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	04/10/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interview and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse neglect for 1 of 11 Residents (Resident #1) whose records were reviewed for abuse and neglect. 1. Resident #1 told RT A she yelled at her on 03/01/2025 when Resident #1 wanted a larger cup of ice. RT A wrote the allegation was made by Resident #1 in Resident#1's progress notes without reporting the allegation to the Administrator that RT A had yelled at Resident #1. 2. The ADM reported the allegation of Resident Abuse on 03/03/2025, 2 days later to the State Agency when RT A's progress note for Resident #1 was reviewed. The noncompliance was identified as PNC. The noncompliance began on 03/01/2025 and ended on 03/03/2025. The facility had corrected the noncompliance before the survey began. These failures could affect residents who reside at the facility and result in allegations of abuse not investigated immediately and harm to the resident. The findings included: Review of the facility policy, Abuse/Neglect revised 3/29/18, read: The facility will provide and promote the protection of resident rights. It is everyone's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, abuse and situations that may constitute abuse or neglect to any resident in the facility. 3. Facility employees must report all allegations: abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designees will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegations involve abuse or result in serious bodily injury, the report must be made within 2 hours of the allegation. Record Review of Resident #1's electronic face sheet dated 04/09/2025 reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: acute and chronic respiratory failure with hypoxia (inadequate gas exchange by the respiratory system resulting in low oxygen levels), depression (mood disorder that causes a persistent feeling of sadness and loss), anxiety (an emotion characterized by an unpleasant state of inner turmoil), myopathy (disease of the muscles that connect to the bones) and dysphagia (difficulty in swallowing food or liquid). (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
	676297	A. Building B. Wing	04/10/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's Admission MDS assessment dated [DATE] reflected she was sometimes understood and sometimes understands. She scored a 99 on her BIMS which signified the interview could not be completed related to refusal to answer or nonsensical responses. She was dependent for care. Resident's diet was NPO, and she received enteral nutrition. She had a tracheostomy with invasive mechanical ventilation. Record review of Resident #1's comprehensive care plan revised dated 03/01/2025 reflected Focus, may have ice chips per MD orders, Intervention, supervise resident while consuming ice chips. Record review of Resident #1's Active Orders as of: 03/01/2025 reflected Pt may have ice chips in three-fourths of a cup once a shift upon request. Pt must be elevated in an upright position with her cuff deflated with RT supervision at bedside Phone Active 03/01/2025. Record review of RT A's progress note dated 03/1/2025 at 01:15 pm reflected. 3/1/2025 13:15 Activity Note Note Text: The resident accused me of yelling at her, which I did not do. I explained that i have never raised my voice at any of my patient before. I also clarified that because I am wearing a face mask, I naturally speak a little louder than usual. The resident stated, I'm not deaf and claimed that what I said was inappropriate, by saying what i said was Bull shit.She also requested a larger cup of ice. I informed her that I am unable to provide a larger cup and I could not stay in the room longer than 10 minutes, as I am the only RT on the floor now. She responded by saying that was also bullshit and insisted that I did have time to stay longer.SA B was present. The resident then asked if one of them could stay in the room because she felt I was going to yell at her again. SA B stayed in the room with me while I provided the ice to the patient from 12:43 pm - 1:15 pm Observation on 04/08/2025 at 09:15 am of Resident #1 lying on an air mattress in bed revealed she received mechanical ventilation via an oxygen concentrator with tubing connected to her tracheostomy. Interactions between Resident #1 and staff was positive. Interview on 04/08/2025 at 09:22 am with Resident #1, she denied abuse, yelling or issues with staff. She whispered her care was good at the facility and staff treated her well. Interview on 04/08/2025 at 04:42 pm with RT A revealed that she went to provide Resident #1 ice as ordered and Resident #1 requested a bigger cup of ice On 3/1/2025. She stated she wore a mask because Resident #1 was on enhanced barrier precautions. RT A stated she told Resident #1 she would need to check the physician orders and she stated she spoke louder wearing the mask. She stated Resident #1 said You do not have to yell at me, I am not deaf. She stated Resident #1 apologized to her later in the day for being rude. She denied yelling. She stated she reported to her supervisor that Resident #1 was not happy, but she did not think to report the incident to the Administrator who was the abuse and neglect coordinator, but she did annotate the quote from Resident #1 in her progress notes. She stated she had training on abuse and neglect. Interview on 04/09/2025 at 10:50 am with RT D, RT A's supervisor, he stated RT A called him and told him Resident #1 was not happy about the ice. He stated she did not mention anything about Resident #1's allegations. He stated RT staff were trained on abuse and neglect. (continued on next page)

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	04/10/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/2025 at 02:57 pm with SA B revealed she was present in Resident #1's room when RT A provided her the ice chips, and she did not witness RT A yelling or being inappropriate. Interview on 04/10/2025 at 5:33 pm with the DON revealed when the administrative team reviewed the notes from the weekend, they immediately started to investigate the incident and train 100 percent of the staff on abuse and when to report, to whom and provided the ADM's phone number. Interview on 04/10/2025 at 5:53 pm with the ADM revealed Administrator reviewed the abuse and neglect protocol. Seven components. Training important and reporting immediately. Accountable for care at the facility. They provided the in-service to 100% staff after they found RT A's note. They do a meeting and review progress notes and found that communication The Administrator said they do champion rounds and monitor for abuse and neglect. Accountable for the care in the facility. Record review of RT A's in-service attendance record dated 01/12/2025 reflected she received training on abuse/neglect and reporting. The facility course of action prior to surveyor entrance included: Record review of the facility PIR dated 03/03/2025 reflected an investigation into the incident between Resident #1 and RT A was investigated and reported immediately to HHSC. Record review of the Administrator's PIR dated 03/03/2025 revealed: All required notifications were made which included the Medical Director, Responsible Party, Physician, QA Ad Hoc Committee and HHSC. Record review of RT A's personnel folder reflected no issues of concern. Record review dated 04/10/2025- 118 staff, all staff, were in-serviced on using a staff roster were checked off and signed for in-services titled: Abuse/Neglect and Reporting. STAFF INTERVIEWS ON TRAINING: 04/10/2025 from 2:57 PM to 5:33 PM revealed staff were scheduled for 12-hour shifts, many worked both day, evening, and night shifts. On 04/10/2025 at total of 6 LVN's (E, F, G, H, I and J), 4 CNA's (K, L, M and N), 1 CMA (O), 1 SA (B) 1 PT (C) and 2 RTs (A and D), 2 RN's, (DON, ADON) were interviewed on reporting, abuse, and neglect. They were trained to report to the ADM, provided a phone number and instructed to report immediately or within 2 hours. They were instructed on the diverse types of abuse. The noncompliance was identified as PNC. The noncompliance began on 03/01/2025 and ended on 03/03/2025. The facility had corrected the noncompliance before the survey began.

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	04/10/2025

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** 28619 Based on observation, interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin are reported immediately, but no later than 2 hours after the allegation is made for 1 of 3 (Resident #1) residents involved involved in in incidents reviewed for reporting allegations of abuse and neglect 1. Resident #1 told RT A she yelled at her on 03/01/2025 when Resident #1 wanted a larger cup of ice. RT A wrote the allegation was made by Resident #1 in Resident#1's progress notes without reporting the allegation to the Administrator that RT A had yelled at Resident #1. 2. The ADM reported the allegation of Resident Abuse on 03/03/2025, 2 days later to the State Agency when RT A's progress note for Resident #1 was reviewed. The noncompliance was identified as PNC. The noncompliance began on 03/01/2025 and ended on 03/03/2025. The facility had corrected the noncompliance before the survey began. These failures could affect residents who reside at the facility and result in allegations of abuse not investigated immediately and harm to the resident. The findings included: Record Review of Resident #1's electronic face sheet dated 04/09/2025 reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: acute and chronic respiratory failure with hypoxia (inadequate gas exchange by the respiratory system resulting in low oxygen levels), depression (mood disorder that causes a persistent feeling of sadness and loss), anxiety (an emotion characterized by an unpleasant state of inner turmoil), myopathy (disease of the muscles that connect to the bones) and dysphagia (difficulty in swallowing food or liquid). Record Review of Resident #1's Admission MDS assessment dated [DATE] reflected she was sometimes understood and sometimes understands. She scored a 99 on her BIMS which signified the interview could not be completed related to refusal to answer or nonsensical responses. She was dependent for care. Resident's diet was NPO, and she received enteral nutrition. She had a tracheostomy with invasive mechanical ventilation. Record review of Resident #1's comprehensive care plan revised dated 03/01/2025 reflected Focus, may have ice chips per MD orders, Intervention, supervise resident while consuming ice chips. Record review of Resident #1's Active Orders as of: 03/01/2025 reflected Pt may have ice chips in three-fourths of a cup once a shift upon request. Pt must be elevated in an upright position with her cuff deflated with RT supervision at bedside Phone Active 03/01/2025. Record review of RT A's progress note dated 03/1/2025 at 01:15 pm reflected. (continued on next page)

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	04/10/2025

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	3/1/2025 13:15 Activity Note Note Text: The resident accused me of yelling at her, which I did not do. I explained that i have never raised my voice at any of my patient before. I also clarified that because I am wearing a face mask, I naturally speak a little louder than usual. The resident stated, I'm not deaf and claimed that what I said was inappropriate, by saying what i said was Bull shit.She also requested a larger cup of ice. I informed her that I am unable to provide a larger cup and I could not stay in the room longer than 10 minutes, as I am the only RT on the floor now. She responded by saying that was also bullshit and insisted that I did have time to stay longer.SA B was present. The resident then asked if one of them could stay in the room because she felt I was going to yell at her again. SA B stayed in the room with me while I provided the ice to the patient from 12:43 pm - 1:15 pm Observation on 04/08/2025 at 09:15 am of Resident #1 lying on an air mattress in bed revealed she received mechanical ventilation via an oxygen concentrator with tubing connected to her tracheostomy. Interactions between Resident #1 and staff was positive. Interview on 04/08/2025 at 09:22 am with Resident #1, she denied abuse, yelling or issues with staff. She whispered her care was good at the facility and staff treated her well. Interview on 04/08/2025 at 04:42 pm with RT A revealed that she went to provide Resident #1 ice as ordered and Resident #1 requested a bigger cup of ice On 3/1/2025. She stated she wore a mask because Resident #1 was on enhanced barrier precautions. RT A stated she told Resident #1 she would need to check the physician orders and she stated she spoke louder wearing the mask. She stated Resident #1 said You do not have to yell at me, I am not deaf. She stated Resident #1 apologized to her later in the day for being rude. She denied yelling. She stated she reported to her supervisor that Resident #1 was not happy, but she did not think to report the incident to the Administrator who was the abuse and neglect coordinator, but she did annotate the quote from Resident #1 in her progress notes. She stated she had training on abuse and neglect. Interview on 04/09/2025 at 10:50 am with RT D, RT A's supervisor, he stated RT A called him and told him Resident #1 was not happy about the ice. He stated she did not mention anything about Resident #1's allegations. He stated RT staff were trained on abuse and neglect. Interview on 04/10/2025 at 02:57 pm with SA B revealed she was present in Resident #1's room when RT A provided her the ice chips, and she did not witness RT A yelling or being inappropriate. Interview on 04/10/2025 at 5:33 pm with the DON revealed when the administrative team reviewed the notes from the weekend, they immediately started to investigate the incident and train 100 percent of the staff on abuse and when to report, to whom and provided the ADM's phone number. Interview on 04/10/2025 at 5:53 pm with the ADM revealed Administrator reviewed the abuse and neglect protocol. Seven components. Training important and reporting immediately. Accountable for care at the facility. They provided the in-service to 100% staff after they found RT A's note. They do a meeting and review progress notes and found that communication The Administrator said they do champion rounds and monitor for abuse and neglect. Accountable for the care in the facility. Record review of RT A's in-service attendance record dated 01/12/2025 reflected she received training on abuse/neglect and reporting. (continued on next page)

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	04/10/2025

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	The facility course of action prior to surveyor entrance included: Record review of the facility PIR dated 03/03/2025 reflected an investigation into the incident between Resident #1 and RT A was investigated and reported immediately to HHSC. Record review of the Administrator's PIR dated 03/03/2025 revealed: All required notifications were made which included the Medical Director, Responsible Party, Physician, QA Ad Hoc Committee and HHSC. Record review of RT A's personnel folder reflected no issues of concern. Record review dated 04/10/2025- 118 staff, all staff, were in-serviced on using a staff roster were checked off and signed for in-services titled: Abuse/Neglect and Reporting. STAFF INTERVIEWS ON TRAINING: 04/10/2025 from 2:57 PM to 5:33 PM revealed staff were scheduled for 12-hour shifts, many worked both day, evening, and night shifts. On 04/10/2025 at total of 6 LVN's (E, F, G, H, I and J), 4 CNA's (K, L, M and N), 1 CMA (O), 1 SA (B) 1 PT (C) and 2 RTs (A and D), 2 RN's, (DON, ADON) were interviewed on reporting, abuse, and neglect. They were trained to report to the ADM, provided a phone number and instructed to report immediately or within 2 hours. They were instructed on the diverse types of abuse. Review of the facility policy, Abuse/Neglect revised 3/29/18, read: The facility will provide and promote the protection of resident rights. It is everyone's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, abuse and situations that may constitute abuse or neglect to any resident in the facility. 3. Facility employees must report all allegations: abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designees will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegations involve abuse or result in serious bodily injury, the report must be made within 2 hours of the allegation. The noncompliance was identified as PNC. The noncompliance began on 03/01/2025 and ended on 03/03/2025. The facility had corrected the noncompliance before the survey began.