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	07/02/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident had the right to secure and confidential personal and clinical records for 1 of 1 resident (Resident #1) reviewed for Privacy and Confidentiality. The facility failed to ensure Resident #1's clinical information was not sent to other facilities without the resident's and responsible party's permission. This failure could result in residents' personal information being exposed to unauthorized individuals. Based on interview and record review, the facility failed to ensure that each resident had the right to secure and confidential personal and clinical records for 1 resident (Resident #1) reviewed for Privacy and Confidentiality. The facility failed to ensure resident #1's clinical information was not sent to other facilities without the resident's and responsible party's permission. This failure could result in residents' personal information being exposed to unauthorized individuals. Findings included: Record review of the Face Sheet for Resident #1 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included altered mental status, (a sudden or significant change in a person's baseline awareness, cognition, or consciousness), hallucinations (sensory experiences that seem entirely real but are created by your mind without an actual external stimulus), and Type 2 diabetes mellitus without complications (indicates the body doesn't use insulin properly but hasn't sustained damage to the kidneys, nerves or eyes). Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 13 indicating she was cognitively intact. Record review of Resident #1's initial Care Plan dated 6/29/26 indicated she used anti-anxiety medication for anxiety and had impaired cognitive function or impaired thought processes related to a new environment. Record review of Resident #1's Elopement Assessment revealed she had a cognitive impairment or diagnosis associated with impaired judgment or wayfinding (for example dementia, Alzheimer's disease, delirium, psychosis, severe mood disorder); she has a history of elopement or an attempted elopement while at home; the family or responsible party expressed concern that the resident may attempt to leave the facility unsafely, and the resident has verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door. Record review of the hospital discharge notes dated 06/27/26 revealed Suspect some dementia with psychosis, Neurology consulted, continue with low-dose Seroquel and as needed antipsychotics, possibly has Lewy body dementia (a progressive brain disorder caused by abnormal protein deposits, called Lewy bodies, in the brain). Will need outpatient neuro for further evaluation. There was also a note that reflected [NAME] dependence - counseling done - continue to wean off. Record review of Resident #1's Progress Notes dated 06/30/26 by the Social Worker indicated SWr sent transfer referrals for [Resident #1] to [area nursing facilities] as per [Resident #1's] wishes. Interview on 07/02/26 at 10:18 a.m. with FM A, revealed that Resident #1 entered the facility on 06/27/26 from the hospital. Resident #1 had taken the medication, temazepam, for over 2 years and was asking for it. Resident #1 and the family were told that it had not been prescribed but they could give her something else to help her sleep. FM A stated they thought the nurse had told them they could bring her medication from home so that was what they did, and they put it in Resident #1's purse in her bedside table. FM A stated she did not read the list of prohibited items when she signed the admission paperwork since a nurse did the paperwork with her (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and just told her where to sign. FM A stated when they told the nurse they had brought it, she said it could not be in the resident's room and had to be prescribed by the doctor. FM A stated the nurse then proceeded to take the medication out of the room which then upset the resident. FM A then stated that a couple of days after the incident, the family was told the resident could not stay there and needed to find alternate placement. FM A stated no discharge notice was given. FM A stated they had already discussed placement with a memory care facility and were just waiting for the facility to complete remodeling of the room which would take at least a week. FM A stated the insurance had told them Resident #1 could receive rehab at the current facility until July 16, 2026. During an interview on 07/02/2026 at 1:05 pm, FM A stated she felt things were going better now but FM B was receiving calls from other facilities about admission which neither family member had requested. FM A was afraid the facility was going to force them to leave due to the medication issue and they really wanted Resident #1 to just make one move to the memory care unit. During an interview with the Adm Dir on 7/2/26 at 2:15 pm, the admissions and discharge processes were discussed. The Adm Dir stated they started doing discharge plans at admission. The Adm Dir stated they did have a list of items that could not be brought into the facility, such as medication, which was in the admission Packet, and she went over that with the family during the admission process. During an interview with the ADON on 7/2/26 at 2:35 pm, the ADON stated the facility started the discharge process at admission. The ADON stated We have weekly meetings and make sure the resident had a safe place to discharge. The ADON stated therapy and the doctor had input into the discharge process. The ADON stated they conducted a 72-hour care plan meeting and discussed discharge plans at that time. She stated the facility could provide the family options for facilities, and they gave them a list of facilities that may be able to take the resident. During an interview with the Social Worker on 07/02/26 at 3:10 pm, he stated the team had a 72-hour care plan meeting to discuss discharge plans. He stated they normally asked the family if they had a preference to see if they had a certain facility or part of town, they wanted resident to be in. The Social Worker was asked how he knew that Resident #1 wanted to move. The Social Worker stated that Resident #1 had asked to move and told me she didn't want to stay but the family didn't want to move her. Since the resident only spoke Spanish, the Social Worker was asked if he was able to speak with Resident #1 in Spanish. The Social Worker stated that he had some nurses translate for him and through the nurses notes I did confirm with her that she wanted to move. The Social Worker then stated that Resident #1 has a BIMS score of 13, so he doubted that she had dementia and said, with that score, I'm not sure she has a diagnosis of dementia. The Social Worker further stated that he knew the family wanted her to go to a local memory care unit, but he didn't know if she would qualify. The Social Worker stated he sent out referrals based on the request of Resident #1. During an interview with the Ops Manager on 07/02/26 at 5:07 pm, the issues regarding the family's concerns of not giving permission to send clinical information to other facilities was discussed as well as the issue with medication concerns. The Ops Manager stated the facility usually assisted families in finding alternate placement and was not aware Resident #1's family had already made other arrangements. He felt the discussion about alternate placement was held during the initial care plan meeting. During an interview with the MDS Coordinator on 07/02/26 at 5:15 pm, she stated the team met on 06/29/26 for the 72-hour care plan meeting. The MDS Coordinator stated the POA, FM B, was on the phone for the meeting. She said they discussed the fact the facility did not have a Medicaid Pending bed so she would need to find alternate placement. During an interview on 07/02/26 at 5:20 pm, the Ops Manager pointed out the documentation from the care plan meeting that reflected IDT team called [POA] to have the initial care plan because Resident #1 was asleep (and sometimes confused). The team confirmed that she wanted LTC and SWr is to assist in finding her LTC as [facility] doesn't have a Medicaid pending bed. During a phone interview on 07/02/26 at 5:30 pm, FM B/POA was asked about the discussion at the meeting. FM B stated Resident #1 liked the facility and wanted to stay but the facility told her they didn't have a Medicaid pending bed. FM B/POA stated she told them she would find placement (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #1 and did not ask for referrals to be sent to other facilities. FM B/POA further stated she and FM A were told the day after the meeting by the Social Worker and his assistant Resident #1 could no longer stay at the facility. The FM B/POA stated she didn't know what had changed, except for the issue with medication which had been resolved, since the initial agreement was that Resident #1 was going to get therapy in the facility until July 16th and would then either discharge to their preferred memory care unit or they would have to pay $218 per day which the family agreed to do if needed. FM B/POA stated she did not believe it was right that Resident #1's information had been shared with other facilities without her permission. She further stated she just wanted to stop receiving calls and emails from those facilities. Record review of the undated Policy/Procedure for Discharge Planning Process:The Facility's discharge planning process shall:Provide and document sufficient preparation and orientation to residents, in a form and manner that the resident can understand, to ensure safe and orderly transfer or discharge from the Facility.d. Involve the interdisciplinary team (IDT) in the ongoing process of developing the discharge plan. The IDT shall include: the resident's attending physician, a registered nurse and nurse's aide with responsibility for the resident, a staff member from food and nutrition services, the resident and the resident's representative (to the extent possible). h. Document that a resident has been asked about their interest in receiving information regarding returning to the community. i. If the resident indicates an interest in returning to the community, the Facility shall document any referrals to local contact agencies or other appropriate entities made for this purpose. 4. The Facility shall document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.