STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676012	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Park Nursing & Rehabilitation Center	8503 Mystic Park San Antonio, TX 78254

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review the facility failed to provide a clean, comfortable, and homelike environment with housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 2 of 6 residents (Residents #3 and #4) reviewed for resident rights: Residents #3 and #4 shared a room with a strong odor of urine. This failure could place residents at risk of embarrassment, humiliation, low self-esteem, and not residing in a sanitary and comfortable, homelike environment. The findings were: Record review of Resident #3's face sheet dated 12/18/24 revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included cerebral palsy (a congenital disorder of movement, muscle tone, or posture due to damage or abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance.), Epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures), and unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed the resident's speech was unclear, and no BIMS interview was completed. The resident was dependent on staff for toileting, bathing, and personal hygiene. The resident was frequently incontinent of urine and bowel. The resident usually understands and was sometimes able to be understood. Record review of Resident #3's care plan revised on 3/22/24 revealed a focus for ADL self-care with a goal to maintain current level of function in bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene. Interventions were for staff assistance. Another focus for incontinence revised on 3/22/24 and interventions included checking the resident's brief and cleaning the resident. Another focus for a potential behavior problem revised 8/12/24 included the resident urinating in common areas or in his bed after being taken to the toilet by staff. Interventions included to anticipate and meet needs, psych evaluation and treatment, and praise. (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: 676012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's face sheet dated 12/19/24 revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included unspecified dementia, mild with other behavioral disturbance (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), aphasia following cerebral infarction (disorder that impairs the expression and understanding of language as well as reading and writing following a stroke), and muscle wasting and atrophy not elsewhere classified multiple sites (wasting or loss of muscle tissue). Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed the resident's speech was unclear, and no BIMS interview was completed. Assessment for daily decision making indicated the resident was severely cognitively impaired. The resident was totally dependent on staff for toileting, bathing, and personal hygiene. The resident was frequently incontinent of urine and bowel. The resident usually understands and was sometimes able to be understood. Record review of Resident #4's care plan revised on 11/24/24 revealed a focus for the resident refusing to participate in activities and refusing to come out of his room for daily activities with a goal for the resident to be satisfied. Interventions included to invite and encourage to participate in activities. Record review of the housekeeping employee schedule for November 2024 and December 2024 revealed a starred note at the bottom of the schedules *note clean (Resident #3 and #4's rm #) twice per day AM and PM. In an observation and interview on 12/16/24 at 3:00 p.m. upon entering Residents #3 and #4's shared room, a strong odor of urine was noted. Resident #3 was on a low bed on the floor with no sheets, had two blankets balled up, 1 sock on and 1 sock off. Resident #3 was dressed in sweatpants and a t-shirt. Resident #3's mattress was slid slightly away from the wall and the frame of the bed. Resident #3 smiled at me when calling his name but was unable to answer questions. The resident was observed moving around in the bed at will. A fall mat with a gray zipped covering was on the floor next to his bed. The source of the urine odor was unknown. CNA A was passing by in the hallway and stated she and another CNA were assigned to Resident #3. CNA A did not enter the room, but when asked if the room always smelled like that, CNA A stated yes, due to Resident #3 urinating on the floor at night. During attempts to interview Resident #4, he made eye contact, but did not reply to my questions. In an observation and interview on 12/16/24 at 3:08 p.m. in Residents #3 and #4's shared room, the strong odor of urine remained, and the DON stated, she could smell the urine and stated the room was on a twice daily cleaning schedule and they used special cleaning solution in the room due to Resident #3 urinating on the floor and other places at will. The DON stated she would check with housekeeping on cleaning the room and what specific solution they used. In an observation on 12/16/24 at 3:39 p.m. Residents #3 and #4's shared room continued with the strong urine smell, and Resident #3's fall mat remained in place next to his bed. Residents #3 and #4 did not appear to be wet and had no wet areas to their clothing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mystic Park Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8503 Mystic Park San Antonio, TX 78254	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 12/16/24 at 3:50 p.m. of Residents #3 and #4's shared room and the strong urine odor remained present in the room but stronger on Resident #3's side of the room. The fall mat next to Resident #3's bed remained and the resident was in the bed. Upon lifting the corner of the fall mat the underside of the mat and the floor were both wet with standing liquid on the fall mat and floor. The DON arrived to the room at 3:58 p.m. and after donning gloves lifted the fall mat and the entire underside of the fall mat and under mat on the floor was wet with standing liquid with whitish bubble looking lines scattered in different areas. After putting on a glove, this surveyor observed a corner where the foam was viewable by the zipper to the fall mat cover and the foam inside the zipped cover was observed to leave wetness on the glove and was wet. The odor of the liquid on the floor, the underside of the mat, and the foam had the same strong urine odor. The Administrator came to the room at 4:00 p.m. and stated the room was cleaned twice daily due to the resident urinating on the floor. The fall mat would be thrown in the trash and replaced with a new one but was switched out when wet to be cleaned. In an observation on 12/18/24 at 11:45 a.m. in Residents #3 and #4's shared room, Resident #4 was in bed watching TV, Resident #3 was not in the room. The fall mat on the floor was a blue one and appeared to be new or in like new condition and was clean and dry. A slight urine odor was detected but no excessive or strong urine odors were noted in the room. In an interview on 12/18/24 at 2:07 p.m. the DON stated Resident #3's fall mat was a new mat and they threw the old fall mat in the trash because the actual foam inside the fall mat was wet. The DON stated the room was cleaned twice daily and if the fall mat had been urinated on it was sent to the laundry for cleaning and switched out with another fall mat. In an interview on 12/19/24 at 3:31 p.m. the DON stated during the observation on 12/16/24 at 3:58 p.m. in Residents #3 and #4's shared room, the standing liquid looked like a combination of cleaning solution and urine. The DON stated it smelled like a combination to her as well. The DON stated she only smelled urine in the room when Resident #3 urinated on the floor and they would get housekeeping to clean. The DON stated Resident #4 had never complained of it being an issue. The DON stated it was important the room did not smell like urine to ensure a sanitary, homelike environment. When asked if she would want to sleep in that room with that smell, the DON stated she would not. In an interview on 12/19/24 at 3:52 p.m. the Administrator stated during the observation on 12/16/24 at 4:00 p.m. he could only smell the urine a little bit. The Administrator stated the room was cleaned twice daily and as needed. The Administrator stated the old fall mat was thrown away and replaced with a new one and the room was cleaned as well. The Administrator stated it was important for the room to not smell like urine to ensure a sanitary homelike environment and respect for the residents. In an interview on 12/19/24 at 4:02pm with HK B and HK C they stated they were both familiar with Residents #3 and #4's shared room. HK B stated it was cleaned twice daily. HK C stated it was cleaned twice daily around 8:00 a.m. and again after 1:00 p.m. and when requested by staff due to Resident #3 urinating. HK C further stated they did clean the fall mats especially in that room due to the resident urinating on the floor and him moving the mat. HK B stated they clean every nook and cranny in that room due to the resident urinating on stuff and they moved the bed as well to clean. HK C stated they did a deep cleaning twice daily. HK B and HK C both stated the room was cleaned with the same cleaning solutions that other rooms were cleaned with. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated policy on resident rights indicated . Residents have the right to 1. Be treated with respect and dignity as well as . Have a clean and safe environment .

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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 - Few	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** 42031 44020 Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was 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 in accordance with State law through established procedures for 2 of 6 residents (Residents #1 and #2), reviewed for abuse and neglect. 1. Resident #1 was found to have a 9X3 abrasion to the back of her right shoulder and an abrasion to her right elbow on 8/15/24 that was not witnessed and not reported to HHSC. 2. The facility failed to report an unobserved fall where Resident #2 was sent for a hospital evaluation. This failure could place residents at risk of abuse and or neglect. The findings were: 1. Record review of Resident #1's face sheet dated 12/19/24 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included Alzheimer's disease unspecified (general term for memory loss and other cognitive abilities serious enough to interfere with daily life), restlessness and agitation, and muscle wasting and atrophy not elsewhere classified multiple sites (wasting or loss of muscle tissue). Record review of Resident #1's discharge return anticipated MDS assessment dated [DATE] revealed the resident's BIMS was blank and her cognitive assessment indicated the resident was severely impaired cognitively. The resident had inattention and disorganized thinking. The resident was frequently incontinent of urine and always incontinent of bowel and was receiving hospice services. Record review of Resident #1's undated care plan revealed a focus for high fall risk due to Alzheimer's disease, weakness, and lack of coordination revised on 3/15/24 with interventions that included toileting the resident, sensory bracelet, among others. Another focus for actual falls due to poor balance and safety awareness. Interventions included a bolster mattress, encourage activities, and wear a soft helmet. Record review of Resident #1's provider investigation report from a facility self-report dated 8/27/24 revealed a skin evaluation dated 8/26/24 by RN F Rugburn scrape to right posterior shoulder and right elbow are resolving and remain closed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes revealed a late entry with an effective date of 8/23/24 at 7:21 p.m. by RN F Late Entry for 8/23/2024. Resident continues with resolving rugburn scrapes to right elbow and right posterior back. Right elbow has a light reddish/brown discoloration. Right posterior shoulder is mostly pink skin with a small amount of reddish/brown discoloration. Skin prep is being applied to right elbow daily. Right posterior shoulder is being treated with a dry dressing 2 times per week and PRN. Resident has severe EPS (Extrapyramidal side effects - drug induced involuntary movements that one cannot control) and has constant movement of her extremities and severe pelvic thrusting. Record review of Resident #1's progress notes revealed a note by RN F dated 8/15/24 with no time the resident was found to have a 9x3 abrasion (medical record did not specify cm or in) to the back of her right shoulder and an abrasion to her right elbow that were likely from the resident's EPS movements. In an observation on 12/16/24 at 3:16 p.m. Resident #1 was seated in a wheelchair in the secure unit dining room at a table with a sensory board in front of her. The resident would periodically move her hands to the soft helmet or push the wheelchair to roll backwards using her feet. The resident was not able to answer questions appropriately. A staff member was standing near the resident and redirecting her attention to the sensory board and the resident would lean forward and touch the activity board but was unable to stay focused on any tasks. No EPS movements of pelvic thrusting or shoulder movements were observed, no tremors, or repetitive movements were observed. In an interview on 12/19/24 at 10:25 a.m. the Administrator stated RN F was no longer at the facility and had transferred to a sister facility. The contact number for RN F was requested and never received. In an interview on 12/19/24 at 2:40 p.m. the ADON stated, Resident #1's EPS movements have decreased significantly. The ADON stated the abrasion to the back and elbow on 8/15/24 were likely from the resident's EPS movements. The ADON stated it was important to investigate injuries to determine the cause and to make sure it was not abuse. The ADON stated she felt it was the resident's EPS movements at the time that caused the abrasions. In an interview on 12/19/24 3:31pm the DON stated Resident #1's constant movements were the cause of the abrasion to her back/shoulder and elbow. The DON stated she thought the EPS movements were care planned but stated she was unable to find them on the care plan. The DON stated these injuries were not reported to HHSC because she felt they did not fall under the categories for reporting according to the Provider letter . The DON stated it was important to report injuries to ensure the proper investigation was being completed. In an interview on 12/19/24 at 3:52 p.m. the Administrator stated he did not recall at that time why the abrasions for Resident #1 on 8/15/24 were not reported to HHSC. The Administrator stated it was important for injuries to be reported so an investigation took place and to find out the source of the injury. The Administrator stated the health and safety of the residents would be the risks for not reporting. The Administrator stated some incidents were not reported to HHSC due to following the guidance of the Provider Letter PL-2024-14. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #2's face sheet, dated 12/18/2024, revealed Resident #2 was admitted on [DATE] with diagnoses which included: Alzheimer's disease, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified osteoarthritis, unspecified site, need for assistance with personal care, muscle weakness (generalized), difficulty in walking, not elsewhere classified, and other abnormalities of gait and mobility. Record review of Resident #2's Quarterly MDS assessment, dated 11/01/2024, revealed Resident #2's BIMS score was 00 indicating severe cognitive impairment and she was dependent of staff for sitting to lying, lying to sitting on side of bed, sit to stand and chair/bed to chair transfers (helper does all of the effort). Record review of Resident #2's care plan date initiated 08/16/2024 had a focus of Has had an actual fall r/t Poor Balance .08/15/24: Fall from WC; No injury, 10/25/24 Fall from WC; Abrasion to L side of face. revealing a revision date of 10/28/2024. Care plan interventions/tasks read 08/15/24: staff to assist resident to bed after dinner services date initiated 08/16/2024, 10/25/2024: Nonskid socks provided when OOB Date initiated: 10/28/2024. Record review of Resident #2's nursing progress note dated 10/25/2024, time 07:30 a.m. read Resident had a fall resulting to a discoloration to left side of forehead and bridge of nose. Remained alert c/o pain was given 650 mg of Tylenol. Notified PA and family. Resident was sent to [hospital name] to be evaluated Record review of Resident #2's Fall Risk Evaluation effective date 08/15/2024 read Category: High Risk. During an interview on 12/18/2024 at 11:11 a.m. LVN D stated she believed Resident #2 had leaned forward in her wheelchair and fallen from the wheelchair in the television area. Stating resident was face down when she was found and unable to communicate or describe what had happened. LVN D stated assessed resident and resident was sent out to the emergency room for an evaluation due to her having discoloration to her face. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2024 at 5:39 p.m. the DON stated Resident #2 was sent out to the ER because she was on an anti-coagulant (blood thinner). The DON further stated the facility will usually send residents to the ER for evaluation when they suffer a fall and are taking an anti-coagulant to rule out a bleed. The DON stated she had been reporting falls with injury until the updated provider letter. The DON provided a copy of the provider letter PL 2024-14 (Replaces PL 2019-17) Title: Abuse, Neglect, exploitation, misappropriation of Resident Property and other incidents that a nursing facility (NF), Must Report to the Health and Human Services Commission (HHSC). The DON referred to Page 4 of 13 pages section titled Do Not Report * an injury that is not suspicious or of unknown source. as the reason for not reporting the incident. The DON stated a root cause analysis was done and interviews were performed by the ADON. The DON stated the fall occurred at 6:15 a.m. and this was typically when they were getting residents up for the dining room and would have been getting residents ready for the breakfast. The DON further stated residents were placed near the nursing station and in the common area before going into the dining room. The DON stated the incident was not reported because it was not suspicious, she was following the provider letter from August 2024, resident tended to attempt to stand up at times which could potentially cause a fall when leaning forward to get up, resident received an anti-coagulant and resident was sent to the ER as per the facility policy and procedures. During an interview on 12/18/2024 at 5:43 p.m. the ADON stated when a resident was found on the floor, they considered it a fall due to the change in plane. The ADON stated there were no witnesses and Resident #2 was not able to tell her what happened. The ADON stated the investigation process of the incident involved interviewing staff when the resident was found, how they found the resident. The ADON stated Resident #2 would try to get up at times on her own and in her attempts to get up, she would lean forward. The ADON stated Resident #2 was sent to the ER to ensure there were no other injuries. During an interview on 12/19/2024 at 2:13 p.m. with CNA E, she stated the day Resident #2 fell , she was already up in the common area when CNA E arrived at 6:00 a.m. for her shift. CNA E further stated she heard staff call for assistance because Resident #2 had fallen. CNA E stated Resident #2, at times, would lean forward in her wheelchair and fidget with her leg rest of the wheelchair. During an interview on 12/19/2024 at 3:52 p.m. the ADM stated when incidents occurred, they followed the guidance of the provider letter that had been updated in August of 2024. The ADM stated it was important for unobserved incidents to be reported to the authorities to ensure investigations take place. He further stated reporting helped in finding out the source and helped to ensure the resident were safe. Record review of facility's Incident/Accidents policy, no date, read, Policy: It is the policy of this facility to ensure all incidents/accidents occurring on our premises are investigated and reported to the administrator and/or DON. Procedure: 3. Investigation and follow up. B. Should the incident/accident meet the requirements of reporting to the State Department of Health, the Administrator of Director of Nursing will follow regulations. Record review of facility's undated Anticoagulants related to Falls policy read, Policy: It is the policy of the facility to ensure proper treatment is conducted for residents who are on anticoagulants that sustain falls. Procedures: 1. If resident sustains an unwitnessed fall and unable to give description, med profile must be checked for anticoagulant use. If resident takes anticoagulants, notify physician, and send out to ER for a CT of the head to rule out head [NAME]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy undated for incidents and accidents . 3. B. Should incident/accident meet the requirements of reporting to the State Department of Health, the Administrator or Director of Nursing will follow regulations.