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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Nursing and Rehabilitation Center	7302 Oak Manor Dr San Antonio, TX 78229

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to review the residents' total program of care, including medications and treatments, at each visit for 2 of 8 residents (Resident #1 and #2) reviewed for resident records. 1. The facility failed to ensure the physician's progress notes for Resident #1 were updated to reflect Resident #1 no longer receiving a Lidocaine patch (for polyneuropathy) at bedtime.2. The facility failed to ensure the physician's progress notes for Resident #2 were updated to reflect Resident #2 no longer receiving Benztropine Mesylate (for tremors) at bedtime. This failure could place residents at risk for incorrect treatment decisions and incorrect medication administration, compromising patient safety. The findings included: 1. Record review of Resident #1's admission Record, dated 12/09/25, reflected a [AGE] year-old female with an admission date of 09/11/25 and a re-admission date of 09/23/25. It further reflected that the resident had diagnoses that included polyneuropathy (nerve disease caused by nerve damage). Record review of Resident #1's MDS Assessment (no type identified), dated 10/03/25, reflected Resident #1 had a BIMS score of 14 out of 15, indicating intact cognition. Record review of Resident #1's care plan, undated, reflected no mention of taking medications for polyneuropathy. Record review of Resident #1's Medication Administration Record from October to December, dated 12/09/25, reflected Lidocaine External Patch 5% was discontinued on 10/20/2025. Record review of Resident #1's Order Summary Report, dated 12/09/25, reflected no doctor's orders for a Lidocaine patch. Record review of Resident #1's most recent Physician Progress Notes as of 12/09/25, dated 12/08/25 at 02:49 PM, reflected . Neuropathy -Continue Gabapentin TID, Lidocaine patch HS. Interview on 12/10/25 at 01:53 PM, LVN B revealed Resident #1 did not have doctor's orders for a lidocaine patch, but the doctor's progress notes did say to continue the lidocaine patch at night. She revealed she was unaware of the last time she administered a Lidocaine patch to Resident #1. She revealed she had to call the doctor to make sure Resident #1 should not be receiving lidocaine patch because it was in her doctor's progress notes but not in her orders. She revealed it was important to make sure the doctor's progress notes reflected the doctor's orders for continuity of care. 2. Record review of Resident #2's admission Record, dated 12/09/25, reflected a [AGE] year-old male with an admission date of 10/12/2025 and a re-admission date of 10/20/25. It further reflected that the resident had diagnoses that included abnormalities of gait and mobility. Record review of Resident #2's quarterly MDS Assessment, dated 11/21/25, reflected Resident #2 had a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #2's care plan, undated, reflected no mention of taking medications for tremors. Record review of Resident #2's discontinued medications, undated, reflected Resident #2 had Benztropine Mesylate discontinued on 03/24/25. Record review of Resident #2's Order Summary Report, dated 12/09/25, reflected no doctor's orders for Benztropine Mesylate. Record review of Resident #2's most recent Physician Progress Notes as of 12/09/25, dated 11/28/25 at 02:49 PM, reflected . Essential tremors -managed -[Continue] Benztropine. Interview on 12/10/25 at 01:17 PM, LVN A reviewed the doctor's orders for Resident #2 and confirmed resident had not been receiving Benztropine since 03/24/25. She revealed the doctor's progress notes did say resident was receiving Benztropine. She revealed she was responsible for reviewing doctor's progress notes to make sure the medications were the same as the doctor's orders to ensure consistency in resident care. Interview on 12/10/25 at 02:39PM, the DON revealed it was best practice to focus on the actual doctor's orders instead of doctor's progress notes. She was not aware of why these medications were still on the doctor's progress notes when they were not in the residents' doctor's orders. She revealed she would need to have a conversation with the doctors to get this updated. She revealed it could affect resident care because if they send the progress notes to any facility it could affect the continuity of care. She revealed she did not oversee the accuracy of the doctor's progress notes and it should be the responsibility for the doctors to review their notes for accuracy. She revealed she ensured doctor's notes were completed but did not review the quality of the doctor's notes. Interview on 12/10/25 at 03:39 PM, the MD revealed he ensured his progress notes were complete to reflect resident's current plan of care. He revealed sometimes they may miss updating their progress notes to reflect every change the resident has had, to include medication updates. He revealed he ensured the doctor's orders that controlled what the medications the residents received were appropriate, so resident care was not negatively affected. He revealed they could work on updating their doctor's progress notes. He revealed he was made aware of the medication discrepancies with Resident #1 and Resident #2 and this will be fixed. Record review of