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	04/17/2026

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 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** Based on interviews and records review, the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical and nursing needs for 1 of 3 residents (Resident #1) reviewed for care planning. The facility failed to ensure Resident #1's comprehensive care plan included the resident's need for oral suction. This failure could result in residents not receiving the intended care. Findings included:Record review of Resident #1's admission Record dated 4/16/2026 reflected a [AGE] year-old female admitted to the facility on [DATE], with relevant diagnoses that included dysphagia (the inability to swallow normally). Record review of Resident #1's quarterly MDS submitted 2/27/2026 reflected a BIMS score of 0 due to the resident's inability to be understood. Section 06110 (Special Treatments, Procedures, and Programs) of the MDS did not indicate Resident #1 required suctioning on admission, while a resident, or at discharge. Record review of Resident #1's Care Plan Report printed 4/16/2026 did not reveal interventions related to oral suctioning. Record review of Resident #1's Order Summary Report dated 4/16/2026 reflected a physician's order for NPO diet NPO texture, NPO consistency [sic] dated 2/13/2026.Resident #1 was unable to participate in an interview attempted on 4/16/2026 due to cognitive and functional decline. In an interview on 4/16/2026 at 1:05 PM, LVN B said Resident #1 required occasional oral suctioning. He was unsure if Resident #1 had a physician's order or care planning for the suctioning. He said he knew Resident #1 required the treatment occasionally because he had been working with her for a while and there was suctioning equipment in her room, which indicated it was needed. In an interview on 4/16/2026 at 2:32 PM, RN A said he had performed oral suctioning on Resident #1 during the shift on 4/14/2026. He said Resident #1 occasionally required oral suctioning due to her medical history. In an interview with MDS on 4/17/2026 at 10:10 AM, she said Resident #1's care plan did not include the need for suctioning because there was not a physician's order for suction. She said she created that area of the care plan based on physician's orders. She said the suctioning treatment should be included in the care plan to ensure Resident #1 received the treatment as needed. In an interview with the DON on 4/16/2026 at 1:57 PM, she said she had just started the position of DON and was unaware Resident #1 required occasional oral suctioning. She said this intervention should be in the care plan to ensure proper care. Record review of the facility policy titled Comprehensive Care Planning (undated) reflected the following:Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 3 residents (Resident #1) reviewed for respiratory care.The facility failed to ensure Resident #1 had a signed, physician's order for oral suctioning.This failure could result in residents not receiving intended care. Findings included:Record review of Resident #1's admission Record dated 4/16/2026 reflected a [AGE] year-old female admitted to the facility on [DATE], with relevant diagnoses that included dysphagia (the inability to swallow normally). Record review of Resident #1's quarterly MDS submitted 2/27/2026 reflected a BIMS score of 0 due to the resident's inability to be understood. Section 06110 (Special Treatments, Procedures, and Programs) of the MDS did not indicate Resident #1 required suctioning on admission, while a resident, or at discharge. Record review of Resident #1's Care Plan Report printed 4/16/2026 did not reveal interventions related to oral suctioning. Record review of Resident #1's Order Summary Report dated 4/16/2026 reflected a physician's order for NPO diet NPO texture, NPO consistency [sic] dated 2/13/2026. Further review of the report revealed there was no order for suction. Resident #1 was unable to participate in an interview attempted on 4/16/2026 due to cognitive and functional decline. In an interview on 4/16/2026 at 1:05 PM, LVN B said Resident #1 required occasional oral suctioning. He was unsure if Resident #1 had a physician's order or care planning for the suctioning. He said he knew Resident #1 required the treatment occasionally because he had been working with her for a while and there was suctioning equipment in her room, which indicated it was needed. In an interview on 4/16/2026 at 2:32 PM, RN A said he had performed oral suctioning on Resident #1 during the shift on 4/14/2026. He said Resident #1 occasionally required oral suctioning due to her medical history. He was unsure if there was a physician's order for suctioning. In an interview on 4/16/2026 at 1:57 PM, the DON said she recently become the DON for the facility, and she was unaware Resident #1 required occasional oral suctioning. She said Resident #1 should have had a physician's order for suctioning. Record review of the facility policy titled Airway Suctioning (undated) reflected the following:Suctioning is prescribed for residents unable to clear the airway by coughing .