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	03/19/2026

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 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 observations, interviews and record reviews, the facility failed to ensure assessments accurately reflected the status of the residents for 1of 9 residents (Residents #1) reviewed for resident assessments. The facility failed to ensure Resident #1's diet was accurately reflected on her significant change MDS assessment, dated 02/17/2025. This failure could place residents at risk of missed or inaccurate care.The findings included: Record review of Resident #1's electronic face sheet dated 03/16/2026 reflected a [AGE] year-old female admitted on [DATE]. Her diagnoses included: acute (comes on quickly) and chronic (long-term problem) respiratory failure with hypoxia (the inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function), neuromuscular dysfunction of bladder(when a person lacks bladder control due to brain, spinal cord or nerve problems), insomnia (inability to sleep), morbid obesity (a body mass index of 35 or higher with related health conditions), type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood), bipolar disorder (a mental health condition that causes extreme mood swings), tracheostomy status (a surgically created hole, in the windpipe, also known as the trachea to allow air to pass, and help with breathing) and polyphagia (a feeling of extreme, insatiable hunger). Review of Resident #1's significant change MDS assessment dated [DATE] reflected she was on a mechanically altered diet. Her cognitive status was intact, and she was dependent on staff for assistance with ADLs. Record review of Resident #1's comprehensive care plan dated 03/03/2025 reflected Focus, diet order, regular diet, regular texture and regular consistency. Record review of Resident #1's Active Orders as of: 03/16/2026 reflected Regular diet, regular texture, regular consistency per hospice, start date 12/02/2025. Observation on 03/18/2026 1:00 p.m., Resident #1 was lying in bed being assisted with eating her lunch. She was provided with regular food, regular texture with regular consistency. Record review of Resident #1's meal ticket on 03/18/2026 reflected Regular diet, regular texture and regular consistency. During an interview on 03/18/2026 at 1:05 p.m., Resident #1 responded she was on a regular diet and had been since she was first admitted . During an interview on 03/19/2026 at 1:30 p.m., MDS A stated she missed the CPAP, which should have been noted under non-invasive mechanical ventilator. MDS B said she did not know how she missed it and was accountable for the accuracy of the MDS. She stated an inaccurate MDS could result in missed care for a resident. During an interview on 03/19/2026 at 2:50 p.m., MDS A stated Resident #1's significant change MDS assessment dated [DATE] needed to reflect she received a regular diet, and it did not. She stated she did not know how the regular diet was missed. During an interview on 03/19/2026 at 3:00 p.m., the ADON stated staff assisted Resident #1 continually with feeding. She stated the resident orders food from outside, and her family brings in food. She stated Resident #1 was on a regular diet and that the MDS accuracy was important to show what the residents needed for care and inaccuracy could lead to missed care. During an interview on 03/19/2026 at 4:00 p.m., the ADM stated MDS accuracy was important and it showed the care a resident required. Record review of the facility policy and procedure titled Minimum Data Set Policy for MDS assessment Data Accuracy (undated) reflected The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who are familiar with his/her physical, mental and psychosocial well-being. 1. The assessment accurately reflects the resident's status. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, dated October 2025 reflected The RAI process has multiple regulatory requirements. Federal regulation required the assessment accurately reflects the resident's status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 1 of 3 residents (Residents #2) reviewed for infection control, in that: The facility failed to ensure LVN B removed soiled gloves, sanitized hands, and put on clean gloves after cleaning feces from the anal area of Resident #2 and before placing a clean incontinent brief on the resident. These failures could place residents at-risk for infection due to improper care practices.The findings included: Record review of Resident #2's face sheet, dated 03/18/2026, revealed a [AGE] year-old female, admitted on [DATE]. Her diagnoses included: pneumonia (inflammation of the lungs, usually caused by an infection), methicillin resistant staphylococcus aureus infection (a group of staph bacteria that are resistant to common antibiotics), pressure ulcer of sacral region, stage 4 (the most severe form of pressure injury involving full-thickness loss with exposed muscle and bone), type 2 diabetes mellitus (chronic disease characterized by high levels of sugar in the blood), tracheostomy (surgical opening in the wind pipe to assist in air exchange and breathing), gastrostomy (surgical opening and tube to the stomach to assist with intake of fluids, medicines, enteral feeding) and neuromuscular dysfunction of bladder (lack of bladder control due to brain, spinal cord or nerve problems). Record review of Resident #2's 5-day scheduled MDS assessment, dated 02/12/2026, revealed the resident rarely understood she could rarely be understood. She was not a candidate for a BIMS which signified her cognitive status was severely impaired. She was dependent on staff for ADLs. She had a stage 4 pressure ulcer. Record review of Resident #2's care plan dated 03/17/2026, revealed Focus, has bowel incontinence, Interventions, provide peri care after each incontinent episode.Observation on 03/19/2026 at 10:30 a.m., LVN B performed incontinent care for Resident #2. LVN B wiped feces from Resident #2's anal area and threw the wipe in the trash. She continued to move the dirty brief further under the resident in preparation for inserting a clean brief. LVN B took a clean brief and placed it under Resident #2's clean buttocks without discarding her soiled gloves, sanitizing her hands, and putting on clean gloves. She continued to complete Resident #2's incontinent care. During an interview on 03/19/2026 at 10:45 a.m. LVN B stated she should have removed her soiled gloves, sanitized her hands, and put on clean gloves prior to placing a clean brief under Resident #2. She stated she had infection control training and performed treatments for facility residents. She stated she did not know why she did not remove her soiled gloves. During an interview with the ADON on 03/19/2026 at 3:00 p.m., she stated the nurse should have changed her gloves after cleaning Resident #2's anal area to prevent cross contamination of other items. She stated infection control training was provided and staff's skills were checked annually. She stated the DON was ultimately accountable for the nursing care in the facility. Record review of LVN B's Nurse Proficiency Audit dated 08/2023, reflected she satisfactorily passed her proficiency of Infection Control, proper hand washing, prevents cross contamination and universal precautions. Record review of the facility policy and procedure titled Perineal Care dated 05/11/2022 reflected gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area, doff gloves and perform hand hygiene. Record review of the facility policy and procedure titled Hand Hygiene (undated) reflected you may use alcohol-based hand cleaner or soap/water for the following: after contact with a resident's mucous membranes, body fluids or excretions.