STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675150	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Rehab at Ennis	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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observations, interviews, and record review, the facility failed to complete a significant change MDS assessment within 14 days after a significant change of condition for 1 of 6 (Resident #3) residents reviewed for comprehensive assessments. The facility did not complete a significant change MDS for Resident #3 after she was admitted to hospice services. This failure could place residents at risk of not having their individual needs met when a significant change in condition occurs. Findings included: Review of Resident #3's comprehensive MDS, dated [DATE], reflected an [AGE] year-old female originally admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (memory loss), anxiety (a feeling of fear, tension, or worry), depression (persistent feelings of sadness), hypothyroidism (when the thyroid gland does not produce enough thyroid hormone), and diabetes mellitus (increased blood sugar levels). Resident #3 had a BIMS score of 00, indicating severe cognitive impairment. Review of Resident #3's care plan revealed she was admitted to hospice services for diagnoses of senile degeneration of the brain (progressive deterioration of brain tissue and function that occurs beyond what is considered normal aging) on 2/6/25. Review of Resident #3's clinical physician's order dated 02/06/2025 revealed she was admitted to hospice services due to a diagnosis of senile degeneration of the brain (progressive deterioration of brain tissue and function that occurs beyond what is considered normal aging). Review of Resident #3's MDS assessments in the EHR revealed no significant change assessment was conducted after Resident #3 was admitted to hospice services. In an observation on 2/25/2025 at 9:20am Resident #3 was sitting in her wheelchair in her room watching television. She had what appeared to be a baby fidget blanket in her lap and she was moving some of the flaps with her fingers. She appeared clean and well kept. An interview was attempted but Resident #3 was unable to hold a conversation with the state surveyor. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/26/2025 at 11:58 AM with the MDSC who has worked at the facility for almost 7 years, she stated that she had just completed Resident #3's annual MDS assessment on 12/28/24 and she probably forgot to do the significant change assessment after the physician's order on 2/6/25. She stated that hospice was considered a significant change. When a resident had a significant change, she was to speak with the resident, family, and hospice about their goals. She physically assesses residents to see what has changed, she will ask about the diagnoses, and why the decision to obtain hospice services was made. She said she was trained by the reimbursement specialist on doing MDS assessments accurately. She stated that if a significant change MDS was not done it could impede payments given to the facility, as well as impeding care that the resident was to receive that she could not see. In an interview on 02/26/2025 at 12:16 PM with the DON who has worked at the facility for 5 years, she stated that the MDS coordinator was responsible for completing a significant change MDS after discussion with the IDT, the family, and hospice. She stated that hospice was considered a significant change, and that the MDSC was trained in accurately conducting MDS assessments. She stated that her responsibilities (regarding MDS) as the DON, included reviewing records, ensuring DNR's were completed, and that she just assumed that the significant change assessment gets completed. She stated that negative impacts could be that goals could potentially not get done on the care plan and that problems in the MDS would trigger different things on the care plan. Review of the facility's Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy policy undated reflected, The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. According to CMS 's RAI Version 3.0 Manual; the MDS is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and outside agencies. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status. Review of the RAI dated October 2024 reflected, If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA). For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date must be no later than 14 days from the ARD and no later than 14 days from the determination date of the significant change in status or the significant error, respectively. A significant change is a major decline or improvement in a resident's status that: (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on interviews and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 (Resident #31) of 6 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #31's significant change MDS accurately reflected his hospice status. This failure could place residents at risk of not having their individual needs met when a significant change in condition occurs. Findings included: Review of Resident #31's closed record significant change MDS dated [DATE] revealed he was a [AGE] year-old male who initially admitted to the facility on [DATE] with a re-admitted [DATE]. His diagnoses included: cancer, malnutrition, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), adult failure to thrive, lack of coordination, and acute pain due to trauma. His BIMS was 03, which indicated severe cognitive impairment. In Section O - Special Treatments, Procedures, and Programs, K1. Hospice Care was not checked, rather, Z1. None of the Above had been checked indicating resident had no special treatments, procedures, or programs. Review of Resident #31's care plan revealed he was admitted to hospice services for diagnoses of malignant neoplasm of the left kidney, except renal pelvis (a disease in which kidney cells grow out of control, not affecting the pelvis) on 10/25/2024. Review of Resident #31's clinical physician's order dated 10/25/2024 revealed he was admitted to hospice services due to malignant neoplasm of the left kidney, except renal pelvis (a disease in which kidney cells grow out of control, not affecting the pelvis). In an interview on 02/26/2025 at 1:32 PM with the MDSC who has worked at the facility for almost 7 years, she stated that hospice should have been checked in Section O in Resident #31's significant change MDS. She said she was trained by the reimbursement specialist on doing the MDS assessments accurately. She stated that if a significant change MDS was not done accurately it could impede payments given to the facility, as well as impeding care that the resident was to receive that she could not see. In an interview on 02/26/2025 at 12:16 PM with the DON who has worked at the facility for 5 years, she stated that the MDS coordinator was responsible for completing a significant change MDS after discussion with the IDT, the family, and hospice. She stated that the MDSC was trained in accurately conducting MDS assessments. She stated that her responsibilities (regarding MDS) as the DON, included reviewing records and ensuring DNR's were completed. Review of facility's Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy policy undated reflected, (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. According to CMS's RAI Version 3.0 Manual; the MDS is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and outside agencies. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: 2. The assessment accurately reflects the resident's status. Review of the RAI dated October 2024 reflected, An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. o If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the admission assessment, checking the Hospice Care item, O0110K1.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49410 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for dietary services. 1. The facility failed to ensure that the dry storage items were free from expired foods. 2. The facility failed to ensure kitchen staff followed proper hand hygiene during meal preparations. 3. The facility failed to ensure that the puree blender was cleaned between menu items. These failures could place residents at risk for food contamination and foodborne illness. Findings included: An observation was made on [DATE] at 10:49 AM in the kitchen. The observation in the kitchen's dry storage area revealed expired food. Sysco Imperial thickened orange juice from concentrate had a date labeled and expiration of [DATE]. An observation was made of 4 boxes of thickened dairy drink that did not have an expiration date on them. An observation was made on [DATE] at 11:15AM in the kitchen for the process of hand washing. During this observation Ck #1 had turned the sink water on, scrubbed their hands with soap, grabbed a paper towel to turn off the sink, and used the same dirty paper towel to dry their hands. An observation was made on [DATE] at 11:23AM in the kitchen for the process of puree. During this observation Ck #1 pureed vegetables in the puree blender. Ck #1 completed the puree of the vegetables and placed the lid in the compartment sink. Ck #1 then grabbed the lid and placed it back onto the puree blender and continued to blend the vegetables. Ck #1 did not wash the lid before placing it back onto the blender. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was made on [DATE] at 11:33AM with the DM who stated they have been employed at the facility for 1 year. The DM stated that the policy for the puree process was to make sure the blender was clean, put the food in the blender, put beef or chicken broth to give them some flavor, and wash between menu item use. The DM stated a negative impact this could cause for the residents was cross contamination. The DM stated that trainings have not been provided on this specific topic. The DM stated that the policy for handwashing was that staff were to wash their hands anytime they were messing with the food and sanitizing the dishes when using them. The DM described the hand washing process as staff should turn the sink on, wet their hands, rub soap up to the forearm, scrub for a little bit and let the soap sink in, wash their hands off, grab a paper towel, dry their hands, and turn the sink off. The DM stated a negative impact this could have on residents was possibly food borne illnesses. The DM stated that training has been provided for this topic. The DM stated that the expectation for expired food was to throw it away if it was expired. The DM stated that food items should be dated and labeled. The DM stated a negative impact expired food could have on residents were they could get sick. An interview was made on [DATE] at 11:40AM with Ck #1 who stated they have been employed at the facility for 3 years. Ck #1 stated that they had received training on handwashing and sanitizing a couple of months ago. Ck #1 explained the puree process as washing the used dish after every food item. Ck #1 stated you do not want to put meat with vegetables. Ck #1 stated a negative impact that could have on a resident was having food built up on the processor. Ck #1 stated that they had reused the lid after pureeing the item because they believed the water was still on. During this interview Ck #1 identified the handwashing process as turn the water on, use soap, rinse up to elbows, use a napkin to dry your hands, turn off the water with the napkin, and throw the napkin in the trash. Ck #1 stated a negative impact this could have on resident if not followed properly was getting the resident's sick. Ck #1 stated they did not remember doing that. Ck #1 stated the expectation for receiving food items was to date and label the food items. Ck #1 stated that the food should be thrown away if it was expired. An interview was conducted on [DATE] at 11:44 AM with the ADM of the facility. The ADM stated they have been working at the facility since [DATE]. The ADM stated that the expectation for cleaning and sanitizing dishes was to clean the dishes after every meal service to utilize the dishwasher. The ADM stated the expectation was to clean and sanitize the dish item if it was put in the sink and wash it before using it again. The ADM stated a negative impact it could have on a resident would be the dish could have residual food, contamination, and potentially bacteria. The ADM stated the expectation for hand washing was staff should wash their hands, follow the handwashing guidelines after they touch food, touch trays, and they should be consistently washing their hands in the kitchen. The ADM identifies the steps to washing hands as using warm water, scrub your hands with soap, use a paper towel to turn faucet off, and grab a different clean paper towel to dry their hands. The ADM stated a negative impact this could have on a resident was it could cause contamination, food borne illnesses, and potentially allergens. The ADM stated that training for handwashing and dish sanitizing was completed by the dietary manager for the team below them. The ADM stated to refer to the policy for the facility's policy on handwashing and sanitizing. The ADM stated the expectation for expired food was to remove the item from the shelf, fridge, or freezer, and discard the food item. The ADM stated a negative impact this could cause for residents was passing bacteria and possible different food borne allergens. The ADM stated to refer to the policy for the policy on expired food. Record Review of policy Food Preparation and Services dated [DATE] revealed the following information: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices including: 1. Appropriate measures are used to prevent cross contamination. These include: a. Cleaning and sanitizing work surface and food-contact equipment between uses, following food code guidelines. 2. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Record Review of policy Food Receiving and Storage dated [DATE] revealed the following information. 1. Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). Such foods will be rotated using a first in first out system. 2. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). 3. Opened containers and beverages must be dated when opened and have a use by date. Record Review of policy Sanitation dated [DATE] revealed the following information. 1. All equipment, food contact surfaces, and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. 2. Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observations, interviews, and record review, the facility failed to follow their own established smoking policy for 5 (Residents #4, #27, #35, #48, and #50) of 8 residents reviewed for smoking. 1. The facility failed to ensure that Residents #4, #48, and #50 did not keep their personal cigarette lighters in their rooms per facility policy. 2. The facility failed to ensure that Resident #35 only used his e-cigarettes inside the designated smoking areas. 3. The facility failed to address where e-cigarettes should be stored, how to handle the devices, batteries, and refill cartridges. This failure could place residents at risk of an unsafe smoking environment and injury. Findings included: Review of the facility's Smoking Residents updated 02/21/2025, provided by the facility, identified Resident #4, #27, #35, #48, and #50 as smokers. Review of Resident #4's quarterly MDS assessment dated [DATE] revealed she was a [AGE] year-old female who initially admitted to the facility on [DATE]. Her diagnoses included: high cholesterol, anxiety, depression, bipolar, schizophrenia, low back pain, and need for assistance with personal care. Her BIMS score was a 14 indicating she was cognitively intact. Review of Resident #4's care plan dated last revised 02/24/2025 revealed she was care planned for being addicted to smoking cigarettes, dipping snuff, and vaping. Interventions included showing resident where designated smoking areas were, and to keep all smoking materials in designated area. Review of Resident #4's safe smoking assessment dated [DATE] revealed the resident was safe to smoke without supervision and was informed of smoking policies/procedures. An interview and observation on 02/24/2025 at 11:06 AM with Resident #4 revealed that she kept her cigarette's and the lighter inside her purse that hung on her wheelchair. She stated that she could go outside whenever she wanted to smoke, if it was too cold, she would just grin and bear it by staying inside and skipping her smoke breaks. She typically smoked about 3 cigarettes a day. She used an oxygen concentrator at night while sleeping. She stated that she has not been told to turn her lighter into the nurse's station but that she would never smoke inside. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #27's annual MDS assessment dated [DATE] revealed he was a [AGE] year-old male who initially admitted to the facility on [DATE]. His diagnoses included: cancer, diabetes mellitus (increased blood sugar levels), anxiety (a feeling of fear, tension, or worry), bipolar, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), alcohol abuse, and high blood pressure. His BIMS score was a 15 indicating he was cognitively intact. Review of Resident #27's care plan dated last revised 2/05/2025 revealed he was addicted to smoking cigarettes, dipping snuff, and recently only used a vape. Interventions included to show resident where designated smoking areas were, keep all smoking materials in designated area at the nurse's station, and to monitor resident when smoking to ensure resident safety. Review of Resident #27's safe smoking assessment dated [DATE] revealed the resident was safe to smoke his vape without supervision and was informed of smoking policies/procedures. In an interview on 02/24/2025 at 11:23AM with Resident #27he stated that he did not smoke cigarettes but did use a vape. He stated that the facility had an alarm that would set off if they smoked inside. Resident #27 stated that he had a heavy coat for the cold weather for outside for smoking. Resident #27 stated that they could go outside and vape whenever they would like to. In an observation on 02/24/2025 at 11:30AM Resident #27 pointed to his vape on his table. He had access to the vape and kept it in his room. Review of Resident #35's quarterly MDS assessment dated [DATE] revealed he was a [AGE] year-old male who admitted to the facility 02/08/2021. His diagnoses included: high blood pressure, multiple sclerosis, anxiety (a feeling of fear, tension, or worry), depression, psychotic disorder, Lyme disease, nicotine dependence, adjustment disorder, and pseudobulbar affect (inappropriate involuntary laughing and crying). His BIMS score was a 15 indicating he was cognitively intact. Review of Resident #35's care plan dated last revised 2/04/2025 revealed he was addicted to smoking tobacco in the form of cigarettes, pipe, or cigars; as well as using nicotine pouches/chewing tobacco, vaping, and has a history & recently smoked marijuana/cannabis. He has a history of keeping a cigar cutter and scissors at bedside and has been found smoking inside his room. He also periodically uses chewing tobacco/smokeless tobacco and a vape. He was noncompliant with keeping smoking products and materials at nurses' desk and periodically return smoking items to nursing desk. An occurrence on 4/15/24 where resident insisted on growing Marijuana in smoking area. The ADM removed it each time it was found which made the resident angry and caused behaviors. Interventions included to show Resident #35 where designated smoking areas were. Keep all the smoking materials in designated area. The resident was instructed to stop acquiring marijuana buds, seeds etc. for planting in the facility. The resident was instructed to stop planting marijuana in facility pots. Instructed it was a hazard to his health and against the law to have with each episode of finding his plants growing, Smoking assessment to be completed monthly. Review of Resident #35's safe smoking assessment dated [DATE] revealed the resident was safe to smoke without supervision and was informed of smoking policies/procedures. (continued on next page)

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/24/2025 at 2:38PM Resident #35 stated that they did not smoke cigarettes, but they did use a vape. Resident #35 stated that the facility staff did not allow the residents to smoke inside the facility. Resident #35 stated that if it was cold, they would put on a jacket, and smoke outside if they wanted to. He stated they were allowed to smoke whenever they would like to. In an observation on 02/24/2025 at 12:05PM Resident #48 pulled a pack of cigarettes out of her jacket pocket and inside the cigarette container were cigarettes and a lighter. Resident #48 had access to the cigarettes and lighter and kept it in her room. Review of Resident #48's annual MDS assessment dated [DATE] revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included: low blood sodium levels, anxiety, psychotic disorder, cataracts, and cachexia (a condition which causes significant weight loss and muscle loss). Her BIMS score was a 13 which indicated she was cognitively intact. Review of Resident #48's care plan dated last revised 01/02/2025 revealed she was addicted to smoking cigarettes and drinking alcohol. She was periodically non-compliant with returning smoking supplies to the nurse's desk. Smoking safety assessment shows the resident was safe to smoke unsupervised. Interventions included to explain and show the resident where designated smoking areas were. Keep all smoking materials in designated area. Smoking assessment to be completed monthly. Review of Resident #48's safe smoking assessment dated [DATE] revealed the resident was safe to smoke without supervision and was informed of smoking policies/procedures. In an observation on 02/24/2025 at 02:40PM, in Resident #35's bedroom, Resident #35 pointed to a vape that was on his bedside table. Resident #35 had access to the vape and kept it in his room. In an interview on 02/24/2025 at 11:58AM with Resident #48 she stated that she kept her lighter and cigarettes in her smoking jacket. She stated she did not smoke inside the facility. She stated that she smoked outside and if it was cold, she would use a jacket to smoke outside. Resident #48 stated they were able to smoke whenever they would like to. Review of Resident #50's MDS assessment dated [DATE] revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included: thyroid disorder, non-Alzheimer's dementia, high blood pressure, seizure disorder, bipolar, prediabetes, repeated falls, lack of coordination, and muscle weakness. His BIMS score was an 11, indicating moderate cognitive impairment. Review of Resident #50's care plan dated last revised 01/28/2025 revealed he was addicted to smoking a pipe. Interventions included showing the resident where designated smoking areas were, keep all smoking materials in designated area at the nurse's station, and to monitor resident when smoking to ensure resident safety. Review of Resident #50's safe smoking assessment dated [DATE] revealed resident was safe to smoke his pipe without supervision and was informed of smoking policies/procedures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675150	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Rehab at Ennis	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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/24/2025 at 2:09 PM with Resident #50 he stated he smoked cigars and a pipe. He stated the facility frequently assessed and educated him on smoking safety and smoking safety around oxygen. He stated he had a brown suitcase or got other cases that he kept his tobacco products and spare pipes in. He kept the box with him or in his room. He further stated, I keep my lighter (Zippo) and my butane (disposable lighter) in my pocket or if I go to sleep, I place them on the table next to me. He stated that the facility has not tried to collect the lighter and butane but if they try someone is going to get hurt. The Zippo lighter used liquid lighter fuel which he stated that he keeps with him also. He stated, my butane was sealed by the factory, only fuel I keep is Zippo lighter fuel to refill the cotton type material in the Zippo lighter. An observation on 02/24/2025 at 11:42 AM revealed there were 2 residents (Resident #48 and #50) in the outside middle courtyard smoking. Resident #48 lit her own cigarette and was sitting in her wheelchair smoking it. Resident #50 lit his tobacco pipe and was sitting in his wheelchair smoking it. No staff were present. An observation on 02/24/2025 at 12:16 PM revealed Resident #35 pulled an e-cigarette out of his sock and smoked it while waiting on his lunch tray in the facility dining room. In an interview on 02/25/2025 at 10:37 AM with CNA A she stated that she was not sure if residents could keep smoking materials in their rooms. She stated that residents could go out to smoke when they wanted, and that staff followed behind them with the lighter. She stated that Resident #35 stayed in trouble and that using e-cigarettes were not allowed inside the building. In an interview on 02/25/2025 at 10:45 AM the CRN stated that the staff working at the nurse's station will use a binder to mark residents out when going to smoke, and mark them back in when they come in. She stated that residents know to look for her when she was here so that they could turn their smoking materials back into the nurse's station. She said that staff was supposed to follow the residents outside with a lighter to light the cigarettes. When she looked in the smoking box for Resident #4's cigarette's and lighter she could not locate them. In an interview on 02/26/2025 at 11:02 AM, the ADM stated his expectation was that lighters were to be kept at the nurse's station and not in any resident's possession, but that residents could keep their cigarettes in their rooms. He stated that all residents get evaluated monthly using a safe smoking evaluation and all residents deemed safe to smoke without supervision may smoke without staff present in the designated smoking area. Review of the facility policy titled Smoking Policy- Residents last revised July 2017 reflected the following: The facility shall establish and maintain safe resident smoking practices. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Electronic cigarettes may be permitted inside designated areas only. 12. No resident is allowed to keep combustible smoking materials (lighter, matches, etc.) in their possession at any time.