

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2024
NAME OF PROVIDER OR SUPPLIER The Rio at Mission Trails		STREET ADDRESS, CITY, STATE, ZIP CODE 6211 S New Braunfels Ave San Antonio, TX 78223	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</p> <p>Based on observation, interview and record review, the facility failed to ensure residents have a right to be treated with respect and dignity, including: the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents, for 1 of 6 residents (Resident #1) reviewed for resident rights, in that:</p> <p>The facility failed to allow Resident #1 to keep his off-loading boots or return them to him or his family.</p> <p>This failure could place residents needing assistance at risk for diminished quality of life, loss of dignity and self-worth.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 7/14/24, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, hereditary and idiopathic neuropathy, cardiac arrest, atrial fibrillation, tracheostomy status, and gastrostomy status.</p> <p>Record review of Resident #1's most recent quarterly MDS assessment, dated 4/28/24, revealed the resident was fully intact for daily decision-making skills. The MDS indicated the resident needed substantial/maximum assistance for shower/bathe self and dependent on a helper to transfer out of bed.</p> <p>Record review of Resident #1's care plan revealed the resident had paraplegia, last revised on 1/4/24, with interventions for PT, OT, ST evaluate and treat as needed. Also, the resident had foot drop and required a wedge initiated on 6/5/24 with intervention to provide resident foot wedge.</p> <p>Observation and interview on 7/13/24 at 2:46 p.m., revealed Resident #1 was sitting up in his bed. Resident #1 stated he had some medical boots that he used to prevent foot drop. Resident #1 stated a male staff came to his room one day and took his boots away. Resident #1 did not have any cushions, off-loading boots, or assistive devices on. Both feet appeared to be in a dropped position, with the toes pointing downward and the ankle unable to flex upward. The resident stated he was unable to lift or move his feet. The resident stated the boots were given to him when he was in the hospital.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint interview on 7/13/24 at 4:38 p.m. ADON A and the Administrator stated Resident #1's boots were taken from him because there was no medical need for them and were told they could cause issues such as pressure wounds. They stated they had no order for the resident to use the boots so he could not use them. They stated they threw the resident's boots away because they were not viewed as his personal property.</p> <p>During an interview on 7/14/24 at 5:38 p.m. the DOR stated he advised the Administrator that off-loading boots could cause infection or eventually amputations and should only be used for residents who had pressure wounds. The DOR stated he was an OT and PT was not his area of expertise so he could not evaluate the resident for footdrop. The DOR stated they would elevate the bed to raise the resident's legs, use pillows, or a wedge. The DOR stated the resident told him the boots were a gift. The DOR stated the resident could have kept the boots if he had an order for them.</p> <p>During a follow-up interview on 7/14/24 at 6:59 p.m. Resident #1 stated they brought him a wedge to use but he did not like it. He stated his feet still were in a dropped position and he felt uncomfortable.</p> <p>Record review of the facility policy titled, Resident Rights, dated 11/28/16, stated Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States . Respect/and dignity . The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</p> <p>Based on observation, interview and record review the facility failed to provide necessary services to maintain good grooming, and personal hygiene for residents who were unable to carry out activities of daily living for 1 of 6 Residents (Resident #1) whose records were reviewed for grooming and personal hygiene.</p> <p>The facility failed to ensure Resident #1 received scheduled showers on 7/10/24 and 7/12/24.</p> <p>This failure could affect any resident and contribute to feelings of poor self-esteem and hopelessness.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 7/14/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, hereditary and idiopathic neuropathy, cardiac arrest, atrial fibrillation, tracheostomy status, and gastrostomy status.</p> <p>Record review of Resident #1's most recent quarterly MDS assessment, dated 4/28/24 revealed the resident was fully intact for daily decision-making skills. The MDS indicated the resident needed substantial/maximum assistance for shower/bathe self and dependent on a helper to transfer out of bed.</p> <p>Record review of Resident #1's care plan revealed the resident had paraplegia, last revised on 1/4/24, with interventions to assist with ADLs and locomotion as required .</p> <p>Record review of Resident #1's task record for July 2024 reflected he received a shower on 7/8/24, missed a shower on 7/10/24, and showered on 7/12/24. Hospitality aide B initials were on the task record and indicated she showered the resident on 7/8/24 and 7/12/24.</p> <p>Observation and interview on 7/13/24 at 2:46 p.m., revealed Resident #1 was sitting up in his bed. Resident #1 smelled like body odor, his hair was oily, shiny, clumped together, and laid flat on his head. Resident #1 stated he had not had a shower since Monday 7/8/24 or Tuesday 7/9/24. The Resident stated he was supposed to get showers on Tuesdays, Thursdays, and Saturdays. Resident #1 stated he had never refused or declined a shower.</p> <p>During an interview on 7/14/24 at 4:38 p.m. ADON A stated Hospitality Aide B did not shower Resident #1. ADON A stated Hospitality Aide B was not a certified nurse and could not perform patient care task such as showers. ADON A stated they had a shower aide who showered residents at the facility. ADON A stated shower schedules were determined for resident's based on residents' personal preferences for days and frequency.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 7/14/24 at 6:14 p.m. Hospitality Aide B stated she was a CNA at the facility. Hospitality Aide B had on a badge that showed her name and said she was CNA. Hospitality Aide B then stated she was a noncertified nurse aide. Hospitality Aide B stated she did not shower resident and only helped transfer residents. Hospitality Aide B stated there was a shower aide who would shower residents and if the shower aide was not working then she would shower residents. Hospitality Aide B stated she had not showered Resident #1 that week. Hospitality Aide B was then shown the task record with her initials for showering Resident #1. Hospitality Aide B then stated the shower aide would shower the residents and she would always document for her. Hospitality Aide B stated if residents refuse showers, they document it in the task record and let the nurse know. Hospitality Aide B stated she did not know of any residents who refused showers.</p> <p>The shower aide was not available for interview.</p> <p>During a follow up observation and interview on 7/14/24 at 6:59 p.m. Resident #1 again stated he had not been showered since earlier in the week. ADON A was in the room and stated the resident looked clean, his hair did not look greasy, and had a shower on Friday 7/12/24. Resident #1 stated to the ADON that he had not had a shower since earlier in the week. Resident #1 told the ADON Remember we talked about me getting showers on Tuesdays, Thursdays, and Saturdays. ADON A shook her head no and disagreed with Resident #1.</p> <p>During an interview on 7/14/24 at 8:10 p.m. the Administrator and ADON stated Resident #1 had refused showers, but it was not documented.</p> <p>Record review of the facility policy titled Bath, Tub/Shower, dated 2003, stated Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation. A medicated tub bath can also be provided to treat skin conditions. The aging skin becomes dry, wrinkled, thinner and blemished with various aging spots over time and is easily affected by environmental temperature and humidity, sun exposure, soaps, and clothing fabrics. The frequency and type of bathing depends on resident preference, skin condition, tolerance and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed. Goals 1. The resident will experience improved comfort and cleanliness by bathing. 2. The resident will maintain intact skin integrity. 3. The resident will be free from soil, odor, dryness, and pruritus following bathing .</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</p> <p>Based on observation, interview and record review revealed the facility failed to provide specialized rehabilitative services for 1 of 1 Resident's (Resident #1) whose records were reviewed for rehabilitative services.</p> <p>The facility failed to ensure Resident #1 was evaluated by PT for foot drop and a possible brace.</p> <p>This failure could place residents at risk of decline or decrease in their physical capabilities.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 7/14/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, hereditary and idiopathic neuropathy, cardiac arrest, atrial fibrillation, tracheostomy status, and gastrostomy status.</p> <p>Record review of Resident #1's most recent quarterly MDS assessment, dated 4/28/24 revealed the resident was fully intact for daily decision-making skills. The MDS indicated the resident needed substantial/maximum assistance for shower/bathe self and dependent on a helper to transfer out of bed.</p> <p>Record review of Resident #1's care plan revealed the resident had paraplegia, last revised on 1/4/24, with interventions for PT, OT, ST evaluate and treat as needed. Also, the resident had foot drop and required a wedge initiated on 6/5/24 with intervention to provide resident foot wedge.</p> <p>Record review of Resident #1's physician orders, dated 7/13/24, revealed an order for therapy to evaluate for foot drop and possible brace without metal, dated 7/8/24.</p> <p>Observation and interview on 7/13/24 at 2:46 p.m., revealed Resident #1 was sitting up in his bed. Resident #1 stated he had some medical boots that he used to prevent foot drop. Resident #1 did not have any cushions, off-loading boots, or assistive devices on. Both feet appeared to be in a dropped position, with the toes pointing downward and the ankle unable to flex upward. The resident stated he was unable to lift or move his feet. The resident stated the boots were given to him when he was in the hospital. Resident #1 stated he had received OT services but had not had any PT services to address his foot drop.</p> <p>During an interview on 7/14/24 at 5:38 p.m. the DOR stated he worked with Resident #1 on OT services that mostly involved the use of his hands to hold a urinal. The DOR stated PT needed to evaluate Resident #1 for his foot drop because that was outside his scope of practice. The DOR stated they needed a full time PT but were unable to fill the position. The DOR stated they had one PT who had limited availability. The DOR stated the PT had last been at the facility on 7/10/24 but did not evaluate Resident #1 for his foot drop. The DOR stated the facility would normally try to evaluate a resident with in 48 hours.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/14/24 at 6:30 p.m. the Administrator stated he thought the resident had already been evaluated by PT. The Administrator stated Resident #1 would be evaluated the following day.</p> <p>Record review of the facility policy titled, Resident Rights, dated 9/2020, Stated Policy: Any resident identified by the interdisciplinary team, as requiring a rehabilitation screen will have the screening initiated by Physical or Occupational Therapist or Assistant, or Speech Language Pathologist. All residents are to be screened upon admit to the facility, readmission from a hospital stay, after any fall and with any change in condition as deemed necessary by the IDT. Procedures: 1. A resident is referred for a rehabilitation screen in response to any of the following: a. Status change in on or more of the following areas: i. Contracture risks or Splinting needs ii. Mobility, Balance, and Safety concerns iii. Seating and Positioning concerns iv. Self-feeding and Swallowing difficulty V. Adaptive Equipment needs vi. Difficulty performing Self-care tasks vii. Difficulty Communicating needs b. The comprehensive Facility Nursing Assessment, completed upon admission quarterly, and PRN .A rehab screen is a hands-off process by which the therapist reviews the medical record, observes the patient/resident, and interviews the patient/resident, caregivers, interdisciplinary team, and/or family to identify the patient's/resident's prior level of function, expectations for return of function and discharge plan. The screening process requires no more than 10 to 15 minutes of the therapists time. Screening is a non-billable procedure and does not require the use of a billing log. The therapist does not provide skilled intervention based on a screen. The only recommendation that can be made from the screening process is to evaluate or not evaluate. Include a comment regarding why skilled therapy is not warranted at that time, if that is the outcome of the screen. The screening form is placed under the Rehab section of the medical record or per facility policy. It is not necessary for the therapist to screen patient/resident if an evaluation has been ordered. me of the screen may be to proceed with a request for additional nursing atign, a request for physician's orders to evaluate, or that no additional rehabilitation services are required at this time.</p>		