Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676041	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Mission at Blue Skies of Texas East	4949 Ravenswood Dr San Antonio, TX 78227

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interviews and record reviews the facility failed to ensure the facility did not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion for 1 of 8 residents (Resident #2) reviewed for abuse, neglect, and or exploitation. The facility failed to ensure residents were free from physical abuse on 09/30/2024, while Resident #2 was laying on her bed CNA H placed a pillow over Resident #2's face and stated, Pillow Therapy! The noncompliance was identified as PNC. The noncompliance began on 09/30/2024 and ended on 10/01/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for harm by abuse. The findings included: A record review of Resident #2's admission record, dated 12/31/2024, revealed an admitted [DATE] with diagnoses which included chronic obstructive pulmonary disease, anxiety, and hemiplegia and hemiparesis. A record review of Resident #2's quarterly MDS, dated [DATE], revealed Resident #2 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 14 which indicated no cognitive impairment. further review revealed Resident was asked Over the last 2 weeks, have you been bothered by any of the following problems? . feeling down, depressed, or hopeless? . yes . 2-6 days . trouble falling asleep or staying asleep, or sleeping too much? Yes . frequency 1 day A record review of Resident #2's care plan, dated 12/31/2024, revealed Resident #2 had a focus for COPD, (Resident #2) has COPD complication with episodes of SOB, sleep apnea, And interventions which included monitor for signs and symptoms of depression . monitor for signs and symptoms of anxiety (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's email record, dated 09/30/2024, revealed the DON D emailed the state agency, Hello, I am self-reporting an incident that occurred today at 1730 (5:30 PM). It was brought to my attention by CNA B that he witnessed CNA H place a pillow over a resident's head stating, pillow therapy. Statements have been received from CNA B, the resident, while in presence of her (Representative) and the alleged perpetrator CNA H. Ms. CNA H described this action as part of a running joke between her and the resident. Resident in question is housed in (name of hall) household room (number), Thank you, (DON), RN. A record review of the facility's CMS form 3613 Provider Investigation report dated 10/01/2024 revealed an incident date of 09/302024 with an alleged perpetrator of CNA H. Further review revealed, Description of the allegation: (CNA B) witness sic(ed) (CNA H) place a pillow over the Resident's head stating it is pillow therapy A record review of CNA B's witness statement dated 10/02/2024 revealed, a typical day in (name of neighborhood in the facility) CNA H cares for residents who either do not have the best memory or cannot communicate efficiently (rooms within the home) this has been going on for a while. I am concerned about our resident's safety only because if she was so comfortable with giving (Resident #2) pillow Therapy while I was in the room it makes me wonder what she is or is capable of doing while I am not in the room watching her. A record review of the facility's schedule dated 09/30/2024 revealed CNA H and CNA B were scheduled to work the 3:00 PM to 11:00 PM schedule for Resident #2's home within the facility. Interviews with CNA B and CNA H were attempted without success, CNA B and CNA H were no longer employed by the facility. An interview with Resident #2 representative was attempted without success. During an interview on 1/3/2025 at 9:23 AM LVN J stated she had received a report from DON I that CNA H had held a pillow over Resident #2's face and she immediately assessed Resident #2 without injury and communicated the findings to the physician and Resident #2's representative. During an interview on 12/30/2024 at 03:05 PM the Administrator stated the facility investigated an allegation of abuse for Resident #2. The Administrator stated on September 30th, 2024, the interim DON I received a report that CNA H placed a pillow over Resident #2's face. The Administrator stated the facility's staff Education Coordinator then interviewed CNA H in which she admitted the action took place in jest. The facility suspended CNA H and reported the allegation of abuse to the state agency. The Administrator stated Resident #2 and peer residents were assessed for safety and no one was evidenced harmed. The Administrator stated the staff received an in-service for ANE prevention on 10/01/2024. The Administrator stated CNA H was terminated for the incident. A record review of the facility's in-service, dated 10/01/2024, titled, Abuse, Neglect, Exploitation, conducted by DON I revealed training for staff prevention and reporting alleged abuse, neglect, and or exploitation. Further review revealed 47 employees received the in-service. A record review of the facility's employee roster, dated 09/30/2024, revealed 47 employees. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/2025 at 11:10 AM DON I stated CNA H was interviewed on 09/30/2024 and she admitted she was jokingly placed the pillow over Resident #2's face and was sincerely sorry for the misjudgment. The DON I stated CNA H was immediately suspended, and Resident #2 and peer residents were assessed for safety with no one evidencing injury or reports of abuse, neglect, and or exploitation. During an interview on 12/31/2024 at 3:49 PM Resident #2's representative stated Resident #2 was well cared for at the facility and was satisfied with her safety and treatment. During an interview on 01/02/2025 at 11:50 AM Resident #3's representative stated she was satisfied with Resident #3's care to include diabetes management and dignified and respectful care. Record reviews of the facility's investigations revealed peer residents were reviewed for safety with and documented with questionnaires which revealed no evidence of alleged ANE and all the staff received an in-service for ANE prevention and reporting allegations of ANE. A record review of the facility's Abuse, Neglect, and Exploitation Policy, dated April 2024, revealed, PURPOSE: To establish a uniform policy and procedures for reporting and responding to abuse, neglect, exploitation (ANE), and misappropriation of resident property. POLICY: It is the policy of (the facility) to provide protection for the health, welfare and rights of each resident residing in its facilities. The following procedures have been developed with the intent to prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The procedures will include at a minimum the following elements: screening, training, prevention, identification, investigation, protection, and reporting/response. An evaluation of the facilities ANE policy will be conducted through the facility's Quality Assurance and Performance Improvement Committee (QAPI) as appropriate.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interviews and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 1 of 13 residents (Resident #1) reviewed for diabetic medical interventions. The facility failed to ensure Resident #1 had supporting orders for his diagnosis of diabetes mellitus upon admission to the facility from the hospital on 05/29/2024 and led to Resident #1 not being assessed for daily blood sugar levels for the months of June 2024, August 2024, and September 2024, resulting on 10/18/2024, a hemoglobin A1C (HbA1c, a blood test that shows what your average blood sugar level was over the past two to three months) lab level of 9.9% (A1c normal level below 5.7; diabetes level = 6.5 or higher) and a finger stick blood sugar assessments of 300 at 06:00 AM and 453 at 06:00 PM (A healthy (normal) fasting blood glucose level for someone without diabetes is 70 to 99 mg/dL (3.9 to 5.5 mmol/L). Values between 50 and 70 mg/dL (2.8 to 3.9 mmol/L) for people without diabetes can be normal). The noncompliance was identified as PNC. The IJ began on 05/29/2024 and ended on 10/18/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for harm by complications of high blood sugar levels. The findings included: A record review of Resident #1' admission record dated 01/03/2025, revealed an admitted [DATE] with diagnoses which included diabetes mellitus type II (the body's resistance to utilizing blood sugar and leading to high levels of blood sugar with disease complications), and congestive heart failure (A heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath, and swelling). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 had received insulin injections during the last 7 day look back period, 7 = record the number of days that insulin injections were received during the last 7 days A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was an [AGE] year-old male admitted for long term care, assessed with a BIMS score of 00 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #1's care plan dated 06/14/2024 revealed a focus for diabetes, (Resident #1) will be free from any s/sx of hyperglycemia through the review date. Date Initiated: 01/26/2024 . For BS< 70 and unable to consume nutrition orally give glucagon. Position resident on side to prevent aspiration. Staff to remain with resident at all times. Repeat BG in 15 min if the resident is able and willing to consume nutrition, repeat finger stick BG and re-treat every 15 minutes until BG > 70 or without symptoms. Date Initiated: 05/03/2024. Give diabetic meds as ordered and report any adverse reactions to md. Date Initiated: 01/26/2024. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #1's May 2024 physicians' orders revealed the physician had prescribed for Resident #1 to be monitored for blood sugar levels, For BG <70 and unable to consume nutrition orally: *give glucagon *position resident on side to prevent aspiration STAFF TO REMAIN WITH RESIDENT AT ALL TIMES Repeat BG in 15 sic(minute)s, if the resident is able and willing to consume nutrition, repeat finger stick BG, and re-treat every 15 minutes until BG >70 mg/dL without symptoms every 15 minutes as needed for Hypoglycemia and unable to swallow If the resident is not able or willing to consume nutrition within 15 minutes, give another dose of glucagon, and call for emergency help, i.e., 911. For Blood Glucose < 70mg/dL and is able to take orally. Give 15 Grams Carbohydrates of either from the following: *1/2 cup fruit juice or regular soda * 1TBSP honey, sugar, syrup, or jelly * 4-5 Saltine Crackers REMAIN WITH RESIDENT AT ALL TIMES REPEAT BG AND RE-TREAT EVERY 15 MINUTES UNTIL BG > 70 AND WITHOUT SYMPTOMS every 15 minutes as needed for hypoglycemia BG < 70 mg/DL and able to swallow fluids If more than 1 hour until next meal/snack, give 15 grams of carbohydrates with ~5 grams protein: e.g., 1/2 sandwich with 1 TBSP peanut/nut butter*, 3 graham crackers with 1 TBSP peanut/nut butter * A record review of Resident #1's May 2024 physicians' orders revealed the physician had prescribed for Resident #1 to receive insulin injections and oral medications daily, (insulin lispro brand name) Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 2U; 201 - 250 = 4U; 251 - 300 = 6U; 301 - 350 = 8U; 351 - 400 = 10U Call MD if Blood Sugar is >400, subcutaneously two times a day for Diabetes Mellitus related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Call MD if greater than 400. (Brand name linagliptin) Oral Tablet 5 MG (Linagliptin) Give 1 tablet by mouth one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS A record review of Resident #1's June 2024 physicians' order summary dated 01/01/2025 revealed Resident #1 diagnoses of diabetes with no orders for insulin lispro, no orders for monitoring blood sugar levels, no orders for oral linagliptin for diabetes interventions. A record review of Resident #1's nursing progress notes revealed on 05/22/2024 LVN C Documented Resident #1 was sent out to another hospital due to swelling complications, Resident returned from hospital via stretcher accompanied by EMT's and (Resident #1's Representative). Resident abdomen noted to be distended and edema noted to BLE. Resident also noted to have non-productive cough. DON notified (hospital) representative of residents' arrival and condition and suggested resident to be sent out to (name of hospital) Hospital for eval and treat. Report called to Nurse (RN Name) RN. Resident transported via (name of ambulance) ambulance service on stretcher accompanied by EMT's and (Resident #1's Representative). A record review of Resident #1's nursing progress notes revealed on 05/29/2024 LVN C documented, Resident arrived from (Name of hospital) Hospital approximately 2140 (09:40 PM) via (name of ambulance) ambulance on a stretcher accompanied by (Resident #1's Representative) and two EMT's. Resident was admitted to hospital for fluid volume overload. Resident transferred to bed. Breath sounds even and unlabored with productive cough. No c/o pain or discomfort. Skin assessment entered. Consents signed by daughter. VS are BP 113/65, T 97.8, P 66, rr 17, o2 96% on RA. On call notified of residents' arrival. Bed in lowest position, call light in reach. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/31/2024 at 11:50 AM LVN D stated she was the charge nurse for sage home and had been employed at the facility for the past 4 years. LVN D stated she was the nurse for Resident #1 and had been his nurse for the 6:00 AM to 2:00 PM shift during May 2024 to now (December 2024). LVN D stated Resident #1 was diagnosed with diabetes and was prescribed anti-diabetic medications with daily finger blood sugar checks in May 2024, specifically sliding scale insulin lispro. LVN D stated when Resident #1 came back from the hospital and was admitted he did not have diabetic orders nor interventions. LVN D stated she believed Resident #1 was not prescribed diabetic interventions due to post hospitalization changes. LVN D stated she was not aware of Resident #1's diabetic orders and interventions until October 2024. LVN D stated Resident #1's blood sugar levels were high and were addressed with accuchecks and oral medications. During an interview on 12/31/2024 at 12:40 PM the Administrator stated DON A was the DON in May and June 2024. The Administrator stated the current DON B was the DON. The Administrator stated Resident #1 was admitted to the facility from the hospital at the end of May 2024 and in October 2024 DON B received a complaint from Resident #1's Veteran's Social Worker and the NP. The Administrator stated she and DON B began an investigation and DON B reported the incident to the state agency. The Administrator stated she was disappointed that DON A had not reviewed Resident #1's admission records to reveal no evidence for interventions and or supports for Resident #1's diagnosis of diabetes. During an interview on 01/01/2025 at 12:30 PM LVN C stated she was the nurse on duty when Resident #1 return from the hospital on 05/29/2024 and she was the nurse who reviewed Resident #1's hospital discharge orders for medications and treatments. LVN C stated she had called the on-call physician and given a report on Resident #1 and received orders to continue hospital discharge medications and treatments. LVN C stated she had not given the on-call physician a report of Resident #1's May 2024, diagnosis of diabetes with medications and monitoring, which included twice a day blood sugar monitoring with finger sticks, sliding scale insulin injections, and an oral linagliptin, a diabetes control medication. LVN C stated she had not reconciled, reviewed, and compared the previous orders for diabetes and the current hospital discharge orders for the diagnosis of diabetes and stated, I report to the on-call physician the discharge hospital orders . we are strict about following hospital discharge orders. LVN C stated she had not communicated to the MD, The NP, DON A, nor the ADON, that she had not reconciled, reviewed, and compared the previous orders for diabetes and the current hospital discharge orders for the diagnosis of diabetes. During an interview on at the previous DON, DON A, stated he was the DON at the facility during May 2024 through July 2024 and he and the interdisciplinary team, which included the Administrator and the ADON, daily reviewed the 24-hour report and new admissions for safety. DON A stated he could not recall the morning meetings from June 2024 but did state the tools utilized to review residents for safety would include a review of the 24-hr. report, nursing, notes, and previous orders and current orders. DON A stated the person responsible to ensure Resident safety with reconciliation of physician orders was the ADON. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/01/2025 at 10:30 AM NP stated he was the NP for Resident #1, and he was aware Resident #1 was a diabetic with twice a day blood-sugar checks, sliding scale insulin injections and oral anti-diabetic medications. NP stated he had not received a report from the nursing staff that Resident #1 had not received daily finger stick to assess for blood sugar levels, had not received daily sliding scale insulin injections, nor received the daily oral anti-diabetic medication for 4 months. NP stated he had ordered blood labs to reveal blood sugar levels that were within acceptable levels for an [AGE] year-old male who had just returned from the hospital recovering from an on-going clostridium difficile infection complicated by chronic heart failure disease. NP stated he believed the interventions for Resident #1's underlying diabetes were effective as evidenced by the blood glucose labs he had ordered and thus had not ordered any further interventions until he followed up with an HbA1c blood lab in October 2024 which revealed a high blood sugar level of 9.9%. NP stated he then intervened with oral anti-diabetic medications, laboratory tests, and daily blood sugar finger sticks which resulted in a managed blood sugar level. During an interview on 12/31/2024 at 12:10 PM, the Medical Director stated he was aware Resident #1 was treated at the hospital in May 2024 for complications of a clostridium difficile infection complicated by CHF. The MD stated he was not aware Resident #1 was admitted from the hospital in May 2024 without interventions for his diabetes and, at a minimum, should have been assessed daily for blood sugar levels. The medical director stated the risk to Resident #1 would have been complications of hyperglycemia (high levels of sugar in the blood). The MD stated clinically it was understandable for Resident #1 to not have high blood sugar levels during the episodes where he was recovering from the clostridium difficile infection, not eating, due to nausea, vomiting, and diarrhea. The MD stated Resident #1 responded to the infection treatments, recovered, and began eating again and thus contributed to the gradual increase in blood sugar levels without monitoring. During an interview on at the administrator stated Resident #1 was being seen and cared for by the MD and the NP and were focused on the serious infection of clostridium difficile and Resident #1 was assessed for blood sugar levels which were within normal limits. The administrator stated the NP and the MD did intervene with further interventions to manage Resident #1's diabetes and blood sugar levels when in October 2024 the resulted A1c lab revealed a high result. The administrator stated the facility provided care for Resident #1, Resident #1 had recovered from the infection, and the facility continued to provide quality care for Resident #1. A record review of the facility's Abuse, Neglect and Exploitation Policy dated April 2024, revealed, PURPOSE: To establish a uniform policy and procedures for reporting and responding to abuse, neglect, exploitation (ANE), and misappropriation of resident property. It is the policy of (The Facility) to provide protection for the health, welfare and rights of each resident residing in its facilities. The following procedures have been developed with the intent to prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The procedures will include at a minimum the following elements: screening, training, prevention, identification, investigation, protection, and reporting/response. An evaluation of the facilities ANE policy will be conducted through the facility's Quality Assurance and Performance Improvement Committee (QAPI) as appropriate. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/02/2025 at 6:46 PM LVN D stated she works 7:00 AM - 3:00 PM shift and would reconcile orders to include new orders from the hospital compared to all previous discharge orders and sbar the doctor to include all diagnoses and their interventions and make recommendations to the doctor. During an interview on 12/31/2024 at 3:49 PM Resident #2's representative stated Resident #2 was well cared for at the facility and was satisfied with her safety and treatment. During an interview on 01/02/2025 at 11:50 AM Resident #3's representative stated she was satisfied with Resident #3's care to include diabetes management and dignified and respectful care. A record review of the facility's Audit of Diabetic Residents dated 10/24/2024, revealed 10 of 10 residents with diagnoses of diabetes were reviewed for safety to include diabetic medications and interventions. The noncompliance was identified as PNC. The IJ began on 05/29/2024 and ended on 10/18/2024. The facility had corrected the noncompliance before the survey began.