STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675306	A. Building B. Wing	06/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Nursing and Rehabilitation	696 Fm 99 Karnes City, TX 78118

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interview, and record review, the facility failed to ensure the environment was free of accident hazards and supervision of staff for 1 of 7 residents (Resident #1) reviewed for accidents and hazards, in that: The facility failed to ensure Resident #1 had a low bed (bed positioned near the floor) as ordered on 04/16/2024 and instead had a regular bed in the lowest position. Resident #1 fell from the bed in the higher position and onto the mat beside her bed and she sustained a C2 vertebral fracture. An IJ was identified on 05/31/2024. The IJ template was provided to the facility on [DATE] at 4:00 PM. While the IJ was removed on 06/01/2024 the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm because all staff had not been trained on low bed orders and compliance. This deficient practice could affect residents and place them at risk for accidents resulting in fractures, disability, or death. The findings included: Record review of Resident #1's electronic face sheet, dated 05/30/2024, reflected she was admitted to the facility on [DATE] with diagnoses which included: dementia (condition characterized by a loss of cognitive functioning, the ability to think, remember, or reason), schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), mood disorder (feeling sad or anxious affects emotions), muscle wasting (deterioration or thinning of muscle mass), difficulty in walking (unsteady or abnormal gait), not elsewhere classified, lack of coordination (disruption in communication between the areas of the brain that control balance, movement and coordination), atrophy (progressive and degenerative shrinkage of muscles and nerve tissues), and aphasia (comprehension and communication disorder). (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's quarterly MDS assessment with an ARD of 05/07/2024 reflected she was understood and usually understands, and the resident had scored a 04/15 on her BIMS, which signified she was severely cognitively impaired. Further review revealed the resident had functional limitations in range of motion to her lower extremity (hip, knee, ankle, foot) and used a wheelchair for mobility, the resident required extensive assistance with her ADLs, and the resident had falls since her admission/entry or reentry or the prior assessment which noted 1 fall with no injury. Record review of Resident #1's Emergency Documentation record dated 05/29/2024 reflected Assessment/Plan, Type II fracture of dens (projection of the 2nd cervical neck bone), discharge. Resident #1 was sent to a level 3 trauma center and Transition of Care report dated 05/29/2024 reflected C2 dens (Cervical or neck bone odontoid process break at second vertebrae level) (can cause pain, tingling, numbness or weakness in arms or legs) fracture after unwitnessed fall. Record review of Resident #1's comprehensive person-centered care plan revised 01/16/2024 reflected Focus, at risk for falls r/t, impaired vision, cognitive deficit and muscle weakness, Interventions, floor mat while in bed, the bed in low position at night. Record review of Resident #1's Fall Risk assessment dated [DATE] reflected a score of 14.0 which signified high risk. Record review of Resident #1's Event Nurses Note-Fall dated 05/29/2024 reflected unwitnessed, hit head, discovered on floor, Interventions in place prior to this fall on 05/29/2024, floor mat and low bed, interventions in response to this fall, floor mat and low bed. Record review of Resident #1's physician orders Active as of: 05/30/2024 reflected May have low bed, Phone, Active, 04/16/2024. Record review of Resident #1's Kardex dated 05/30/2024 (information given to CNAs for care of resident) did not reflect low bed with mat. Observation on 05/30/2024 at 10:45 AM of Resident #1 revealed she was lying in bed with a neck collar on. She had a low bed with a mat on the floor. Observation on 05/30/2024 at 11:30 AM of Resident #1 revealed she was sitting on the side of her low bed with no neck collar on. The neck collar was lying on the bed beside her. During an interview on 05/30/2024 at 3:05 PM CNA A, stated Resident #1 was not in a low bed at the time of the resident's unwitnessed fall on 05/29/2024 because she worked that day. CNA A stated she tried to give the resident breakfast the next day and the resident complained of her neck hurting. The resident was sent to the hospital. She stated she switched Resident #1's bed to a low bed on 05/29/2024 at the direction of the DON when Resident #1 returned from the hospital. She stated the low bed may have had influence. She stated Resident #1 may not have fallen out; she would have just crawled onto the mat. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/30/2024 at 03:26 PM with LVN C, stated Resident #1 had an unwitnessed fall on the night of 05/29/2024. LVN C stated she was doing neurological checks (evaluates brain and nervous system functioning), and Resident #1's neurological responses were within normal limits. LVN C stated when Resident #1 moved from lying to sitting, she had pain in her neck. LVN C notified the DON, ADON and the physician, and the resident was sent to the hospital. LVN C stated Resident #1 had a normal bed, not one that could be put in a low position. LVN C stated if Resident #1 was ordered a low bed, she should have had a low bed. During an interview on 05/30/2024 at 3:40 PM the DON, stated Resident #1's bed was a normal bed in the lowest position. The DON stated Resident #1 was never ordered a low bed and the order seen was not an active order. The DON stated she switched Resident #1's bed to a low bed when the resident returned from the hospital because the resident could no longer get out of bed by herself. During an interview on 05/31/2024 at 09:03 a.m. with MD B, he stated the order for the low bed on 04/16/2024 was an active order and he wanted Resident #1 to have a low bed, closest to the floor. MD B stated he was told by staff the resident was unsteady and had falls. MD B clarified that a normal bed in the lowest position was not what he ordered for the resident. He stated if Resident #1 had been on a low bed, she may not have fractured her neck. During an interview on 06/01/2024 at 2:05 p.m. with the RN C she stated fall preventive measures were important. RN C stated it was important to distinguish between a bed in a low position or a low bed because of the issue of falls and what the elderly required. During an interview on 06/01/2024 at 02:09 PM with the DON she stated fall preventive measures are implemented to keep residents safe, and they needed to be accurate and reflected in the Kardex. During an interview on 06/01/2024 at 02:13 PM with the ADM he stated he was at the facility for one week, and he felt like in-services were required and getting back to the basics with communications, especially for the best interest of resident safety. Record review of the facility policy and procedure titled Preventive Strategies to Reduce Fall Risk revised date October 5, 2016, reflected The goal of fall prevention is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility, 7. Environment: Keep bed in low position., Keep the bed wheels locked., Use mobility handles or 1/4 rails in bed, low bed, scoop mattress, bolsters, or any combination of the previous per physician's order. This failure resulted in an identification of an Immediate Jeopardy on 05/30/2024 at 4:00 PM. The Administrator was informed and provided the IJ template at 4:00 PM, and a Plan of Removal (POR) was requested. The plan of removal was accepted on 05/31/24 at 09:40 PM and reflected: Facility: [Facility Name] Date: 5/31/24 Plan of Removal (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Problem:: F689 Accidents/Hazards Interventions for safe resident environment: - Low bed was initiated on 5/30/24 in response to fall on 5/29/24. - The affected resident's clinical record was reviewed to ensure all fall prevention interventions (previous and newly initiated) are care planned and are located on the Kardex to communicate to nursing staff by DON, Regional Compliance nurse on 5/30/24. - Completed a low bed audit and all residents with orders for a low bed had a low bed in place. Audit was completed on 5/30/24 by Regional Compliance Nurse, Area Director of Operations, and facility Administrator. - The following in-services were initiated by the Regional Compliance nurse and DON on 5/30/2024. Inservices will be completed by 5/31/24. Any staff member not present or in-serviced on 5/30/2024 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during their orientation period. - Licensed Nurses: FT, PRN, Agency 1. Ensure that any physician ordered or care planned fall prevention interventions are followed. 2. CHARGE NURSES-ENSURE PRE AND POST FALL INTERVENTIONS ARE APPROPRIATE TO FALL AND DOCUMENTED CORRECTLY IN EVENT NOTE. ONLY CHECK LOW BED IF RESI IS ON A LOW BED. DOCUMENT BED IN LOWEST POSITION UNDER OTHER. 3. Nurse - Reporting changes of condition to the physician and DON/ADON immediately - Nurse Aids: FT, PRN, Agency 1. How to use the Kardex in PCC and to follow fall prevention interventions - all residents with multiple falls or had an injury from fall in the last 60 days were reviewed to ensure appropriate fall prevention interventions are care planned and are located on the Kardex to communicate to nursing staff on 5/30/24 by Regional Compliance Nurse. - Kardex audit to ensure all safety measures were included completed by ADON on 5/31/24. - The Medical Director [physician's name] was notified of the immediate jeopardy situation on 5/31/2024 at _1621_. - Ad Hoc QAPI meeting will be held on 5/31/24 to discuss the IJ and review plan of removal. Monitoring: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- DON and Administrator will review all falls during the morning meeting starting 5/30/24 to ensure appropriate interventions have been implemented. Monitoring will occur 5 days per week for a minimum of 6 weeks. - DON/designee will Ask 10 nursing staff members per week how to locate fall prevention interventions for a resident x 4 weeks or until compliance is met. Document date/time, the staff member's name if they responded correctly, and any corrective action if needed. - The DON and/or ADON will review Event reports to ensure interventions are documented correctly. - The above will be reviewed during the facility monthly QA meeting for no less than 60 days, or until the Administrator determines substantial compliance has been achieved and maintained. SURVEYOR VALIDATIONS: OBSERVATIONS and RECORD REVIEWS: Reviewed all residents who required a low bed and mat or fall prevention measures: to include Resident #1. List of Residents: Orders, Care Plan review and Kardex - Observed 17 residents ordered low beds, all complied safety measures observed to be in place such as low beds, scoop mattresses or floor mats at bedside, orders, care plans and Kardex noted. Record reviewed residents with other safety measures for falls such as mats on floor at bedside or scoop mattresses. All complied, present in care plans and in Kardex. MONITORING: - Record review of Ask 10 nursing staff per week how to locate fall prevention interventions. Document date/time, the staff members name, if they responded correctly and any corrective actions needed: reflected 5 staff were interviewed and satisfactorily checked off. - Record review of monitoring sheet, started on 5/30/2024, with NA D, CNA A, CNA E and LVN C, all staff were able to locate fall prevention interventions. - Record review of DON and ADON will review Event reports to ensure interventions are documented correctly, reflected review started on checklist dated 05/30/2024 and no events were noted. - Record review of the above will be reviewed during the facility QA meeting for no less than 60 days reflected a QAPI spreadsheet which addressed fall monitoring and preventions. 06/01/2024 at 11:40 a.m. LVN G, day shift worker. Able to show preventive measures in physician orders, care plan and Kardex for Resident #1. 06/01/2024 at 11:45 a.m. CNA E, revealed she was able to demonstrate how to look up a resident Kardex to find the safety information such as a low bed with mat for Resident #2. No issues noted. Knew to go to charge nurse if was unsure of information for resident safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	06/01/2024 at 12:01 PM, Hospitality Aide H able to demonstrate how to look up a resident Kardex to find the safety information such as low bed, scoop mattress and fall mat for Resident #3. Record review of monitoring check sheet reflected the monitoring that follows was initiated on 05/30/2024. The DON and Administrator will continue to review all falls during morning meeting starting 05/30/2024 (done per and ensure appropriate interventions have been implemented). Monitoring will occur for 5 days per week for a minimum of 6 weeks. Record review of calendar and checklist revealed compliance. Record review of notification of IJ revealed the Medical Director was notified by the DON on 5/29/2024 at 4:21 PM. Record review of ADHOC QAPI meeting dated in 05/29/2024 was held with 9 members. Record review of staff (nursing) in-services dated 05/30/2024 reflected a total of 30 nursing staff were in-serviced on fall prevention, orders, care plans and Kardex's for a total of 100% nursing staff. TRAINING RECEIVED BY STAFF: (VALIDATION) VERIFICATION 1. Ensure the physician ordered or care planned fall prevention interventions are followed. 2. Charge nurses-ensure pre and post fall interventions are appropriate to fall and documented correctly in event note. Only check low bed if resident is on a low bed, document bed in lowest position under other. 3. Nurse-Reporting changes of condition to the physician and DON/ADON immediately. Nurse Aides: FT, PRN, Agency (No agency nursing staff at present) 1. How to use the Kardex in PCC and to follow fall prevention interventions. (Observations listed above, Interviews below). INTERVIEWS: STAFF (TOTAL of 30 Nursing Staff Members in facility). DAY SHIFT: 5 EACH plus two PRN 1. 06/01/2024 at 11:40 a.m. Interview with LVN G revealed that physician orders and care plan fall prevention are followed, pre and post fall interventions are appropriate and documented, report any change of condition immediately. To document if the bed is in the lowest position or a low bed. 2. 06/01/2024 at 11:52 AM, Interview with CNA E revealed that physician orders or care plans are followed for fall prevention. Check to make sure pre and post fall interventions are appropriate. Reporting any changes in condition immediately. How to find fall interventions in Kardex. Ask nurse if unsure of fall interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	3. 06/01/2024 at 12:07 PM, Interview with Hospitality Aide H revealed she was trained on how to use the Kardex to find information on fall prevention measures, check bed positions and fall mats, and to report to the nurse immediately any changes in condition. 4. 06/01/2024 at 12:15 PM, Interview with CNA F revealed she was trained on how to use the Kardex in PCC to find information on fall prevention measures for residents, and how to make sure they are in place. If we have a resident with a change in condition to report it to the nurse immediately. 5. 06/01/2024 at 12:19 PM with LVN I revealed she was recently trained on how to follow physician orders for fall prevention, bed in the lowest position. Low bed versus a regular bed. To check to see if interventions are in place. Document if the resident has a low bed or bed in the lowest position. Report any changes in condition immediately. 6. PRN 06/01/2024 at 12:40 PM with Medication Aide J revealed she was recently trained on fall prevention, low beds, how to look up fall prevention interventions in the PCC Kardex, and how to check for having the fall preventions in place. If a resident has a change in condition, she stated she would report it to the nurse immediately. 7. PRN 06/01/2024 at 12:55 PM with LVN K revealed she was recently trained on fall prevention, checking orders, care plans and making sure fall prevention measures are in place. How to document correctly low bed or other and to report and changes in condition immediately. NIGHT SHIFT: 4 EACH and one PRN 1. 06/01/2024 at 1:07 PM with CNA L revealed she was recently trained on fall prevention, checking the Kardex, and if the resident has a change in condition report it to the nurse immediately. Check to make sure resident fall prevention measures are in place. 2. 06/01/2024 at 1:16 PM with LVN M revealed she was recently trained on fall prevention, checking the physician orders, care plan for interventions for residents who are at high risk for falls. To document about low bed or other if a resident has a bed to only be placed in a low position. She stated she needed to check to make sure fall interventions are in place as ordered, and to report any changes in condition immediately. 3. 06/01/2024 at 1:22 PM with PRN NA N revealed she was trained on how to find out what fall preventive measures are in place for residents using the Kardex. To check to make sure the resident fall prevention measures are in place. If any questions go to the nurse. If resident has a change in condition notify the nurse immediately. 4. 06/01/2024 at 1:32 PM with NA O revealed that when a resident falls to notify immediately, and to check the Kardex for what preventive measures are in place. If a resident has a change in condition to report to nurse immediately. 5. 06/01/2024 at 1:35 PM LVN P revealed she was trained on to check physician orders and to check to see what the resident has for fall prevention measures and to make sure they are in place. Document if low bed or other if bed is in the low position. Change in condition we report immediately to the doctor or DON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/01/2024 at 3:00 PM., the Administrator was notified the IJ was removed. However, the facility remained out of compliance at a level of potential harm with a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm because the facility's need to monitor the implementation and effectiveness of their plan of removal.