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No. 0938-0391

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 04/03/2026

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 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 interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 6 residents (Resident #88) who were reviewed for resident assessments. The facility failed to document Resident #88's use of pain medication on the quarterly MDS assessment. This failure could place residents at risk of improper or incorrect care or of not receiving services necessary for their physical, mental, and psychosocial well-being.The findings included: Record review of Resident #88's admission sheet dated 5/05/2023, with an original admission date of 01/18/2022 documented a [AGE] year-old male resident with diagnoses including cerebral infarction (stroke), type 2 diabetes mellitus, MDD, spinal stenosis (the narrowing of one or more spaces within the spinal canal), PTSD, anxiety, and hypertension (high blood pressure). Record review of Resident #88's quarterly MDS assessment, dated 01/05/2026 documented a BIMS score of 15 indicating intact cognition. Further review of the resident's MDS revealed the assessment recorded an answer of 0 in section J0100: Pain Management. At any time in the last 5 days has the resident A. Received scheduled pain medication regimen? 0. No. Record review of Resident #88's order summary documented an order for Tramadol (an opioid analgesic for pain) with an order date of 9/07/2025. Tramadol was ordered as Tramadol 50mg, Give 1 tablet by mouth three times a day for SPINAL STENOSIS. Record review of Resident #88's January 2026 MAR documented the resident received Tramadol as prescribed during the lookback period from 01/01/2026 through 01/05/2026. Record review of Resident #88s care plan with an initiation date of 12/26/2025 documented the resident Is on Pain medication Therapy .SPINAL STENOSIS, HEMIPLEGIA AND HEMIPARESIS, with a goal of Will be free of any discomfort or adverse side effects from pain medication through the review date. During an interview with MDS LVN B on 4/02/2026 at 1:40 PM, MDS LVN B stated for MDS assessments the accuracy is ensured by me and MDS LVN C. MDS LVN B stated, it is important for the MDS to be accurate, because it depicts everything at that ARD date, everything for that resident. MDS LVN B stated, you want it to be accurate and show an accurate picture of the resident. MDS LVN B stated, I don't think an inaccurate MDS would affect the resident in any way. MDS LVN B stated yes, Resident #88's Tramadol should have been coded on the MDS because he was receiving scheduled pain medication. During a second interview with MDS LVN B, on 4/02/2026 at 2:15 PM, MDS LVN B stated they follow the RAI manual from CMS as the policy for MDS assessmentsDuring an interview the DON on 4/02/2026 at 2:58 PM, the DON stated yes the MDS assessments should be accurate, because we want to make sure we are painting a clear picture of the resident. The DON stated her expectation was for staff to complete accurate MDS assessments, because that is the resident assessment. The DON stated MDS inaccuracies could not have an effect on the resident themself.Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025, noted Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen Code 1, yes: if the medical record contains documentation that a scheduled pain medication was received.

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 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 interview and record review, the facility failed to coordinate assessments with the PASRR program for 1 of 6 residents (Resident #88) reviewed for PASRR assessments. The facility did not refer Resident #88 to the appropriate state-designated mental health authority for review with the diagnoses of MDD and PTSD. This failure could place residents at risk of a diminished quality of life related to not receiving or benefiting from specialized services.The findings included: Record review of Resident #88's admission sheet dated 5/05/2023, with an original admission date of 01/18/2022 documented a [AGE] year-old male resident with diagnoses including cerebral infarction (stroke), type 2 diabetes mellitus, MDD, spinal stenosis (the narrowing of one or more spaces within the spinal canal), PTSD, anxiety, and hypertension (high blood pressure). Record review of Resident #88's quarterly MDS assessment, dated 01/05/2026 documented a BIMS score of 15 indicating intact cognition. Further review of the resident's assessment recorded in Section I - Active Diagnoses, Psychiatric/Mood Disorder, the diagnoses of I5900. Depression and I6100. Post Traumatic Stress Disorder. Record review of Resident #88's order summary included an active order for the antidepressant medication Celexa, with an order date of 5/05/2023. Celexa was ordered as Celexa 10 mg, Give 1 tablet by mouth one time a day for depression. Record review of Resident #88s January 2026 MAR documented the resident was receiving Celexa as prescribed. Record review of Resident #88's care plan with an initiation date of 11/17/2024 noted the resident is At Risk for Re-traumatization r/t history of trauma/ Post-Traumatic Stress Disorder (PTSD) He reports Post Traumatic Stress Disorder after episode of being trapped in a manhole of some sort and history of being assaulted. Further review of Resident #88's care plan with an initiation date of 01/11/2023 note the resident HAS A MOOD PROBLEM R/T MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE ANXIETY DISORDER, UNSPECIFIED OTHER PSYCHOACTIVE SUBSTANCE ABUSE HOMELESSNESS. Record review of physician progress note dated 11/18/2022 documented EXAM: Increased yelling out, Impulsive, Mood changes, Delusions, Increased anxiety, Wheelchair, Easily angers, Disoriented, Withdrawn, and diagnoses including Major depressive disorder, recurrent, severe with psychotic symptoms, and Generalized anxiety disorder. Record review of Resident #88's behavioral health services note dated 11/02/2023 documented in Past History: 2. Treatment goal: Psychiatric History: Patient has extensive history of psychiatric treatment and hospitalizations, he is unable to state medications that have been trialed in the past. He reports Post Traumatic Stress Disorder after episode of being trapped in a manhole of some sort and history of being assaulted, and Treatment Schedule: weekly due to recent variability of mood and behaviors. Record review of psychiatry follow up dated 4/30/2025 documented under Active Medical Problems diagnoses including MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE and POST-TRAUMATIC STRESS DISORDER, CHRONIC. During an interview with MDS LVN C on 4/02/2026 at 9:58 AM, MDS LVN C stated, there should not have been another PL1 done for the MDD, because we do not usually do a PL1 for MDD. MDS LVN C stated ID, MS, Cerebral palsy, are the diagnoses they do a PL1 for, and we do audits with qualifying diagnoses from CMS. MDS LVN C stated, we do not do a PL1 for MDD, and Resident #88's diagnosis of PTSD could have been after the audit, but it should not matter if the diagnosis occurred after the audit. MDS LVN C stated, if a diagnosis comes in, I'm the one who is responsible for redoing the PASSR. MDS LVN C stated he and MDS LVN B have the job to find out what the new diagnoses are, and they go through the clinicals, put in the new diagnoses. MDS LVN C stated, it is important to conduct the PL1, because if it is positive they can provide services. MDS LVN C stated yes, MDD and bipolar are both mood disorders, and they affect mood, some are more considered than others. During an interview with the Administrator on 4/02/2026 at 11:50 AM, the Administrator stated they took over the company on October 1, 2022, and Resident #88 was here prior (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to that. The Administrator further stated, based off of our policy we run a PL1 if there is a significant change, and since we have taken over, Resident #88 has had no behaviors or anything. The Administrator stated we follow the policy and procedures on that, and they did not have anything significant change on Resident #88 since they took over. During a second interview with MDS LVN C on 4/02/2026 at 11:53 AM, LVN MDS C stated he could not find a policy on how soon you can put in a PL1 or how far along, and he could not find anything that said that or on HHSC. MDS LVN C stated, the policy is based off HHSC. MDS LVN C further stated for the PTSD it is a case-by-case basis. MDS LVN C stated, Resident #88 was not exhibiting any type of red flags or behaviors indicating that he had PTSD, and we would not do a PL1 if he is not having behaviors. Record review of the facility policy titled PASARR Screening, undated, noted It is the policy of this facility to complete an accurate PASARR screening for individuals with a mental disorder and individuals with intellectual disability. and 7. A new PASRR evaluation is required if a residents condition changes significantly.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #7) reviewed for incontinent care:The facility failed to ensure CNA D provided proper incontinent care to Resident #7. CNA D made several passes with one disposable wipe to clean the resident's penis. This failure could place residents at-risk for infection and skin break down due to improper care practices.The findings included:Record review of Resident #7's face sheet dated 4/1/26 reflected an [AGE] year old male admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses that included obstructive and reflux uropathy (a condition in which the normal flow of urine is blocked somewhere along the urinary tract), need for assistance with personal care, benign prostatic hyperplasia (a condition in which the prostate gland becomes enlarged, but not cancerous, which makes it harder to urinate) with lower urinary tract symptoms, and history of urinary tract infections.Record review of Resident #7's most recent quarterly MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills, required substantial/maximal assistance with toileting hygiene, and was frequently incontinent of bowel and bladder.Record review of Resident #7's comprehensive care plan with initiated date 3/30/26 reflected the resident was treated with antibiotic therapy related to a urinary tract infection with interventions that included to check for incontinence, wash, rinse, and dry soiled areas, and provide antibiotic therapy as ordered. During an observation of incontinent care to Resident #7 on 4/1/26 at 4:04 p.m., CNA D made several passes with one disposable wipe in a back-and-forth motion when cleaning the resident's penis. During a joint interview with CNA D and CNA E on 4/1/26 at 4:15 p.m., CNA D stated he did not recall using only one wipe to clean Resident #7's penis. CNA E, who assisted CNA D stated she observed CNA D make more than one pass with one disposable wipe to clean Resident #7's penis. Both CNA D and CNA E stated, when using a disposable wipe during incontinent care, it was best practice to use the wipe once and then toss it in the trash instead of making several passes with one disposable wipe. Both CNA D and CNA E stated using the disposable wipe more than once was a break in infection control, or cross contamination and could result in the resident getting a rash, a skin issue, or develop an infection. During an interview on 4/1/26 at 4:26 p.m., the DON stated, when a disposable wipe was used during incontinent care, you should only use the wipe once and then toss it out. The DON stated, using a disposable wipe for more than one pass was an infection control issue and could result in the resident getting an infection. The DON stated it would take more than one disposable wipe to clean the resident's penis.Record review of the facility document titled Policy/Procedure Incontinence Care, undated, reflected in part, .It is the policy of this facility to provide incontinence care for those residents requiring assistance with bladder and/or bowel incontinence. Staff providing incontinence care will do so while maintaining the dignity of the resident and providing care in a respectful manner.Wash peri area using front to back strokes.Record review of CNA D's competency training document titled Perineal Care, dated 1/19/26 reflected CNA D had satisfied the requirement for providing incontinent care. Review of CNA D's competency training document reflected the following: Male: Pull back foreskin if male is uncircumcised. Wipe the tip of penis using circular motion beginning at urethra. Continue wiping down the penis to the scrotum and inner thighs. Use different wipe for each stroke.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles for 1 (200 hall nurse cart) of 4 medication carts observed for medication storage. A blue pill was lying on the ground by the 200 hall nurse cart. This failure could place residents who receive medications at risk of not receiving the intended therapeutic effects of their prescribed medications and experiencing unintended and harmful effects of medications prescribed to others. The findings included: On 3/31/26 at 10:24 AM a blue pill was observed on the floor of the 200 hall by the 200 hall nurse cart. In an interview with NA A on 3/31/2026 at 10:24 AM, NA A stated, it looks like a medication was lying on the ground. In an interview with MDS LVN B on 3/31/26 at 10:25 AM, MDS LVN B stated, it looks like a blue pill was lying on the floor. MDS LVN B stated the pill, should not be on the floor for patient safety, we don't want anyone to come by and pick it up. MDS LVN B stated they are supposed to pick it up, and if a resident picked it up there could be an issue with patient safety if someone took a pill and they didn't know what it was, it could be harmful. During an interview with RN J on 3/31/26 at 10:40 AM, RN J stated she was responsible for the 200-hall nurse cart. When shown the picture of the pill on the floor, RN J stated, it looks like a pill. RN J stated a pill should not be lying on the floor because, anyone can pick it up, it is not safe and it should be discarded, it can affect the body in a negative way if they take it and it is not theirs's; it could be mistaken for something else. During an interview with the DON on 3/31/26 at 2:27 PM, the DON stated, there should not pill be pills on the floor, if a pill is on the floor, it should be discarded in the proper way. The DON further stated we don't want pills on floor because anyone can pick it up, and that is bad because they could consume it or put it somewhere it shouldn't be and other people can get to it. Review of facility policy titled Medication Access and Storage, undated, noted It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications: and 1. The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview and record review, the facility failed to employ sufficient staff with the appropriate competencies, and skills set to carry out the functions of the food and nutrition service for 1 (Cook I) of 11 dietary staff reviewed for qualified dietary staff. The facility failed to ensure [NAME] I had a current Food Handler Certificate. This failure could place residents who ate food from the facility's kitchen at risk of not having their nutritional needs met and place them at risk for food born illnesses.Findings included: Record review of a certificate titled Texas Food Manager Certification Program, dated 03/03/2021 and stated, expires 5 years from the effective date, The certificate belonged to [NAME] I. A handwritten date of 03/03/2026 was written on the certificate. The bottom of the document also contained a handwritten word Keyed with a check mark next to it. Record review of the facility's staff list, no date, revealed [NAME] I was hired on 06/18/25. During an observation on 3/31/26 at 9:15 a.m. [NAME] I was in the kitchen cleaning a microwave. He stated he would be preparing pure diets around 11 a.m. that morning if this surveyor wanted to observe. During an interview on 04/02/26 at 4:40 p.m. the DS stated the only food handler certificate he had for [NAME] I was the one hanging on the wall dated 03/03/2021. The DS stated all staff was expected to have current food handlers certificates if they were working in the kitchen. The DS stated he would check to see if the cook had a current certificate. During an interview on 04/02/26 at 5:00 p.m. the Administrator stated he would check with HR because [NAME] I should have a current food handlers' certificate. During an interview on 04/03/26 at 9:50 a.m. the Administrator stated HR had provided him with a copy of [NAME] I's current food handler's certificate. During an attempt on 04/03/26 at 10:07 a.m. [NAME] I did not respond to an attempted interview. Record review of a certificate titled Texas Food Manager Certification Program, dated 03/04/26, revealed [NAME] I had completed the Texas Food Safety Manger Certification Examination, stated, expires 5 years from the effective date. The same handwritten word keyed with a check mark was in the same spot on the new document. Record review of [NAME] I's food handler's certificate through online database verification, dated 03/04/26, revealed the certificate number was for [NAME] I. The name of the course was Texas Food Manager Exam English. The date the certificate was issued was 03/02/2021 and the date of expiration was 03/01/2026. During a follow-up interview, on 04/03/26, at 11:08 a.m. the Administrator stated HR must have given him the wrong certificate and she was unavailable to talk to due to a private matter. The Administrator stated he expected staff to have current food handlers' certificates because they were in the kitchen handling food. Record review of the facility's policy titled Dietary Services, Meals and Food, no date, revealed It is the policy of this facility to ensure dietary services are provided to our residents operating within the confines of Texas state regulations. Procedure: 1. The dietary manager is responsible for the total food service of this facility and responsible for ensuring food handler certifications are current for dietary staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: 1. The facility failed to keep dish racks off the floor 2. The facility failed to discard dirty oil. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.The findings included: 1. During an observation on 03/31/26 at 9:23 a.m. one dish rack with two other dish racks on top of it was directly on the floor next to the sink in the kitchen. During an interview on 03/31/26 at 9:23 a.m. the DS stated the dish racks should not be on the floor they should be on top of a pallet when not in use because the floor was dirty. 2. During an observation on 3/31/26 at 9:31 a.m., the deep fryer located in the kitchen contained oil that was dark brown in color with visible food particles and sediment throughout. The oil was not transparent, and visibility through the oil to the bottom of the fryer was obscured. Residue buildup was noted along the interior surfaces of the fryer. During an interview on 3/31/26 at 9:31 a.m. the DS stated he cleaned the fryer every weekend. The DS stated he last cleaned it on 3/29/26 two days before. The DS stated it was normal for the oil to get that dark because he used it to fry a lot of food for the residents. During a subsequent observation and interview on 04/02/26 at approximately 10:48 a.m., the fryer oil appeared light in color and transparent, with very little visible debris, and the bottom of the fryer was clearly visible. The DS stated they had cleaned the fryer and changed the oil on 3/31/26. During an interview on 4/2/26 at 5:00 p.m. the Administrator stated the dish racks had been removed from the floor and were stored on a pallet. The Administrator stated the oil in the fryer was normal because they used it to fry food and that's how it looks after it was used. He stated they could provide cleaning schedules, and the fryer was last cleaned over the weekend. Record review of a document titled Weekly Deep Cleaning Schedule, dated March 2026, revealed the fryer oil was changed, sides and inside cleaned as needed, boiled out (every 3 months) on:03/04/2603/11/2603/17/2603/28/3103/31/26 Record review of the facility policy titled Dish Handling, no date, revealed, After dish racks have been emptied. Racks must be stored off of the floor. Record review of the facility policy titled Deep Fryer Cleaning Policy & Procedure, no date, revealed, Deep fryer will be cleaned on a regular basis as recommended by the manufacturer.Clean the element whenever the oil is filtered or changed.Clean the fry baskets at the end of the day.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 Dumpsters (Dumpster #1) reviewed for disposal of garbage. The facility failed to ensure Dumpster #1 had a rubber plug at the bottom, there were no stains on the ground outside the dumpster, and trash/food was not on the ground outside the dumpster. These failures could place residents at risk for exposure to germs and diseases carried by vermin and rodents.The findings were: During an observation on 03/31/26 at 9:26 a.m., the exterior dumpster area contained visible dried food debris and spilled waste on the ground next to the dumpster. The surrounding concrete surface had multiple darkened stains and residue. Several pest control traps were observed stored directly on the ground adjacent to the dumpster. The drain opening at the bottom of the dumpster was not sealed with a plug. During an interview on 03/31/26 at 9:26 a.m. the DS stated he was unaware of the food spilled by the dumpster. He stated it may have just happened. This surveyor pointed out that the food appeared dried up and contained rice and a fry. The DS stated they had not served any of that food at breakfast that day. The DS stated he was unsure why the pest traps were stored outside the dumpster. The DS stated he was unaware the drain plug was missing. The DS stated maintenance was responsible for power washing the area around the dumpster. The DS stated the dumpster area should be free of debris and food on the ground because it could attract pest. The DS stated the dumpster needed a plug to prevent any pest from getting into the dumpster and any drainage from leaking out. During an interview on 04/02/2026 at 9:59 a.m. the MS stated he cleaned, and pressure washed the dumpster area every 6 months, and he cleaned it again that week. The MS stated some of the stains were oil from the dumpster trucks. The MS stated the traps were supposed to be picked up by the pest control company, but they never came to get them. The MS stated they went ahead and discarded them now. The MS stated the drain plug was supplied by waste management and they were responsible for placing it on the dumpster. The MS stated he reached out to them to request one be put on the dumpster. The MS stated the drain plug prevented leakage and insects from getting inside the dumpster. The MS stated he would have cleaned the food spilled outside the dumpster, but the survey team saw it before he had that morning. Record review of the facility policy titled Waste Management and Cleaning, no date, revealed .Observation of dumpster area is completed daily by plant team between breakfast and lunch. report maintenance/housekeeping concerns to appropriate department.Check the perimeter area daily for any odors and excess waste

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 2 of 10 residents (Residents #6 and Resident #8) reviewed for medical records. 1. The facility failed to ensure Resident #6's Mental Illness/Dementia Resident Review, form 1012 was completed and accurate. 2. The facility failed to ensure Resident #8's Mental Illness/Dementia Resident Review, form 1012 was completed and accurate.This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records. 1. Record review of Resident #6's admission record, dated 02/26/26, revealed a [AGE] year-old female resident was admitted to the facility on [DATE], with an initial admission date of 01/11/22, her diagnoses included of schizophrenia, unspecified (a chronic mental disorder characterized by disturbances in thought, perception, and behavior), with an onset date of 01/11/22, major depressive disorder, recurrent, moderate (a mood disorder characterized by repeated episodes of depressed mood, loss of interest, and impaired functioning), with an onset date of 01/11/22, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a decline in cognitive function affecting memory, thinking, and the ability to perform daily activities), with an onset date of 01/31/22, unspecified dementia, unspecified severity, with agitation (a decline in cognitive function accompanied by restlessness or emotional distress), with an onset date of 08/18/24. Record review of Resident #6's significant change MDS assessment, dated 3/2/26, revealed she had moderate cognitive impairment for daily decision making. The MDS revealed she had depression, schizophrenia, and non-Alzheimer's dementia. The MDS also revealed she was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. Record review of Resident #6's care plan, initiated 1/24/23, revealed she had mood problems related to schizophrenia, major depressive disorder, and dementia with behavioral disturbances. Interventions included administering medications and assist to identify strengths, positive coping skill and reinforce these. Record review of Resident #6's Mental Illness/Dementia Resident Review (Form 1012), revealed:Section A (Resident and Nursing Facility Identifying Information):Section A was completed with resident identifying information, including name, date of birth , facility name, and PASRR Level 1 was completed on 01/11/22.Section B (Dementia Review):Section B indicated Yes, the individual has a primary diagnosis of dementia. Section B.1 included physician attestation with physician name, license number, license state, and date of onset documented. A physician signature and date of 01/31/22 were present.Section C (Mental Illness Indication):Section C indicated Yes for schizophrenia; however, other listed diagnoses did not have corresponding Yes or No selections completed, and dates of onset were not documented for the applicable diagnoses. The physician signature and date in Section C were not completed. The directions in section C stated If all the responses are No, physician signs and dates the form. A new PL 1 is not needed at this time. Complete Sections D and E.If any of the responses are YES, the nursing facility needs to complete a new PL 1 and Sections D and E of the form. A full PASRR Evaluation will be conducted after the nursing facility submits the new positive PL 1.Section D (Nursing Facility Action):Section D did not have a selected response to indicate whether the PASRR Level 1 remained negative or if a new PASRR Level 1 screening was submitted. 2. Record review of Resident #8's admission record, dated 04/04/25, revealed a [AGE] year-old male resident was admitted to the facility on [DATE], with an initial admission date of 10/23/20, His diagnoses included schizoaffective disorder, bipolar type (a mental health disorder characterized by symptoms of schizophrenia such as hallucinations or delusions along with mood disorder symptoms such as mania or depression), with an onset date of 07/20/23, unspecified dementia, unspecified severity, without (continued on next page)

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 04/03/2026
NAME OF PROVIDER OR SUPPLIER Mystic Park Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a decline in cognitive function affecting memory, thinking, and the ability to perform daily activities), with an onset date of 10/23/20, unspecified psychosis not due to a substance or known physiological condition (a condition involving impaired thoughts and perceptions, including hallucinations or delusions, not attributed to substances or a medical condition), with an onset date of 10/23/20, bipolar disorder, unspecified (a mood disorder characterized by alternating periods of elevated mood and depression), with an onset date of 10/23/20, other specified depressive episodes (a mood disorder involving periods of depressed mood that do not meet full criteria for major depressive disorder), with an onset date of 10/23/20, unspecified mood [affective] disorder (a disorder affecting emotional state that does not meet criteria for a specific mood disorder), with an onset date of 10/23/20, and generalized anxiety disorder (a condition characterized by excessive and persistent worry), with an onset date of 10/23/20. Record review of Resident #8's quarterly MDS assessment, dated 12/26/25, revealed he had moderate cognitive impairment for daily decision making. The MDS revealed he had anxiety, depression, bipolar disorder, psychotic disorder, and non-Alzheimer's dementia. Record review of Resident #8's care plan, initiated 10/31/23, revealed he had psychosocial well-being problem related to schizoaffective disorder, bipolar type, dementia, and resident will frequently hide items, such as his wallet, gloves, or watch. He then forgets where he placed it, will become upset but finds it again after a while. Interventions included allow time to answer questions and to verbalize feelings, perceptions, and fears, encourage participation from resident who depended on others to make own decisions, and when conflict arose, remove residents to a calm safe environment and allow him to vent/share feelings. Record review of Resident #8's Texas Health and Human Services Mental Illness/Dementia Resident Review (Form 1012) revealed:Section A (Resident and Nursing Facility Identifying Information):Section A was completed with resident identifying information, including name, date of birth , facility name, and PASRR Level 1 was completed on 10/23/20.Section B (Dementia Review):Section B indicated Yes, the individual has a primary diagnosis of dementia. Section B.1 revealed the dementia diagnosis date of onset was documented as 10/23/20; however, the (Physician Attestation) physician signature date was not completed on the signature line, and the Physician's printed name was missing. Section C indicated Yes for schizoaffective disorder with a documented onset date of 07/20/23. Further review revealed bipolar disorder was handwritten under Any Other Disorder with a documented onset date of 10/23/20. Additional mental health diagnoses identified in the resident's medical record, including unspecified psychosis not due to a substance or known physiological condition, unspecified mood (affective) disorder, other specified depressive episodes, and generalized anxiety disorder, were not indicated on the form. The directions in section C stated If all the responses are No, physician signs and dates the form. A new PL 1 is not needed at this time. Complete Sections D and E. If any of the responses are YES, the nursing facility needs to complete a new PL 1 and Sections D and E of the form. A full PASRR Evaluation will be conducted after the nursing facility submits the new positive PL 1. Section D (Nursing Facility Action):Section D did not have a selected response to indicate whether the PASRR Level 1 remained negative or if a new PASRR Level 1 screening was submitted. During an interview on 4/2/26 at 2:15 p.m. MDS LVN C stated both Resident #6 had #8 had dementia as a primary diagnosis in the past. MDS LVN C stated 1012 forms were completed by another staff member who was no longer working for the facility. MDS LVN C stated he was unsure why the other staff added information to the 1012 form for Resident #8 3 years after it was signed by the doctor. MDS LVN C stated he understood the form was valid if a doctor signed it. MDS LVN C stated Resident #6 and Resident #8 would not qualify for PASRR services because they both had dementia diagnosis so both of their PASRR level 1 were answered no for mental illness and a 1012 form was completed instead. MDS LVN C stated he was one of the staff responsible for assuring residents PASRR paperwork was accurate. During an interview on 4/2/26 at 3:02 p.m. the DON stated she was unsure if the 1012 forms were completed correctly and she needed to ask her resource because she did not know. The DON never returned for a follow up interview. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 4/2/26 at 3:16 p.m. the Administrator, MDS LVN C, returned with a PASRR assessor on the phone. The PASRR assessor stated when a resident had a primary diagnosis a new 1012 form did not need to be completed if a new mental illness diagnosis was added. The PASRR assessor stated it would not matter how much time had passed by as long as the physician signed the 1012 nothing needed to be changed. The PASRR assessor stated the facility should not add information to the 1012 forms 3 years after it was completed. The PASRR assessor stated the facility should not have touched the forms at all and left them as was. A policy for accuracy of medical records was requested from the Administrator on 04/03/26 and not provided. Record review of the facility policy titled PASARR Screening,, no date, revealed It is the policy of this facility to complete an accurate PASARR screening for individuals with a mental disorder and individuals with intellectual disability.Purpose: To ensure each resident in a nursing facility is screened for a mental disorder or intellectual disability prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.Procedures: 1. The initial screening referred to as a Level I and is completed prior to admission to a nursing facility. 2. A negative Level I screen permits admission to proceed and ends the prescreening process unless possible serious mental disorder or intellectual disability arises later. 3. A positive Level I screen necessitates an in-depth evaluation of the individual, by the state, known as a level II PASARR.7. A new PASARR evaluation is required if a resident's condition changes significantly.

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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 disease and infection for 3 of 8 residents (Residents #79, #5 and #25) reviewed for infection control:1. During the medication pass, the facility failed to ensure LVN H used appropriate hand hygiene between glove changes and when moving from a clean area to a dirty area when administering medication to Resident #79.2. During the medication pass, the facility failed to ensure Med Aide G used appropriate hand hygiene between glove changes and when moving from a clean area to a dirty area when administering medication to Resident #5.3. During the medication pass, the facility failed to ensure LVN F wiped the rubber seal to Resident #25's insulin pen with an alcohol swab prior to administering insulin.These failures could place residents at-risk for infection due to improper care practices.The findings included:1. Record review of Resident #79's face sheet dated 4/2/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included seizures, dementia, and gastrostomy status (medical procedure in which an opening is created through the abdominal wall directly into the stomach).Record review of Resident #79's most recent quarterly MDS assessment dated [DATE] reflected the resident was severely cognitive impaired for daily decision-making skills and was treated with an anti-convulsant.Record review of Resident #79's Order Summary Report dated 4/2/26 reflected the following:- Levetiracetam oral solution 100 mg/ml, give 15 ml via PEG-tube (gastrostomy tube) every 12 hours for seizures with order date 1/9/25 and no end date.Record review of Resident #79's comprehensive care plan with revision date 12/12/25 reflected that the resident had an alteration in neurological status related to epilepsy (seizures) with interventions that included to give medications as ordered.During an observation of the medication pass on 4/2/26 at 8:04 a.m., LVN H, after preparing Resident #79's Levetiracetam for administration, locked and moved the medication cart aside, LVN H returned to the resident's bedside, drew the resident's privacy curtain, then put on a pair of gloves without washing or sanitizing her hands. LVN H, while wearing the gloves, took the resident's bed remote to raise the bed, moved the bedside table and removed her gloves. LVN H then put on a pair of gloves, did not wash or sanitize her hands, and administered the resident's Levetiracetam medication through the gastrostomy tube. During an interview on 4/2/26 at 8:16 a.m., LVN H stated she had forgotten to sanitize her hands between changing gloves and when touching Resident #79's bed remote and bedside table. LVN H stated, it was important to perform proper hand hygiene between glove changes and when moving from a clean area to a dirty area to prevent cross contamination.2. Record review of Resident #5's face sheet dated 4/2/26 reflected a [AGE] year-old male admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses that included diabetes, infection following a procedure, superficial incisional surgical site, need for assistance with personal care, and infection of amputation stump, left lower extremity and osteoarthritis.Record review of Resident #5's most recent comprehensive MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills and was treated for pain.Record review of Resident #5's Order Summary Report dated 4/2/26 reflected the following:- Lidocaine External Patch 4%, apply to left shoulder topically one time a day for pain and remove per schedule with order dated 3/20/26 and no end date.Record review of Resident #5's comprehensive care plan with revision date 1/13/26 reflected the resident had primary osteoarthritis to the left shoulder with interventions that included to give analgesics as ordered by the physician.During an observation of the medication pass on 4/2/26 at 8:56 a.m., Med Aide G administered oral medications to Resident #5, then obtained the Lidocaine patch and a pair of gloves and placed them on the resident's bedside table. Med Aide G then drew Resident #5's privacy curtain, did not wash or sanitize her hands, and put on a pair of gloves. Med Aide G then pulled back Resident #5's shirt and placed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lidocaine patch on the resident's left shoulder.During an interview on 4/2/26 at 9:13 a.m., Med Aide G stated she forgot to sanitize her hands after preparing Resident #5's medications, and after drawing the resident's privacy curtain. Med Aide G stated she should have washed or sanitized her hands before putting on gloves because it was cross contamination and an infection could be passed to the resident or to other residents if not utilizing proper hand hygiene.During an interview on 4/3/26 at 8:20 a.m., the DON stated, it was her expectation, when moving from a clean area to a dirty area that the staff should perform proper hand hygiene to prevent or minimize infection.3. Record review of Resident #25's face sheet dated 4/2/26 reflected a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included type 1 diabetes with hyperglycemia (the body's inability to produce insulin to regulate sugars), long term use of insulin, heart failure, end stage renal disease (the kidney's inability to filter waste and toxins from the blood) and dependence on renal dialysis (a medical treatment that replaces some of the functions of the kidneys).Record review of Resident #25's most recent MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills and was treated with insulin.Record review of Resident #25's Order Summary Report dated 4/2/26 reflected the following:- Humalog insulin 100 units/ml, inject 7 units subcutaneously before meals related to diabetes with order date 4/26/25 and no end date.- Humalog insulin 100 units/ml, inject as per sliding scale subcutaneously before meals and bedtime related to diabetes with order date 4/26/25 and no end date.Record review of Resident #25's comprehensive care plan with revision date 5/23/24 reflected the resident had diabetes with interventions that included to administer diabetes medication as ordered by the doctor.During an observation on 4/2/26 at 3:57 p.m., LVN F retrieved Resident #25's insulin pen from the medication cart and inserted a needle into the insulin pen without sanitizing the rubber seal with an alcohol swab.During an interview on 4/2/26 at 4:02 p.m., LVN F stated she had forgotten to sanitize the rubber seal to Resident #25's insulin pen before inserting a needle into the rubber seal and before injecting Resident #25 with insulin. LVN F stated, cleaning the rubber seal of the insulin pen with an alcohol swab was an important step because it prevented contamination and because you are puncturing the rubber seal with a needle used on the resident. During an interview on 4/3/26 at 8:15 a.m., the DON stated, the rubber seal of an insulin pen was supposed to be cleaned with an alcohol swab prior to inserting the rubber seal with a needle to prevent cross contamination. The DON stated that if cross contamination occurred the resident could get an infection.Record review of LVN F's Insulin Administration Competency Training dated 1/20/26 reflected LVN F had satisfied the requirements for administering insulin. LVN F's Insulin Administration competency training reflected in part, .Remove insulin from drawer and wipe the top of bottle with alcohol.Record review of the facility document titled Infection Prevention and Control Program, undated reflected in part, .The objective of the Infection Prevention and Control Program is to establish written standards, policies and procedures for a system of preventing, identifying, reporting, investigating, and controlling infections following accepted national standards for all residents, staff, volunteers, visitors, and other individuals providing services.The hand hygiene procedures will be followed by staff involved in direct resident contact.Record review of the facility document titled Prevention of Infection, IPCP - Hand Hygiene, undated reflected in part, .This facility considers hand hygiene the primary means to prevent spread of infection.Wash hands with soap.and water for the following situations.When hands are visibly soiled.Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap.and water for the following situations.Before and after direct contact with residents.Before moving from a contaminated body site to a clean body site during resident care.After contact with objects.in the immediate vicinity of the resident.After removing gloves.The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.