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	03/17/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in resident condition for 1 of 3 residents (Resident #1) reviewed for physician notification of changes in condition. The facility failed to notify Resident #1's physician when his blood sugar levels were out of physician ordered parameters on 3/07/2025, 3/10/2025, 3/13/2025 and 3/14/2025. This deficient practice could affect residents with a change of condition and result in not receiving adequate and timely intervention and a decline in condition. The findings included: Record review of Resident #1 face sheet dated 3/14/2025 revealed an [AGE] year-old male admitted on [DATE] with diagnoses which included: type 2 diabetes mellitus without complications, nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it) [NAME] acute on chronic diastolic congestive heart failure (the heart's main pumping chamber becomes stiff and unable to fill properly). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated a severe cognitive impairment and required substantial and/or total dependence for ADL care. The assessment indicated the resident used insulin injections daily. Record review of Resident #1's Care Plan for diabetes mellitus initiated on 3/13/2025 revealed the resident had diabetes with hypoglycemic episodes (incidents of low blood glucose) with interventions which included fasting serum blood sugar as ordered by a physician. Record review of Resident #1's Order Summary Report for March 2025 revealed an order with a start date of 3/07/2025 for accuchecks before meals and at bedtime related to diabetes mellitus .notify MD/NP for blood glucose less than 100 or greater than 350. Record review of Resident #1's blood glucose readings for March 2025 revealed: -3/07/2025 at 8:15 p.m. - 96 mg/dl documented by LVN C (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/10/2025 at 4:38 p.m. - 87 mg/dl documented by LVN B -3/13/2025 at 10:35 a.m. - 93 mg/dl documented by LVN A -3/14/2025 at 11:51 a.m. - 75 mg/dl documented by LVN A Record review of Resident #1's medical record revealed no documentation of notification of physician on 3/07/2025, 3/10/2025, 3/13/2025 or 3/14/2025 for blood glucose readings less than physician ordered parameters of 100 or below. During an observation of two binders at the nurses' station on 3/14/2025 at 11:12 a.m. revealed a collection of laminated facility information on a single ring hanging on a hook. A review of the information contained revealed no guidelines, policies or protocols were included for blood glucose monitoring. A review of a three-ring binder located in a cabinet below the desk labeled agency revealed no information regarding blood glucose monitoring. During an observation and interview on 3/14/2025 at 11:43 p.m., LVN A completed a finger stick blood glucose reading of Resident #1, which resulted in a result of 75 mg/dl. LVN A spoke to Resident #1 and asked how he was feeling. Resident #1 stated he felt fine (limited interview due to baseline cognitive status). During the observation Resident #1 was awake and alert. He was able to interact appropriately with LVN A and he did not have any signs or symptoms of hypoglycemia that were noticeable. His hands were steady, and he was not shaking or jittery and there were no indications of sweating. LVN A told Resident #1 that he needed to eat and that she was going to take him to lunch. LVN A wheeled Resident #1 in his wheelchair to the dining room where he was served a glass of juice while waiting on his meal. Following the interaction LVN A continued on with other tasks unrelated to Resident #1. During an interview on 3/14/2025 at 3:02 p.m., LVN A stated she did not notify Resident #1's physician today (3/14/2025) or on 3/13/2025 following blood sugar readings less than 100. She stated she did not completely read the parameters on the order for notification. She stated she only saw the upper level of 350 for notification. She stated she was trained to immediately act on a blood sugar of less than 60. She stated for low blood glucose she would provide some juice or other form of sugar. She stated although Resident #1's blood sugar was 75 it was not critical low, and lunch was about to be served which would elevate his blood sugar. LVN A stated she assessed the resident to determine if he was symptomatic . She stated she looks for clammy skin, lethargy, sweating and kind of being out of it. She stated Resident #1 had none of those symptoms. She stated she was an agency nurse and had not received any in-service training on low blood sugars or change of condition from the facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025 at 3:25 p.m., LVN B stated she did not notify Resident #1's physician when his blood sugar was less than 100 on 3/10/2025. She stated a normal range for blood glucose levels was 70-110. She stated she did not notify the physician because the resident was getting ready to eat and his blood sugar was in the normal range. She stated she was an agency nurse and the other staff had told her the facility policy was to notify for under 60. She said, it was not really a policy, it was just what they did. She stated she did not see the addition to the blood glucose monitoring order that would have indicated a notification of the physician for a blood glucose less than 100. She stated she was trained to open the orders fully in PCC . She stated in order to view the parameters she would have to click on it to see the full order. She stated that was difficult to do with every patient. She stated she relied on the nurse's report to notify her if there were any changes to an order. She stated she had not received specific training from the facility but there was a binder called Agency cheat sheets with instructions. She stated she had not read the entire binder and it was meant as more of a guideline. During an interview on 3/14/2025 at 4:07 p.m., LVN C stated she did not notify Resident #1's physician when his blood glucose ready was less than 100 on 3/07/2025. She stated she did not see a note to notify the physician. She stated a normal blood glucose was 70-100. She stated they do not typically notify the physician until they drop below 70. She stated she could not recall where or not the order had brackets that indicated parameters to notify the doctor at the time. LVN C stated to her knowledge Resident #1 tended to drop his blood sugars rapidly, but his reading was nothing that alarmed her. She stated he did not have any symptoms of low blood sugar and was alert and oriented at baseline. She stated he was completely asymptomatic. During an interview on 3/14/2025 at 4:53 p.m., the ADON stated previous to 3/07/2025 they did not have parameters for notification of the physician on Resident #1's blood glucose monitoring because the nurses would notify the NP or MD based on nursing judgement. She stated they changed that because they noticed a trend of elevated blood glucose for Resident #1 who had a history of hypoglycemia (low blood glucose). The ADON stated in February 2025 Resident #1 had an infection and had been to the hospital quite a bit and had developed liable blood sugars since his return from the hospital. She stated the parameters were a way to ensure Resident #1 was not overlooked so they added parameters for physician notification. The ADON stated for a diabetic, blood sugars should be between 90-100. If they are a frail diabetic, they like to see them over 100. She stated for someone who is not diabetic a normal reading would be 70-90's. The ADON stated the nurses should follow the physician order and notify the physician for blood glucose levels outside of parameters. She stated the nurses should then follow up with the physician recommendations and carry out any recommended treatment. During an interview on 3/17/2025 at 9:23 a.m., the DON and Administrator stated the did not have a protocol or policy in place for diabetics or blood glucose monitoring. She stated on 3/12/2025 they started working on a protocol, but it was not completed and not all staff had been trained. She stated they treat agency staff as regular staff for training to ensure all are included. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/17/2025 at 12: 55 p.m., the Staffing Educator stated agency staff are held to the same standards as agency staff. She stated if they have an in-service training, agency staff were included. She stated she did not have any in-service training for blood glucose monitoring or change of condition that she was able to locate within the last year. She stated she was new to the facility as of December 2024 and there might have been something before, she came but was not certain. She stated she provided training on diabetic protocol to all staff but had not discussed training agency staff with her supervisor, the DON. She stated she would have to look for a copy of the diabetic protocol to see if she could find it. Nothing was provided to surveyor before exit. During an interview on 3/17/2025 at 2:18 p.m., the DON stated staff should normally notify the physician for a blood glucose less than 60 or 70. She stated Resident #1's provider wanted the notification higher because of his underlying morbidity (sickness or unhealthy state, disease process). The DON stated her expectations was for the staff to follow physician orders for notification because not every resident had the same parameters. She stated it was important so the resident could be treated with he right interventions. Record review of a facility policy, titled Change in Resident's Condition Policy dated May 2024 revealed: I. Purpose: Frontline caregivers play a crucial role in supporting best care practices for their residents, and when a change of condition is notified or communicated early, there is a heightened risk for decline. If a change of condition is detected, staff will notify the attending physician .5. The nurse supervisor/charge nurse will notify the resident's attending physician . when there has been c. there is a significant change in the resident's physical, mental, or psychosocial status.

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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** 38511 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan was individualized specifically for to meet the resdient's needs for the diagnosis of diabetes mellitus based on physician order. This deficient practice could place residents at risk for not receiving proper care and services due to incomplete care plans. The findings included: Record review of Resident #1 face sheet dated 3/14/2025 revealed an [AGE] year-old male admitted on [DATE] with diagnoses which included: type 2 diabetes mellitus without complications, nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it)and acute on chronic diastolic congestive heart failure(the heart's main pumping chamber becomes stiff and unable to fill properly). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated a severe cognitive impairment and required substantial and/or total dependence for ADL care. The assessment indicated the resident used insulin injections daily. Record review of Resident #1's Order Summary Report for March 2025 revealed: -3/07/2025 for accuchecks before meals and at bedtime related to diabetes mellitus .notify MD/NP for blood glucose less than 100 or greater than 350. -03/07/2025 accuchecks (blood glucose) at 2:00 am to monitor for low blood sugar levels, one time a day, notify MD/NP for blood glucose less than 100 or greater than 350. -3/07/2025 Insulin Lispo 100 units/ml inject per sliding scale 151-200 (give) 3 units, 201-250 (give) 5 units, 251-300 (give) 7 units, 301-350 (give) 9 units, 351-400 (give) 11 units subcutaneously before meals and at bedtime related to diabetes mellitus without complications, notify MD/NP for blood glucose less than 100 or greater than 350. -2/27/2025 glipizide oral tablet by mouth 3 times a day for diabetes -12/12/2025 Januvia oral tablet 100 mg, give one tablet by mouth one time a day related to type 2 diabetes mellitus without complications (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/11/2025 glucagon emergency injection kit 1 mg, inject 1 mg intramuscularly as needed for low blood sugar for blood glucose less than 70 mg/dl and patient has no IV access and unresponsive or unable to take oral substance . Record review of Resident #1's Care Plan for diabetes mellitus initiated on 3/13/2025 revealed the resident had diabetes with hypoglycemic episodes (incidents of low blood glucose) with interventions which included fasting serum blood sugar as ordered by a physician and diabetes medication as ordered by doctor. Januvia, glipizide, Lispro, monitor/document for side effects and effectiveness. The care plan did not included physician ordered parameters for notification of blood glucose levels or what steps to take for the resident if the levels were outside of parameters or what symptoms to monitor for low blood sugar). During an interview on 3/17/2025 at 1:06 p.m., the MDS Coordinator stated Resident #1 went to the hospital on 2/11/2025 and was readmitted on [DATE]. She stated on 3/17/2025 his care plan was redone. She stated the MDS Coordinator was responsible for revision of care plans. She stated she learned about changes during morning clinical meetings. After reviewing Resident #1's care plan for diabetes, she stated fasting blood glucose meant accuchecks, not fasting lab glucose readings. She stated she does not put specifics to the resident's care or specifics related to diabetes because those things are listed in his physician orders. She stated she does not include frequency of blood glucose monitoring or notification of physician related to blood glucose because those are also in his physician orders. She stated if staff needed to review how to care for Resident #1, they should review his physician orders. She stated the goal for his diabetes care plan was for Resident #1 to have no complications related to diabetes. She stated again, the nurses should review the physician orders for specifics. The MDS Coordinator stated she had been completing MDS assessments and care plans for the last three years. She stated she was trained by attending classes throughout the year and was taught by another MDS Coordinator. She stated she did not typically put care that was listed in physician orders in the care plan. During an interview on 3/17/2025 at 2:18 p.m., the DON stated accuracy and frequency of blood glucose, monitoring of symptoms, and 100% documentation, especially refusals of care should be documented in the care plan. The DON stated to her knowledge Resident #1 did not have refusals of care. The DON stated it was important to have accurate documentation of the resident's care plan to ensure treatment of the resident with the right interventions. Record review of a facility policy, titled Care Plans-Comprehensive dated May 2024 revealed: An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental and psychological will be developed for each resident. 5. Care Plans are revised as changes in the resident's condition dictate.

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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** 38511 Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for accuracy of records, in that: 1. The facility failed to ensure Resident #1's 2:00 a.m. blood glucose readings were documented in his medical record on 2/24/2025, 2/27/2025, 3/02/2025, 3/03/2025, 3/04/2025 and 3/07/2025. 2. The facility failed to ensure Resident #1's hospital stay from 2/11/2025-2/17/2025 were uploaded into his medical record. These failures could put residents at risk of resident medical records containing incomplete and/orinaccurate information affecting care. The findings included: 1. Record review of Resident #1 face sheet dated 3/14/2025 revealed an [AGE] year-old male admitted on [DATE] with diagnoses which included: type 2 diabetes mellitus without complications, nontraumatic subarachnoid hemorrhage and acute on chronic diastolic congestive heart failure. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated a severe cognitive impairment and required substantial and/or total dependence for ADL care. The assessment indicated the resident used insulin injections daily. Record review of Resident #1's Order Summary Report for March 2025 revealed: -03/07/2025 accuchecks (blood glucose) at 2:00 am to monitor for low blood sugar levels, one time a day, notify MD/NP for blood glucose less than 100 or greater than 350. Record review of Resident #1's medical record including progress notes, MARs and vital signs documentation revealed blood glucose readings were documented in the MAR as completed, however the actual blood glucose levels were not recorded in the medical record as follows: -2/24/2025 missing documentation by LVN D -2/27/2025 missing documentation by LVN F -3/02/2025 missing documentation by LVN H -3/03/2025 missing documentation by LVN D -3/04/2025 missing documentation by LVN J -3/07/2025 missing documentation by LVN J (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025 at 4:18 p.m., LVN F stated she did obtain a 2:00 a.m. blood glucose for Resident #1 on 2/27/2025. She stated normally there was a place to document in PCC, but she could not locate a place to document. She stated she wrote in pink pen on the 24-hour nurses notes the result instead of documenting in the medical record. She stated Resident #1's blood glucose reading was in the 100's overnight and he had no symptoms of low blood sugar. LVN F stated she was an agency nurse. Attempted interview on 3/14/2025 at 4:30 p.m. with agency LVN H. Left a voicemail and sent a text message which read delivered. During an interview on 3/14/2025 at 4:42 p.m. RN J stated he was regular staff at the facility and had started approximately 10 days ago. He stated he did obtain a blood glucose reading during the night on Resident #1 on 3/04/2025 and 3/07/2025. He stated there was no place to add a value of the reading so he did not document the results in the chart. He stated the blood sugar was normal. He stated if it had been out of the ordinary, he would have followed the parameters, notified the physician and documented in Resident #1's progress notes. During an interview on 3/14/2025 at 4:53 p.m., the ADON stated an insurance auditor brought to her attention on 3/07/2025 that Resident #1's 2:00 a.m. blood glucose monitoring was not accurately documented in his medical record on 3/07/2025. She stated the blood glucoses were monitored as indicated by the nurses' initials in the electronic medical record. She stated there just was no place to record the results in the MAR. She stated, at that time she added supplemental documentation to the original order so there was a space for blood sugars input on the MARs. The ADON stated the facility had a triple check system for all new orders. She stated the nurse puts in the order and she (ADON) checks for accuracy. She stated the third check was performed by either the MDS Coordinator or DON. She stated it was a team effort with the IDT team. The ADON stated she (ADON) actively reviews MARS/TARS to ensure staff were documenting monitoring and reviews 24-hour notes. The ADON stated the documentation was overlooked during the checks. During an interview on 3/17/2025 at 10:44 a.m., LVN D stated she was an agency nurse. She stated Resident #1 had orders to check his blood sugar at 2:00 a.m. She stated every time she had checked his blood sugar had been within normal limits. She stated he never had any symptoms of either hyper or hypoglycemia (high or low blood glucose levels). She stated if she documented the reading it would have been in the 24-hour nurses notes, or a progress notes. She stated her answer was not specific because she was not looking at her computer during the interview. She stated she did take the blood sugar; she just was not sure if or where it was recorded. She stated she had worked as agency off and on for 4 years with the facility. She stated she could not remember if she had any training on blood glucose monitoring or documentation. She stated as a nurse, it would be typical for her to record the blood glucose number. She stated it would be important to document in order to see trends. Second attempted interview with agency LVN H on 3/17/2025 at 10:35 a.m. A voicemail was left, and a text was sent requesting a return call. The text message read delivered. No return call was received. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/17/2025 at 2:18 p.m., the DON stated her expectation was for staff entering blood glucose orders to click on the supplemental order when the order was originally entered. She stated if that supplemental order was missing, alternatively the nurses should still record the blood glucose results somewhere in the medical record such as progress notes. She stated it was important to document the results for accuracy. The DON stated the facility did not have a policy for diabetes, diabetic monitoring, or blood glucose monitoring. 2. Record review of Resident #1's February 2025 MAR revealed staff had documented the resident was hospitalized between 2/11/2025-2/17/2025. Record review of Resident #1's medical record on reviewed on 3/14/2025 revealed the resident's hospital records upon re-admission were not uploaded into the electronic medical record for review. During an interview on 3/14/2025 at 2:25 p.m., the Administrative Services Manager stated she oversees Medical Records. She stated Resident #1's hospital records from February were not uploaded into his medical record. She stated after reviewing Resident #1's uploads she was not able to find the file which should be labeled hospital transfer. She stated the medical records clerk was not available for interview. The Administrative Services Manager stated she did audits of medical records. She stated Resident #1's transferring hospital would send records to Admissions. Stated Admissions will upload the medical records. She stated alternatively the resident could have been transferred to the facility with the documents. She stated they would then upload them into the computer. She stated the timeframe for upload was dependent on the physician. She stated the physicians wanted the medical records available at the nurse's station to review. She stated after the physician had an opportunity to review, medical records would take them and usually upload them within a couple of days. The Administrative Services Manager stated timely upload of medical records into the computer was important for communication and continuity of care. During an interview on 3/17/2025 at 2:18 p.m., the DON stated her expectation was for medical records to be uploaded into the resident's medical records within 24-48 hours after they receive them. She stated they had been located and were now uploaded for review (after surveyor intervention). She stated the facility waited for a provider signature and then the documents were uploaded. She stated the Administrative Services Manager was responsible for ensuring it happened. She stated it was important so have the medical records available for review as needed for resident care. Record review of a facility policy, titled Maintenance of Electronic Medical Records (undated) revealed: This facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice. II. a. A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident while maintaining the confidentiality of the residents' information.