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	05/07/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 4 of 5 residents (Residents #1, #2, #3, and #4) reviewed for medical records. 1. The facility failed to ensure Resident #1's medication administration report did not contain blanks. 2. The facility failed to ensure Resident #2's medication administration report did not contain blanks. 3. The facility failed to ensure Resident #3's medication administration report did not contain blanks. 4. The facility failed to ensure Resident #4's medication administration report did not contain blanks. This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records. The findings included: 1. Record review of Resident #1's admission record, dated 5/6/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness or partial paralysis affecting the right side of the body following a stroke), chronic obstructive pulmonary disease (chronic lung disease causing airflow limitation and breathing difficulty), acute respiratory failure with hypoxia (inadequate oxygen levels requiring respiratory support), unspecified protein-calorie malnutrition (poor nutritional status which may impair healing and increase risk for infection), aphasia following cerebral infarction (difficulty communicating following a stroke), dysphasia following cerebral infarction (difficulty swallowing following a stroke increasing risk for aspiration and complications), neuromuscular dysfunction of bladder (impaired bladder function related to nerve dysfunction), tracheostomy status (presence of a surgically created airway opening in the neck), gastrostomy status (presence of a feeding tube inserted into the stomach), and chronic kidney disease stage 3 (moderate decrease in kidney function). Record review of Resident #1's annual MDS assessment, dated 4/28/26 revealed the resident's cognition was severely impaired for daily decision making, with a BIMS score of 3. Record review of Resident #1's care plan revealed the resident had a care planned pressure ulcer identified as Stage 4 to sacrum, initiated 11/10/25 and revised on 04/30/26. The care plan goal stated the resident's pressure ulcer would show signs of healing and remain free from infection through the review date. Interventions included to Administer medications as ordered. Monitor/document for side effects and effectiveness, Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN, Assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD, Educate the resident/family/caregivers as to causes of skin breakdown, and Follow facility policies/protocols for the prevention/treatment of skin breakdown. Record review of Resident #1's May 2026 electronic MAR revealed an order for wound care: sacrum- cleanse with wound cleanser and pat dry. Apply methylene blue foam to wound bed. Apply border gauze, one time a day every Monday, Wednesday, and Friday for stage 4 pressure injury. The order contained blank on 5/4/26. Further review of the MAR revealed the scheduled treatment was left blank with no coding, initials, or documentation to indicate whether the wound care was administered, refused, held, or for (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the daily order. 2. Record review of Resident #2's admission record, dated 5/6/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stage 4 pressure ulcer of sacral region, unspecified dementia with other behavioral disturbance, type 2 diabetes mellitus without complications, unspecified protein-calorie malnutrition, acute respiratory failure with hypoxia, systemic lupus erythematosus, neuromuscular dysfunction of bladder, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle weakness, pneumonia due to inhalation of food and vomit, gastrostomy status, and oral phase dysphagia. Record review of Resident #2's other type MDS assessment, dated 4/15/26 revealed the resident's cognition was severely impaired for daily decision making, and a BIMS score could not be obtained. Record review of Resident #2's care plan, initiated 2/16/26 and revised 3/17/26, revealed the resident had pressure ulcers to the sacrum stage IV, left heel unstageable, and right heel unstageable. The care plan revealed The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions included Do not massage over bony prominences and use mild cleansers for peri-care/washing, Ensure heels are floated with the use of pillows, and The resident requires the use of an air mattress. Record review of Resident #2's April 2026 electronic MAR revealed an order for wound care: left heel - cleanse with NS/WC. pat dry. apply skin prep and leave open to air one time a day for unstageable pressure injury. The order contained blanks on 4/3/26, 4/11/26, and 4/12/26. The MAR also revealed the order was placed on hold from 4/16/26 at 6:43 a.m. through 4/19/26 at 6:43 a.m. and again from 4/19/26 at 5:16 p.m. through 4/22/26 at 5:15 p.m. Record review of the same MAR revealed:- an order for wound care: right heel - cleanse with NS/WC. pat dry. apply medihoney and cover with dry dressing Mon/Wed/Fri and PRN soiling one time a day every Mon, Wed, Fri for pressure injury unstageable-an order for wound care: sacrum - cleanse with wound cleanser. pat dry. apply medihoney, calcium alginate and bordered gauze one time a day every Mon, Wed, Fri for stage 4 pressure injury.Both orders contained a blank entry on 4/3/26. Further review of the MAR revealed the scheduled treatment entries were left blank with no coding, initials, or documentation to indicate whether the treatments were completed, refused, held, or unavailable. 3. Record review of Resident #3's admission record, dated 5/7/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stage 4 pressure ulcer of sacral region, osteomyelitis of vertebra, sacral and sacrococcygeal region, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, emphysema, unspecified severe protein-calorie malnutrition, epilepsy, chronic pain syndrome, muscle weakness, hemiplegia affecting left nondominant side, neuromuscular dysfunction of bladder, tracheostomy status, and gastrostomy status. Record review of Resident #3's admission MDS assessment, dated 3/9/26 revealed the resident's cognition was severely impaired for daily decision making, and a BIMS score could not be obtained. The MDS further revealed she had 1 stage 4 pressure ulcer and received care intervention with a pressure reducing device for bed, pressure ulcer care, applications of dressings, and application of ointments or medications. Record review of Resident #3's April 2026 electronic MAR revealed an order for fluid filled blister (blue) to left heel: cleanse with normal saline, pat dry, paint with betadine, leave OTA every shift for wound care. The order contained blanks on 4/9/26 and 4/14/26. Further review of the MAR revealed the scheduled treatment entries were left blank with no coding, initials, or documentation to indicate whether the treatment was completed, refused, held, or unavailable. 4. Record review of Resident #4's admission record, dated 5/7/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including stage 4 pressure ulcer of unspecified site, acute and chronic respiratory failure with hypoxia, unspecified severe protein-calorie malnutrition, tracheostomy status, gastrostomy status, paraplegia, dysphagia following cerebral infarction, acute kidney failure with tubular necrosis, neuromuscular dysfunction of bladder, acquired absence of kidney, anoxic brain damage, anemia, and gastro-esophageal reflux disease without esophagitis. Record review of Resident #4's other type MDS assessment, dated 5/5/26 revealed the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's cognition was severely impaired for daily decision making, and a BIMS score could not be obtained. Record review of Resident #4's care plan, initiated 4/30/25 and revised 3/16/26, revealed the resident had pressure ulcers including stage 4 to left sacrum (buttock/gluteal fold near anus), stage 4 to left ischial, stage 4 to left outer ankle, stage 4 to left shoulder, and stage 4 to right ischium. The care plan revealed [Resident #4] pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions included Administer medications as ordered. Monitor/document for side effects and effectiveness, Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN, Assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the resident MD, Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, Follow facility policies/protocols for the prevention/treatment of skin breakdown, and Notify nurse immediately of any new areas of skin breakdown: Open area, Redness, Blisters, Bruises, discoloration noted during bath or daily care. Record review of Resident #4's April 2026 electronic MAR revealed orders for:- wound care: sacrum - cleanse with wound cleanser. pat dry. apply medihoney, calcium alginate, and bordered foam one time a day for stage 4 pressure injury,- wound care: left shoulder - cleanse with wound cleanser. pat dry. apply medihoney, calcium alginate, and dry dressing one time a day for stage 4 pressure injury,- wound care: right ischium - cleanse with wound cleanser. pat dry. apply medihoney, calcium alginate and bordered foam one time a day for stage 4 pressure injury,- wound care: left lateral ankle - cleanse with wound cleanser. pat dry. apply medihoney, calcium alginate, and bordered gauze one time a day for stage 4 pressure injury.The orders contained blanks on 4/10/26, 4/22/26, and 4/25/26. The MAR also revealed the orders were placed on hold from 4/14/26 at 7:31 p.m. through 4/17/26 at 1:28 p.m.Further review of the MAR revealed the scheduled treatment entries were left blank with no coding, initials, or documentation to indicate whether the treatments were completed, refused, held, or unavailable. Record review of Residents #1's, #2's, #3's, and #4's skin assessments dated from 3/30/26 through 5/4/26 revealed the residents' wounds had not worsened and all wounds showed a decrease in size during the review period. During an interview on 5/6/26 at 5:31 p.m., LVN C stated he had worked the morning shift from 6:00 a.m. to 6:00 p.m. for the last year. LVN C stated wound care had been a bit of a fiasco and there had been multiple changes in the wound care nurse position. He stated he had filled in at times when there was not a designated wound care nurse. LVN C stated there had been occasions where the facility had a wound care nurse and then all of a sudden they did not, and staff were not informed or aware they were responsible for completing the wound care treatments that day. He stated wound care nurse coverage had been sporadic. LVN C stated he could not say for sure whether wound care treatments associated with blank entries on the MARs had been completed or not completed and stated it was possible the treatments had been done but not documented. LVN C stated there had been times he forgot to document treatments after being called away by other staff and someone later identified the blank entry and had him correct or document it, but due to multiple staffing and management changes that had not really occurred recently. LVN C stated he had been scheduled and responsible for Resident #2's wound care on 4/3/26 and could not state why there had been a blank entry or recall whether the treatment had been completed. LVN C stated failure to provide wound care regularly per physician orders could have led to potential bacteria buildup in the wound. LVN C stated Resident #2 had a colostomy and Foley catheter and may not have required as much incontinent care as other residents, making it possible a dressing may not have been noticed as unchanged for several days. During an interview on 5/6/26 at 4:55 p.m., the DON stated there had been new nurses working on some of the hallways and she did not like seeing blanks on residents' MARs. The DON stated blank entries could have occurred when nurses completed a treatment and then became distracted by residents requesting assistance or other tasks before documenting the treatment. The DON stated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff may have completed the wound care but forgot to document it and acknowledged if it doesn't get documented, it didn't happen. The DON stated if wound care had been completed but not documented, staff could have reviewed the dressing and date on the bandage to determine the treatment had been completed. The DON stated if wound care had not been completed as ordered, the resident could have been at risk for possible infection. Record review of facility policy titled Documentation,, no date, revealed documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident.legal requirements regarding accuracy and completeness, legibility and timing.the facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.the facility will ensure that information is comprehensive and timely and properly signed.document completed assessments in a timely manner and per policy.complete documentation as needed in a timely manner.each entry will be dated and timed.each entry will be signed with proper signature and title.

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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 1 of 3 residents (Resident #1) reviewed for infection control: The facility failed to ensure LVN A maintained proper hand hygiene during wound care for Resident #1 during a wound care observation. This failure could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #1's admission record, dated 5/6/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness or partial paralysis affecting the right side of the body following a stroke), chronic obstructive pulmonary disease (chronic lung disease causing airflow limitation and breathing difficulty), acute respiratory failure with hypoxia (inadequate oxygen levels requiring respiratory support), unspecified protein-calorie malnutrition (poor nutritional status which may impair healing and increase risk for infection), aphasia following cerebral infarction (difficulty communicating following a stroke), dysphasia following cerebral infarction (difficulty swallowing following a stroke increasing risk for aspiration and complications), neuromuscular dysfunction of bladder (impaired bladder function related to nerve dysfunction), tracheostomy status (presence of a surgically created airway opening in the neck), gastrostomy status (presence of a feeding tube inserted into the stomach), and chronic kidney disease stage 3 (moderate decrease in kidney function). Record review of Resident #1's annual MDS assessment, dated 4/28/26 revealed the resident's cognition was severely impaired for daily decision making, with a BIMS score of 3. Record review of Resident #1's care plan revealed the resident had a care planned pressure ulcer identified as Stage 4 to sacrum, initiated 11/10/25 and revised on 04/30/26. The care plan goal stated the resident's pressure ulcer would show signs of healing and remain free from infection through the review date. Interventions included to Administer medications as ordered. Monitor/document for side effects and effectiveness, Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN, Assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD, Educate the resident/family/caregivers as to causes of skin breakdown, and Follow facility policies/protocols for the prevention/treatment of skin breakdown. During an observation on 5/6/26 at 3:27 p.m., LVN A prepared to provide wound care to Resident #1. Resident #1 was lying in bed and did not respond when spoken to. LVN A washed his hands in the bathroom in the resident's room. LVN A then needed to replace his gown. After putting on a new gown, LVN A put on new gloves, pulled the resident's curtain over with his gloved hand, handed LVN B the bed remote with his gloved hand, removed the resident's blankets, turned the resident to her left side, grabbed a paper tape measure, and began measuring the resident's wound to her sacrum area. LVN A's gloves touched the wound bed while he measured the wound with the paper tape. LVN A then stated he needed a trashcan, removed his gloves, went to the bathroom and washed his hands, returned to the resident's bedside, moved the resident's curtain with his bare hand, grabbed new gloves, and put them on. With the same gloves, LVN A then grabbed wet gauze and cleaned the resident's wound bed. LVN A then removed his gloves and washed his hands in the resident's bathroom. LVN A then returned to the bedside, moved the resident's curtain with his bare hand, put on new gloves, grabbed foam dressing, cut it to size, placed it back on the clean field, grabbed dry gauze, wiped the wound bed, then left to wash his hands again. LVN A returned after washing his hands and used his arm to move the resident's curtain. LVN A placed the foam in the resident's wound bed and covered the wound and foam with an island dressing. LVN A dated the dressing. LVN A and LVN B then secured the same brief back onto the resident. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brief had visible blood from the wound on it and pieces of skin from the resident. During an interview on 5/6/26 at 4:00 p.m., LVN A stated you cannot touch objects that are not clean and then touch a resident's wound. LVN A stated he guessed medically it would be considered cross-contamination even if gloves were changed and the wound was cleaned. LVN A stated he did not remember touching the curtain during wound care; however, if he had touched the curtain and then touched the wound or wound care supplies, it would have been cross-contamination that could cause infection. When asked why the resident's brief was not changed and the same brief was reapplied after wound care, LVN A stated the aides usually changed the brief after care was provided. During an interview on 5/6/26 at 4:03 p.m., the Director of Nursing (DON) stated if staff touched the curtain or bedroom remote during wound care, it could have caused cross-contamination because staff did not know what contaminants could have been present on those surfaces. The DON stated hand sanitizer was available and should have been used in between glove changes during wound care. The DON stated cross-contamination during wound care could have placed the resident at risk for possible infection. The DON also stated the nurses could have changed and should have changed the resident's brief during care to ensure a clean brief was applied. Record review of the facility's undated Infection Control Policy & Procedure Manual, policy number AD 03-8.0, no date, revealed Hand Hygiene, hand hygiene continues to be the primary means of preventing the transmission of infection.some situations that require hand hygiene: before and after direct resident contact.before and after performing any invasive procedure.before and after changing a dressing.after contact with a resident's mucous membranes and body fluids or excretions.after handling soiled or used linens, dressings, bedpans, catheters and urinals.after removing gloves or aprons.consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections.gloves were worn to provide protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and nonintact skin.to reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident-care procedures.to reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite can transmit these microorganisms to another resident.gloves must be changed between resident contacts, and hands washed after gloves are removed.wearing gloves does not replace the need for hand washing.failure to change gloves between resident contacts is an infection control hazard.adequate disinfection of bedside equipment and environmental surfaces (e.g. bed rails, bedside tables, carts, commodes, doorknobs, faucet handles).for pathogens.that can survive as a fomite for prolonged periods of time.equipment that is visibly soiled with blood or body fluids will be cleaned immediately with an approved disinfectant.