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 12/18/2024
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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observations, interviews, and record review, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 7 residents (Resident # 2, Resident # 28 and Resident # 80) reviewed for call light. The facility failed to ensure Resident # 2's, Resident # 28's and Resident # 80's call light was within reach. This failure could place residents at risk of achieving independent functioning, dignity, and well-being. Findings include: 1.Record review of Resident #2 's face sheet dated 12/16/24 revealed an 89 - year old female admitted to the facility 7/22/24. Resident # 2 had diagnoses that included Osteoporosis (a disease that causes loss of bone mass over time), Type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) and High blood pressure (when blood flows through your arteries at higher-than-normal pressures). Record review of Resident # 2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 99 which suggested, the resident was unable to complete the interview. Record review of Resident 2's care plan dated 7/22/24 revealed the resident was at risk for falls and to keep call light within reach . Observation 12/16/24 in Resident # 2's room at 8:20 AM revealed the call light was found on floor out of arms reach. Interview with LVN B on 12/16/24 revealed she was the assigned nurse for Resident # 2 and confirmed the call light was on the floor., She stated she did not know how the call light ended up on the floor but would place it within reach of resident # 2 at once. LVN B stated that resident # 2 could risk a possible fall if the call light was not within arm's reach. (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: 676297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #28's face sheet dated 12/16/24 revealed a [AGE] year-old female admitted to the facility 1/8/24. Resident # 28 had diagnoses that included Schizophrenia (chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), Encephalopathy (means damage or disease that affects the brain) and Tachycardia (a condition where the heart rate exceeds 100 beats per minute) . Record review of Resident # 28's Quarterly MDS assessment dated [DATE] revealed a BIMS of 15 which indicated intact cognition. Record review of Resident # 28's care plan dated 1/10/24 revealed the resident was at risk for falls and to keep call light within reach. Observation and interview on 12/16/24 at 8:35 a.m. with resident # 28 revealed the call light was on the floor. ,, She stated that with call light on the floor she would not have a way to call for help. 3. Record review of Resident # 80's face sheet dated 12/16/26 revealed an [AGE] year-old female admitted to the facility 4/20/24. Resident # 80 had diagnoses that included End-stage renal disease (is when the kidneys permanently fail to work) anxiety disorder (is a common disorder characterized by long-lasting anxiety that is not focused on any one object or situation) and High blood pressure (when blood flows through your arteries at higher-than-normal pressures). Record review of Resident # 80's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. Record review of Residents # 80's care plan dated 8/15/24 revealed the resident was at risk for falls and to keep call light within reach . Observation and interview on 12/16/24 at 8:40 a.m. with resident # 80 revealed the call light was on the floor. , She stated that with the call light on the floor she would yell for help today . During an interview with the DON on 12/17/24, at 10:46 AM, revealed she did not have a policy regarding call lights and emphasized the importance of ensuring the call light was accessible to all residents. The DON stated , the lack of accessibility to a call light for any resident could lead to a potential negative outcome if assistance was needed. The DON also mentioned the charge nurses currently monitored that task during their morning rounds daily, and she and her ADON were responsible for overseeing that process.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 22 residents (Resident #48) whose assessments were reviewed, in that: Resident #48's diagnosis of anxiety was not identified as an active diagnosis on the resident's quarterly MDS assessment with an ARD of 11/25/2024. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings were: Record review of Resident #48's face sheet, dated 12/17/2024, revealed an initial admitted [DATE] and a readmitted ,d+[DATE]//2024 with diagnoses that included cirrhosis of the liver (a condition where the liver is permanently damaged and scar tissue replaces healthy tissue), type II diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #48's Physician orders and Medication administration record for December 2024 revealed an order for: Ativan Oral Tablet 0.5 MG (Lorazepam). Give 1 tablet by mouth every 4 hours as needed for Anxiety. Can give Q 4-6. Order date: 10/10/2024. Start date: 10/10/2024 and another order for: Ativan Oral Tablet 0.5 MG (Lorazepam). Give 2 tablets by mouth every 4 hours as needed for Anxiety Can give Q 4-6. Order date: 10/10/2024. Start date: 10/10/2024. Record review of Resident #48's Progress Note dated 11/07/2024 listed Anxiety D/O as one of the resident's diagnoses. Record review of Resident #48's Quarterly MDS dated [DATE], revealed the resident had a BIMS of 99, indicating the resident was unable to complete the interview due to severely impaired cognition. Section I, Active Diagnoses, revealed I5700. Anxiety Disorder was not checked, indicating the resident did not have the diagnosis. During an interview on 12/17/2024 at 3:44 PM, the DON stated Resident #48 was diagnosed with anxiety disorder by both her primary care physician and her hospice physician; however, the diagnosis was listed in the progress notes and was therefore not picked up by the MDS LVN and not transcribed into the resident's list of diagnoses. It was important to ensure all the residents' diagnoses were properly identified to ensure they received proper care. Interview on 12/18/2024 at 1:06 PM, the Administrator stated Resident #48's diagnosis of anxiety was not indicated in the resident's most recent MDS and should have been. It was possible there was a system breakdown on part of medical records, not seeing the diagnosis listed in the resident's progress notes and informing the MDS nurse to add it to the resident's assessment. During an interview on 12/18/2024 at 1:11 PM, the DON stated the facility used the RAI manual as their policy for resident assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18. 11, October 2023, revealed, SECTION I: ACTIVE DIAGNOSES. Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet residents' mental, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 1 of 22 residents (Resident #48) reviewed for care plans. Resident #48's diagnosis of depression and anti-anxiety medication (Ativan) were not addressed in her comprehensive care plan. This failure could affect residents who have care areas not addressed by the care plans by not having their needs met and putting them at risk of not receiving appropriate care. The findings included: Record review of Resident #48's face sheet, dated 12/17/2024, revealed an initial admitted [DATE] and a readmitted ,d+[DATE]//2024 with diagnoses that included cirrhosis of the liver (a condition where the liver is permanently damaged and scar tissue replaces healthy tissue), type II diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #48's Physician orders and Medication administration record for December 2024 revealed an order for: Ativan Oral Tablet 0.5 mg (Lorazepam). Give 1 tablet by mouth every 4 hours as needed for Anxiety. Can give Q 4-6. Order date: 10/10/2024. Start date: 10/10/2024 and another order for: Ativan Oral Tablet 0.5 mg (Lorazepam). Give 2 tablets by mouth every 4 hours as needed for Anxiety Can give Q 4-6. Order date: 10/10/2024. Start date: 10/10/2024. Record review of Resident #48's Progress Note dated 11/07/2024 listed Anxiety D/O as one of the resident's diagnoses. Record review of Resident #48's Quarterly MDS dated [DATE], revealed the resident had a BIMS of 99, indicating the resident was unable to complete the interview due to severely impaired cognition. Record review of Resident #48's Comprehensive Care Plan, updated 09/05/2024, revealed there was no focus area indicating the resident's diagnosis of anxiety disorder and there was no focus area indicating the resident's active orders for anti-anxiety medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 3:44 PM, the DON stated Resident #48 was diagnosed with anxiety disorder by both her primary care physician and her hospice physician; however, the diagnosis was listed in progress notes and was therefore not picked up by the MDS LVN and not transcribed into the resident's list of diagnoses and care plan. It was important to ensure all the residents' health conditions and medications were properly identified in the residents' comprehensive care plans to ensure they received proper care. Record review of facility policy GP mc 03-18.0 Comprehensive Care Planning, undated, revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Each resident will have a person-centered comprehensive care plan developed to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. - The resident's care plan will be reviewed after each admission, quarterly, annual and/or significant change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to interventions. 46131

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46131 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles for, 1 of 4 medication carts observed, in that: The Nurse Medication Cart in the 200-hall contained seven loose medication pills. This failure could place residents who receive medications at risk for not receiving the intended therapeutic effects of medications. The findings were: Observation on 12/17/2024 at 9:20 p.m. of the 200 Hall Nurse Medication Cart revealed there were seven loose medication pills inside one of the drawers. During an interview with CMA D on 12/17/2024 at 9:25 a.m., CMA D confirmed there were seven loose medication pills inside a drawer of the Nurse Medication Cart . , She stated the pills must have droped at some point during her medication pass this morning . During an interview with the DON on 12/17/2024 at 10:20 a.m., she stated medication carts should not have loose medications. They were the responsibility of the medication aide that accepted responsibility for the cart, also the medications carts were supposed to be checked bi-weekly by the ADONs' Record review of the facility policy 2003 revealed Medication Carts revealed, carts must be clean .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36232 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: The facility failed to properly store a 6.5 lb. container of strawberries in the walk-in cooler. This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 12/15/2024 at 10:58 AM revealed a 6.5 lb. container of thawed frozen strawberries in the walk-in cooler that was opened with approximately 1/4 of the container remaining. There was no label on the container indicating the date the container was opened or a use-by date. During an interview on 12/15/2024 at 11:00 AM with DA E he stated the container of strawberries did not have a date indicating the day it was opened and a use by date, and failure to properly date open food items could potentially lead to foodborne illness. During an interview on 12/18/2024, the DM stated all dietary staff were trained upon hire and routinely throughout the year, and all dietary staff had their current food handler certificates. Record review of facility policy number IC 00-8.0, Food Storage and supplies, undated, revealed, All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies . Procedure: 4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36232 Based on observation , interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 2 (Residents #43 and #45) of 22 residents reviewed for medical records. 1. The facility failed to ensure Resident #43's advance directive was listed on the resident's face sheet, consolidated physician's orders, and upon accessing the resident's electronic health record. 2. The facility failed to ensure Resident # 45's diet order was clarified. These deficient practices could place residents at risk of improper care due to inaccurate medical records. The findings were: 1. Record review of Resident #43's face sheet, accessed 12/16/2024, revealed the resident was admitted to the facility on [DATE] and again on 11/18/2024 with diagnoses including: Peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked), urinary tract infection (an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra), and type II diabetes with diabetic chronic kidney disease (a chronic condition where the body does not use insulin effectively or does not produce enough insulin, and can lead to kidney disease). Further review of the face sheet revealed under the section Advance Directive, there was a blank space with no advance directive indicated. Record review of Resident #43's order summary report for the month of December 2024, accessed on 12/16/2024, revealed there was no order listing an advance directive. Review of the facility's cloud-based software program used to store and maintain the resident's EHR revealed, upon accessing Resident #43's EHR, the resident's code status was not visible at the top of any tab in the resident's record. Record review of Resident #43's consolidated care plan, updated 12/05/2024, revealed Resident #43 had an order for Do Not Resuscitate initiated 08/17/2021. During an interview on 12/20/2024 at 9:15 AM, the DON stated Resident #43's code status had been in the resident's EHR the entire time, even though it was not readily visible on the resident's face sheet, order summary report, and at the top of any tab upon accessing the resident's EHR. Any LVN who worked at the facility knew how to access the information when accessing the resident's EHR and going to a specific section in the record where the information was located. Nurses knew the code status of all their residents and would also check the resident's care plan in the event of a code situation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2024 at 9:45 AM, the Regional Resource RN stated Resident #43's advance directive status was not listed on his order summary report so she updated the resident's orders and added the order on 12/17/2024 at 1:23 PM to ensure it would now appear on the resident's orders and would be more readily available. 2. Record review of Resident #45's face sheet, accessed 12/15/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes (is a chronic disease characterized by high levels of sugar in the blood), Hyperlipidemia, (means you have too many fats in your blood), and Hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs). Record review of Resident # 45's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 05 which suggested, severe cognitive impairment Record review of Resident #45's order summary report for the month of December 2024, revealed an order dated 11/21/24 for an NPO diet . Record review of food tray ticket on 12/15/24 , revealed order for puree diet . Observation on 12/15/24 at 11:45 a.m revealed a food tray on the bed side table of Resident # 45. Interview with LVN B on 12/15/24 at 11:50 a.m., she confirmed that a puree food tray was present on Resident #45's bedside table. LVN B stated that Resident # 45 had two different diet orders, and conflicting diet orders could negatively affect Resident # 45 as no one would know which diet order to follow. Interview with the DON on 12/15/24 at 1:11 p.m. revealed that the two diet orders for Resident # 45 should have been clarified and ; she did not know why the resident had two different diet orders but believed it must have been an oversight. The DON stated it was her expectation for licensed nurses to verify all orders and address any conflicting orders promptly. Record review of the facility's policy MR 03-2.02 Physician's Orders, undated, revealed: Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. Steps: 1. Physician's monthly consolidated orders must be reviewed by a licensed nurse to assure they reflect all current orders. Any orders not within the monthly physician's order must be added before physician review. 3. The Physician must approve/sign the monthly consolidated orders within 30 days. 46131