had an order for Regular diet, mechanical soft texture, regular liquids consistency for meals. Resident #7 had a healing stage 4 wound to coccyx. Observation on 3/11/2026 at 4:39 PM revealed Resident #7 had soup and green beans for dinner. Inan interview on 3/11/2026 at 4:40 PM, Resident #7 stated she had enough to eat with the soup. 2. Record review of Resident #85's admission Record dated 03/13/2026 he was admitted on [DATE], re-admitted on [DATE]. Record review of Resident #85's Quarterly MDS dated [DATE] revealed his BIMS score was 15/15 (cognitively intact), and he was independent with eating with no weight loss; weight was 274 pounds. Record review of Resident #85's consolidated orders for March 2026 revealed a diet order for controlled carbohydrate diet, regular texture, and regular liquids consistency. Observation on 3/10/2026 at 04:55 PM revealed Resident #85's dinner tray had vegetable soup and a grilled cheese sandwich. In an interview on 3/10/2026 at 10:44 AM, Resident #85 stated they didn't give him enough food, overall. In an interview on 3/10/2026 at 5 PM, Resident #85 stated he ordered dinner and was enough for tonight, because he ordered a grilled cheese sandwich. In an interview and observation on 3/12/2026 at 02:40 PM, the Dietary Manager revealed that she noticed there was protein missing for dinner on Tuesday, 03/20/2026, but the RD had signed off on the menus meaning the menus were approved by the RD, so she assumed the meal was balanced. In an interview on 3/12/2026 at 06:50 PM, the RD revealed she checked the menu but was not able to review every single meal of every single day because she was at the facility for a limited time. The RD stated she was not at the facility, and could not verify the meal in question did not have protein. The RD revealed it was important to include protein in a meal for balance. She revealed protein would be important for wound healing. Record review of the facility's policy Menus, revised October 2017, reflected 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board . 8. Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal. Record review of the USDA's Dietary Guidelines for Americans, dated 2025-2030, reflected a diet included protein, dairy, healthy fats, vegetables, fruits and whole grains.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #76) reviewed for infection control. The facility failed to ensure CNA C performed hand hygiene while providing incontinence care to Resident #76.This failure could lead to infection or illness. Findings included: Record review of Resident #76's admission Record dated 3/13/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included dementia (a progressive disorder characterized by memory and cognitive decline). Record review of Resident #76's annual MDS submitted 1/7/2026 reflected a BIMS score of 15, which indicated intact cognition. Record review of Resident #76's Care Plan Report printed 3/13/2026 revealed Resident #76 required staff assistance for all ADLs. In an observation and interview on 3/13/2026 at 9:15 AM, CNA C was observed performing incontinence care for Resident #76. CNA C performed 12 glove changes without hand hygiene between removing each set of soiled gloves and applying new, clean gloves. During this time, CNA C removed a soiled brief, cleansed the skin, and applied a new, clean brief to Resident #76. CNA C said she should have used hand sanitizer between each glove change to prevent infections, but she forgot as she was nervous. In an interview with the DON on 3/13/2026 at 10:50 AM, she said staff were expected to perform hand hygiene between every glove change. She said all staff have received training about infection control and hand hygiene. A policy for hand hygiene was requested from the facility but not provided before exit.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews, and record review, the facility failed to post the following information on a daily basis: Facility name, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses or licensed vocational nurses, Certified nurse aides, or retain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater for 4 of 4 (3/10,11,12,13/2026) days in that: 1. The facility did not have the facility name, the total number and actual hours worked by nursing staff 2. The facility failed to retain 18 months of the Nurse Staffing Postings. This could affect all residents and could result in residents not being aware of which staff were working for the day or not being aware of the census for the day. The findings included:Observations on 3/10/2026 at 9:00 AM in the front lobby receptionist area, revealed the nurse staffing posting. The nurse staff posting was missing the facility name and the total number and actual hours worked by nursing staff. Observation on 3/11/2026 at 9:00 AM in Font Lobby, in the receptionist area, was posted the nurse staffing posting. The nurse staff posting was missing the facility name and the total number and actual hours worked by nursing staff. Observation on 3/12/2026 at 9:00 AM with the DON, in font lobby, in the receptionist area, was posted the nurse staffing posting. The nurse staff posting was missing the facility name and the total number and actual hours worked by nursing staff. Observation on 3/13/2026 at 8:35 AM in font lobby, in the receptionist area, was posted the nurse staffing posting. The nurse staff posting was missing the facility name and the total number and actual hours worked by nursing staff. Interview on 3/12/206 at 9:00 AM in front lobby, in the receptionist area, the DON stated the nurse staffing posting did not include the name of facility, total and actual hours for nursing staff and was going to check on the 18 months of retention. The DON stated the ADON posted the nurse staffing position daily. Interview on 3/12/2026 at 6:06 PM with ADON A stated he was responsible for the nurse staffing postings, he did not have 18 months retention and no name of the facility. ADON A stated he had, in a binder, 5 months of nursing staffing postings, including November 2025, December of 2025, January 2026, February 2026, and until March 12, 2026. ADON A stated he was not trained and followed what the previous staff typed out for nurse staffing postings. ADON A stated he was not aware of the Nurse Staffing Posting requirements. Record review of the facility's policy, Posting Direct Care Daily Staffing Numbers, dated July 2016 reflected, Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. 3. Shift staffing information shall be recorded in the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include the following: 1. The name of the facility. G. The actual time worked during that shift for each category and type of nursing staff. 8. Record of staffing information for each shift will be kept for a minimum of 18 months.