

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER Bluebonnet Rehab at Ennis		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 South Oak Grove Rd Ennis, TX 75119	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free from accident hazards and the residents received adequate supervision and assistance to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents. The facility failed to provide Resident #1 with adequate supervision and assistance on 07/10/25 when CNA A began to transfer Resident #1 when using a mechanical lift (specialized device designed to safely transfer individuals with limited mobility). CNA A was conducting a mechanical lift transfer without the required two (2) staff members and stopped the transfer to call for assistance from another staff member while CNA A left Resident #1 suspended in the air in the mechanical lift sling. This failure could place all residents who require mechanical lift assistance at risk for serious injury and accidents. Findings include: Record review of Resident #1's admission record, dated 6/23/25, indicated she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), osteoarthritis - (a degenerative joint disease that causes the cartilage and bone in a joint to break down over time), and diabetes (a group of diseases that result in too much sugar in the blood). Review of Resident #1's MDS reflected Resident #1 had a BIM's score of 00 which indicated Resident #1 was severely cognitively impaired and had functional limitation impairment on both of her lower extremities in range of motion. It also reflected Resident #1 was dependent for transfer from chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). (- helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.) Record review of Resident #1's comprehensive care plan, dated 1/27/25, indicated she was a high risk for falls and had no safety awareness. Goal: Resident #1 would not sustain serious injury through the review date. Interventions included: Hoyer (mechanical lift) for transfers. Record review of Resident #1's comprehensive care plan, dated 1/27/25, indicated she had an ADL self-care performance deficit r/t dementia and muscle weakness. Goal: Resident #1 would demonstrate the appropriate use of adaptive device(s) to increase ability in bed mobility, transfers, eating, dressing, toilet use and personal hygiene, through the review date. Interventions included: TRANSFER: The resident requires 2 staff participation with transfers and HOYER lift- family aware and educated on need for 2 staff Hoyer for transfers and periodically do not use Hoyer lift when they transfer her. Record review of photo provided by FM reflected Resident #1 was in the mechanical lift's sling suspended in the air and left unattended and CNA A was present in the doorway. In an observation on 07/29/25 at 11:20 AM, Resident #1 was observed in her room lying in bed. Resident #1 was pleasantly confused, and she did not respond to questions. Resident #1 appeared to be clean and was dressed appropriate for the weather. Resident #1 showed no signs of pain or distress and only mumbled a few unintelligible words. In an interview on 07/29/2025 at 8:11 AM, the FM stated Resident #1 was left suspended in the air in the sling of the mechanical lift by the CNA for 31-32 seconds and there was no injury during the transfer. She stated resident had had some bumps, cuts, and bruises with some of the other transfers. She stated she was not aware of any other transfers being done with only one staff member present. In an interview on 07/29/25 at 10:57 AM, CNA A stated he had worked in the facility for about a year, and he usually worked the 8-5 shift, but he also filled in on other shifts when they needed him. He stated he had been in-serviced on abuse and neglect, transfers/mechanical lift transfers, and falls/fall prevention. He stated when he transferred a resident with the mechanical lift, there must be 2 staff members present the entire time from start to finish. He stated if there were not 2 staff member present during the mechanical lift transfer, it could have caused a resident to fall or get hurt. He stated the lift could have tilted or anything could have happened. He stated he was not aware of any falls from the mechanical lift. He stated he knew he should not ever leave a resident hanging suspended in air in the sling of the mechanical lift while he went to go look for help or to do anything else. He stated if a resident were left suspended in the air in the sling of the mechanical lift and staff walked away, it could have caused the resident to fall, or the lift could have tilted. In an interview on 07/29/25 at 11:10 AM Interview with staff CNA B, she stated she had worked in the facility for about 5 years, and she worked the 2-10 shift and extra shifts at times. She stated she had been in-serviced regularly on abuse and neglect</p>		