STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676297	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rio at Mission Trails	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)
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** 48366 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused result in serious bodily injury for 1 of 5 residents (Resident #1) whose records were reviewed for abuse and neglect: LVN A failed to report to the Administrator about an allegation of abuse when she was made aware by Resident #1's family member that LVN B was allegedly verbally and physically abusive to Resident #1 when a grievance/complaint report was made on 07/13/24. These deficient practices could affect residents by contributing to further abuse and neglect . The findings included: Record review of Resident #1's Admission record reflected a male admitted [DATE] with diagnoses to include cerebral palsy (a neurological disorder caused by damage or abnormal development in the brain), depression, and anxiety disorder. Record review of Resident #1's admission MDS, dated [DATE], reflected the resident had a BIMS score of 9 out of 15, indicating moderate cognitive impairment. Record review of Resident #1's care plan, dated 10/13/24, reflected The resident has a psychosocial well-being problem r/t lack of motivation, little interest or pleasure in doing things. Record review of grievance/complaint report, dated 07/13/24, received from Complainant C reflected . LVN B came in and got upset tugged him out of the restroom and told him she was not gonna be doing this bullshit everytime you fall down . This report further reflected this complaint was reported to LVN A. During an interview and record review on 11/18/24 at 12:18 PM, Complainant C shared a grievance form she filled out about Resident #1 on 11/18/24. Complainant C stated she made a copy of this form and gave the original form to LVN A. Complainant C revealed Resident #1 said he had fallen in his wheelchair in the restroom and LVN B came in and was rough with him. (continued on next page)

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
	676297	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rio at Mission Trails	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 03:00 PM, Resident #1 revealed LVN B told him that she had enough of him, and she dragged him on the floor. Resident #1 did not reveal any concerns about any other staff. Resident #1 was not able to give more details about LVN B. During an interview on 11/20/24 at 11:10 AM, LVN A revealed Resident #1's family member approached her and wanted to confront LVN B. LVN A informed Resident #1's family member on how to fill out grievances so an investigation could be done. LVN A was able to recall Resident #1's family member said LVN B was rude and was frustrated with Resident #1. She further revealed Resident #1's family member said LVN B was saying bad comments about Resident #1 while providing care. LVN A revealed Resident #1's family member filled out a grievance form and LVN A put it under the DON's door. LVN A revealed she contacted the DON about what happened. LVN A revealed she read some of the grievance form before she put it under the DON's door. LVN A verbally confirmed the grievance reflected . LVN B came in and got upset tugged him out of the restroom and told him she was not gonna be doing this bullshit everytime you fall down . LVN A revealed she didn't think this statement was considered abuse and it was okay for LVN B to express frustration about resident care. She revealed she would have told LVN B to not use these kinds of words around Resident #1. During an interview on 11/20/24 at 03:30PM, the Administrator revealed the staff and families know to call him when there was an allegation of abuse. He revealed staff were not allowed to cuss around the residents and it should be reported. During an interview on 11/21/24 02:48 PM, the DON revealed LVN A did not tell her about Resident #1's family member reporting LVN B being rough with Resident #1. The DON further revealed the ADONs also denied receiving this information from LVN A. The DON revealed this grievance made by Resident #1's family member needed to report this incident to the Health and Human Services Commission. Record review of the facility's policy Abuse/Neglect, dated 9/9/24, reflected, Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services . Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents . The facility administrator or designee will report to HHSC all incidents .