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	08/08/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a care plan to meet the resident's needs for 1 of 3 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan accurately documented the resident's need for supervision when actively eating/drinking. These failures could place residents at risk of their needs not being met. The findings include: Record review of Resident #1 's face sheet, dated 8/6/25, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and discharged to hospital on 7/12/25. Resident #1 had diagnoses which included: heart failure, acute respiratory failure, prostate cancer, pacemaker, Bell's Palsy (dripping of the face), dementia (decline in mental ability), anxiety (a feeling of unease), lack of coordination, and dysphasia (difficulties swallowing). The RP was listed as: family member. Record review of Resident#1's quarterly MDS, dated [DATE], reflected a BIMS score of 03, indicative of severe impairment in cognition. The ADLs for eating was documented as independent and support was set-up. Record review of Resident# 1's Care Plan, dated 2/17/25, reflected the goals and interventions included: Eating as Set up assistance. Record review of Resident#1's Physician' Orders, dated July 2025 reflected: Diet was listed as controlled carb diet; soft and bite texture, Nectar/Mildly Tick consistency. The physician order, revised 11/12/24, reflected the resident required standard swallowing precautions: and Supervision and assistance with positioning and set up of meal tray every shift. Record review of Resident #1's SP evaluation, dated 1/16/24, authored by the SP, read: .Oral Phase=Mild. [mildly impaired to chew and managing food in month]. Record review of Resident #1's SP evaluation, dated 2/19/25, authored by the SP, read: .Supervision for Oral Intake=Distant Supervision. During an interview on 8/6/25 at 10:11 AM, the SP stated: she saw the resident several times and the resident had difficulties with swallowing. The SP evaluation on 01/16/24 reflected a mild oral dysphasia to effectively manage food in his mouth. The SP stated the last evaluation on swallowing was done on 2/19/25 and the findings demonstrated the resident [#1] had mild oral and pharyngeal (second stage of swallowing) and no overt signs of aspiration. The SP stated the resident required close supervision in feeding; distant supervision. The SP defined distant supervision as a staff member being present or within eyesight when feeding or drinking occurred by the resident. The SP stated based on the SP findings after 2/19/25, a staff should not lose eyesight of the resident when the activity of eating or drinking occurred. During an interview on 8/6/25 at 3:44 PM, the Dietician stated: the resident was on a diabetic diet (controlled carbs), soft bite texture, and nectar mildly thicken. The Dietician stated the resident required supervision for eating. The Dietician stated supervision meant the staff had to be in proximity when Resident #1 ate for safety reasons. During an interview on 8/6/25 at 5:10 PM, the DON stated: the process of accurate clinical documentation started with assessments and then completion of the care plan. The DON stated the SP assessment, dated 2/19/25, that Resident#1 required distant supervision and the physician order stated the resident required supervision when eating and drinking. The DON stated she could not give an explanation why the care plan did not mention anything about supervision when the resident was actively eating of drinking liquids.During an interview on 8/7/25 at 11:44 AM, the DON stated she was aware of the SP assessment done on 2/19/25 and the recommendation for supervision of Resident #1 when he actively ate or drank liquid. The DON stated the care plan for Resident #1 did not list any instructions on supervision when the resident actively ate or drank liquids. The DON stated the information was necessary to convey to nursing staff special instructions which involved Resident #1. During a telephone interview on 8/7/25 at 11:48 AM, the MD stated she was aware of the SP recommendation for Resident #1 to be supervised when actively eating and consuming liquids. The MD stated she agreed with the recommendation and when her company took over the medical management of residents, Resident #1's order reflected the resident be supervised when actively eating or drinking. During an interview on 8/7/25 at 4:38 PM, the MDS Nurse stated: the process of documentation was for the facility to conduct assessments, the assessment information was captured in the MDS and then reflected in the care plan. The MDS Nurse stated the clinical record task did not properly capture the SP recommendation on 2/19/25 and the MD order on 11/12/2024; and she had no further explanation. The MDS Nurse stated the data had to be accurate for continuity of care and to avoid any clinical errors. Record review of the facility's Documentation Policy dated January 2025, read: .General Principles.All entries must be factual, accurate, complete, current, and legible. Record review of the facility's, undated, Feeding the Resident procedure read: Resident Care Plan List the type of diet as part of appropriate plan of care If resident is unable to feed

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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 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** Based on interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, that were complete; and accurately documented for 1 of 3 residents (Resident #1) reviewed for documentation. The facility failed to ensure Resident #1's nurse progress notes accurately documented when the resident's vitals were taken. These failures could place residents at risk of their records not accurately documenting interventions, monitoring, and information provided to the interdisciplinary team. The findings include: Record review of Resident #1 's face sheet, dated 8/6/25, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and discharged to hospital on 7/12/25. Resident #1 had diagnoses which included: heart failure, acute respiratory failure, prostate cancer, pacemaker, Bell's Palsy (dripping of the face), dementia (decline in mental ability), anxiety (a feeling of unease), lack of coordination, and dysphasia (difficulties swallowing). The RP was listed as: family member. Record review of Resident #1's Nurse Note, dated 7/12/25 at 9:50 AM, authored by LVN A, reflected the resident went out on pass with family. Record review of Resident #1's Nurse Note, dated 7/12/25 at 12:17 PM, authored by LVN A, reflected the resident returned to the facility at 12:15 PM. Record review of Resident #1's Nurse Note, dated 7/12/25 at 10:31 AM, authored by LVN A, reflected vitals were taken at 10:31 AM and some vital readings listed were: temperature 97.7 Fahrenheit and blood pressure 99/62. Record review of Resident #1's Nurse Note, dated 7/12/25 at 10:36 AM, by LVN A reflected she did a skin check of the resident. The resident's skin was described as Warm & dry.During a telephone interview on 8/7/25 at 3:41 PM, LVN A stated she assessed the resident on 7/12/25 in the morning around 8:00 AM. LVN A stated I made a mistake by entering the notes when the resident was not in the facility. LVN A stated she should have entered the notes at time of occurrence or made a comment of a late entry note. LVN A stated she was in a hurry in writing her nurse notes, on 7/12/25, and made a mistake in listing the resident as continent when the resident had always been incontinent. LVN A stated she was in a hurry and listed the wrong time for the vitals on the 7/12/25 nurse note. LVN A stated the vitals were taken before the resident went out on a family visit on 7/12/25 at 10:00 AM. The LVN A stated accurate documentation informed the interdisciplinary team of services and care given to a resident. During an interview on 8/7/25 at 3:47 PM, the DON stated her expectation was nursing documentation occurred at the time of occurrence or sometime shortly after. The DON stated the nurse [LVN A] could have made a late entry or in the nurse note stated the information written referred to a different time and date. The DON stated she could not explain the inaccurate medical record which involved LVN A and the nurse documentation on 7/12/25 in reference to Resident #1. During an interview on 8/8/25 at 10:08 AM, the Administrator stated: the LVN [A] should have entered her notes as a late entry on 7/12/25. The Administrator stated not labeling the nurse notes as late entry might have caused a confusion to the reader as to when the assessment was done. The Administrator stated the clinical record for any resident had to reflect the current condition of the resident. The Administrator stated, the clinical had to capture the right information. The Administrator stated the information may have been inaccurately documented in the clinical record which involved Resident#1. Regarding the documentation vitals were documented at 10:32 AM for Resident #1 on 7/12/25 when the resident was not in the facility, the Administrator offered the following explanation: not usual for vitals to be done at an earlier time and placed in the formal record at a different time. Record review of the facility's Documentation Policy dated January 2025, read: .General Principles.All entries must be factual, accurate, complete, current, and legible.