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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Park Nursing and 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 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 each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans: The facility failed to ensure Resident #1 had pink neon tape on her wheelchair brakes as stated in her comprehensive care plan. This deficient practice could place residents at risk of receiving improper care and services. The findings included: Record review of Resident #1's face sheet dated 06/30/2026 revealed an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease, unspecified (progressive memory loss and cognitive decline) and unsteadiness on feet. Record review of Resident #1's MDS assessment, dated 06/06/2026, revealed a BIMS score of 0 out of 15 indicating the resident's cognition was severely impaired. Further review of the MDS under Section J - Health Conditions indicated Resident #1 had 2 or more falls' in section J1800. Any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS), whichever is more recent. Record review of Resident #1's care plan, dated 5/28/2024, revealed a focus area for the following: At risk for falls r/t poor mobility, muscle wasting and atrophy- multiple sites, weakness revised on 11/21/2024, with interventions that included 11/5/24: Pink neon tape applied to WC brakes initiated on 07/19/2025. Observation on 06/30/2026 at 10:45 a.m., revealed Resident #1 was asleep in her room with a wheelchair by her bedside with no pink neon tape on the brakes. During an interview on 06/30/2026 at 1:01 p.m., CNA A stated they had access to Resident #1's care plan through their Kardex. CNA A stated Resident #1 was a fall risk, and CNA A was unsure of the fall interventions in place for Resident #1, they could access the Kardex which would show the interventions. CNA A stated they could not remember seeing pink neon brakes on Resident #1's wheelchair brakes. CNA A stated the risk of not following interventions on a comprehensive care plan could be falls occurring. Observation on 06/30/2026 at 1:13 p.m., revealed Resident #1 being pushed by staff in a wheelchair, with no neon pink tape on the brakes, to the common area. During an interview on 06/30/2026 at 1:14 p.m., LVN B stated Resident #1 has had falls in the past. LVN B stated they had access to Resident #1's care plan with their fall interventions listed. LVN B stated on the morning of 06/30/2026 LVN B had switched Resident #1's wheelchair to a smaller wheelchair which LVN B stated they felt was safer for Resident #1. LVN B stated Resident #1's original wheelchair had pink neon tape on their wheelchair brakes, but the one Resident #1 was currently in did not. LVN B stated the pink neon tape to Resident #1's wheelchair was used to help Resident #1 use the wheelchair breaks. LVN B stated the risk of not following interventions on a comprehensive care plan could lead to consequences for the residents. During an interview on 06/30/2026 at 1:36 p.m., the DON stated nurses had access to resident's care plans and CNAs had access to residents Kardex's, and that both the care plan and Kardex showed interventions in place for residents. The DON stated nursing staff should be ensuring the interventions on resident's care plans were put in place. The DON stated LVN B should have contacted the ADON if (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN B felt the current wheelchair for Resident #1 was no longer safe for Resident #1. The DON stated the risk of not following interventions on a comprehensive care plan could lead to the potential for falls. Record review of the facility's policy titled, Fall Management System, dated 10/25, revealed: Policy: It is policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.