

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER Bluebonnet Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes or maintains their quality of life for 3 of 3 residents (Resident #2, Resident #4, and Resident #5) reviewed for dignity. 1. The facility failed to ensure Resident #2's was provided privacy during incontinent care. 2. The facility failed to ensure Resident #4's was provided privacy during incontinent care. 3. The facility failed to ensure Resident #5's was provided privacy during incontinent care. These failures could affect residents by contributing to poor self-esteem, and decreased self-worth and quality of life. Findings included: 1. Record review of Resident #2's Admission Record, dated 11/26/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning) , Hypertension (high blood pressure), Cognitive Communication Deficit (difficulty with thinking and language), Aphasia (disorder that affects a person's ability to communicate), and UTI. Record review of Resident #2's quarterly MDS assessment, dated 9/18/24, revealed the resident's cognitive skills for daily decision making was severely impaired. Further review of the document revealed Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's Care Plan, initiated 1/27/23, revealed: .The resident has bladder incontinence .INCONTINENT care at least q2h .The resident has bowel incontinence .Provide pericare after each incontinent episode . Observation of perineal care for Resident #2, on 11/26/24 beginning at 2:18 pm, revealed CNA A and CNA B closed the door but did not draw the privacy curtain completely closed when incontinent care was provided for Resident #2. Resident #2 was in a private room during the observation. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675306	Facility ID: 675306 If continuation sheet Page 1 of 11

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #4's Admission Record, dated 11/27/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning), Cognitive Communication Deficit (difficulty with thinking and language), UTI, and Hemiplegia (paralysis of one side of the body). Record review of Resident #4's quarterly MDS assessment, dated 10/12/24, revealed the resident's BIMS score was 1, suggesting severely impaired cognition. Further review of the document revealed Resident #4 was always incontinent of bladder and occasionally incontinent of bowel. Record review of Resident #4's Care Plan, initiated 4/1/22, revealed: .The resident has bladder incontinence . INCONTINENT care at least q2h .The resident has bowel incontinence .Provide pericare after each incontinent episode . Observation of incontinent care for Resident #4, on 11/26/24 beginning at 1:43 pm, revealed CNA A and CNA B closed the door but did not draw the privacy curtain completely closed when incontinent care was provided for Resident #4. Further observation revealed Resident #4's roommate pulled on the curtain and tried to gain sight of Resident #4 while care was provided. 3. Record review of Resident #5's Admission Record, dated 11/27/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Cognitive Communication Deficit (difficulty with thinking and language), Dementia (group of thinking and social symptoms that interferes with daily functioning), and Muscle Weakness. Record review of Resident #5's quarterly MDS assessment, dated 11/5/24, revealed the resident's BIMS score was 4, suggesting severely impaired cognition. Further review of this document revealed Resident #5 was always incontinent of bladder. Record review of Resident #5's Care Plan, initiated 11/19/24, revealed: .The resident has bladder incontinence . INCONTINENT care at least q2h . Observation of incontinent care for Resident #5, on 11/26/24 beginning at 3:21 pm, revealed CNA B closed the door but did not draw the privacy curtain completely closed when incontinent care was provided for Resident #5. Resident #5 did not have a roommate during the observation. During an interview on 11/26/24 at 2:45 pm, CNA B said she was expected to always protect the residents' privacy. CNA B further stated she was expected to draw the privacy curtains all the way to protect the residents' privacy during resident care if they had a roommate or if someone walked in, they knew care was being provided and the resident's privacy was not affected. CNA B said residents that were able to walk, and talk could be affected if their privacy was not respected. CNA B further stated Resident #5 allowed anybody in her room and Resident #2 would not know if someone came in or out of her room because she only saw what was in front of her. CNA B said Resident #2 would not know if her privacy was being invaded but she always protected the residents' privacy because that was important. During an interview on 11/26/24 at 4:20 pm, CNA A said she was expected to close the privacy curtains all the way when resident care was provided for the residents' privacy. CNA A further stated when the residents' privacy was not respected it might make the residents feel uncomfortable. (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/27/24 at 12:09 pm, LVN C said her expectation was that privacy was provided to the residents when care was provided. LVN C further stated when care was provided the privacy curtains should be drawn all the way and the door and blinds should be closed so the residents felt comfortable, not embarrassed, and trusted staff even if they were in a private room. During an interview on 11/27/24 at 1:19 pm, the DON said her expectation was for the door to be closed and privacy curtains be pulled all the way, even in a private room, when resident care was provided because anyone could walk into the room. The DON further stated when residents' privacy was not respected it could expose the residents to other residents, family members and staff and could affect their dignity. During an interview on 11/27/24 at 1:59 pm, the Administrator said residents should be given privacy when care was provided by pulling the privacy curtain all the way around and closing the door and blinds so that they were not exposed and to provide dignity to the residents during care. Record review of the facility's policy titled Resident Rights, revised 11/28/16, revealed: .Respect and dignity - The resident has a tight to be treated with respect and dignity .The resident has a right to personal privacy .		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infection for 1 of 3 residents (Residents #2) reviewed for incontinent care. While providing incontinent care for Resident #2, CNA B wiped Resident #2 from the anal area to the vaginal area on (5) occasions. This deficient practice could place residents at risk for infection due to improper care practices. Findings included: Record review of Resident #2's Admission Record, dated 11/26/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning), Hypertension (high blood pressure), Cognitive Communication Deficit (difficulty with thinking and language), Aphasia (disorder that affects a person's ability to communicate), and UTI. Record review of Resident #2's quarterly MDS assessment, dated 9/18/24, revealed the resident's cognitive skills for daily decision making was severely impaired. Further review of the document revealed Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's Care Plan, initiated 1/27/23, revealed: .The resident has bladder incontinence .INCONTINENT care at least q2h .The resident has bowel incontinence .Provide pericare after each incontinent episode . Observation of perineal care for Resident #2, on 11/26/24 beginning at 2:18 pm, revealed CNA B wiped Resident #2 from the anal area to the vaginal area twice. Further observation revealed Resident #2 was turned onto her side and CNA B wiped the resident from the anal area to the vaginal area three times and then from the vaginal area to the anal area. During an interview on 11/26/24 at 2:45 pm CNA B said when incontinent care was provided, female residents should be cleaned from front to back, she thought. CNA B said it was important to wipe front to back during incontinent care to avoid cross contamination and prevent bacteria from the back to the front, possibly causing an infection, UTI, or rash. During an interview on 11/27/24 at 12:09 pm, LVN C said, during perineal care for females, she expected the staff to wipe from front to back and change gloves when they went from dirty to clean to avoid cross contamination and an increase in UTIs. LVN C said everyone was responsible for ensuring infection control practices were followed and nurse managers and nurses on the floor oversaw infection control practices, as well as herself and the DON. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/27/24 at 1:19 pm, the DON said LVN C oversaw infection control practices and ensured staff followed infection control policies and procedures. The DON further stated she expected staff not to wipe from back to front when perineal care was provided to females because that can introduce bacteria into the body causing UTIs that may go undetected. The DON said the charge nurses, LVN C, DON, and Administrator were responsible for ensuring infection control practices were followed. During an interview on 11/27/24 at 1:59 pm, LVN C said nursing management were responsible for ensuring infection control practices were followed otherwise they could cause infection control issues amongst the residents and staff. Record review of the facility's policy titled, Infection Control Plan: Overview, updated 03/2024, revealed: .The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39251 Based on observation, interview, and record review the facility failed to ensure, in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 3 medication carts (Treatment Cart #1) reviewed for medication storage. The facility failed to ensure the treatment cart on D hall was locked while unattended. This failure could place residents at risk of medication misuse and drug diversion. Findings included: Observation and interview on 11/25/24 at 11:41 pm revealed Treatment Cart #1 on D hall was observed to be unlocked and unattended with the drawers facing out. LVN D observed the state investigator open the treatment cart draws and said the treatment cart was unlocked and said all carts were supposed to be locked when unattended because there were medications in the cart that residents could access and drink. Further observation revealed there were wound care treatments in the cart, such as, Triad (cream that help maintain a moist healing environment), Ammonium Lactate (cream used to treat dry skin and minor skin irritation), Wound Cleanser and Barrier Ointment. LVN D said there were three residents on the hall that were mobile with their wheelchairs. LVN D further stated ingestion of any medications in Treatment Cart #1 could cause an adverse reaction or poisoning. During an interview on 11/27/24 at 12:09 pm, LVN C said her expectation was that medication and treatment carts were always locked. LVN C said the facility had mobile residents that could possibly access unlocked carts. LVN C further stated it was important for medication and treatment carts to be locked because residents could come in contact with something that could potentially harm them. During an interview on 11/27/24 at 1:19 pm, the DON said her expectation was for medication and treatment cart be locked. The DON said there were residents that were able to move about the facility unassisted. The DON said it was important that carts remained locked to prevent residents or staff from getting into the carts and possibly ingesting something that they should not. During an interview on 11/27/24 at 1:59 pm, the ADO said medication and treatment carts should be locked because there was a potential for them to be accessed by anyone who could possibly ingest the medications. Record review of the facility's policy titled, Storage of Medication dated 2003, revealed: Medications and biologicals are stored safely, securely, and properly following manufacturer=s [sic] recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . Medication rooms, carts, and medication supplies are locked and attended by persons with authorized access .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents (Resident #4 and Resident #5) and 2 of 2 linen carts reviewed for infection control. 1. The facility failed to use proper infection control practices during perineal care for Resident #2. 2. The facility failed to use proper infection control practices during perineal care for Resident #4. 3. The facility failed to use proper infection control practices during perineal care for Resident #5. 4. The facility failed to ensure clean linen was stored properly on the A hall. 5. The facility failed to ensure clean linen was stored properly on the D hall on (2) occasions. These deficient practices could place residents at risk for infection and decline in health. Findings included: 1. Record review of Resident #2's Admission Record, dated 11/26/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning), Hypertension (high blood pressure), Cognitive Communication Deficit (difficulty with thinking and language), Aphasia (disorder that affects a person's ability to communicate), and UTI. Record review of Resident #2's quarterly MDS assessment, dated 9/18/24, revealed the resident's cognitive skills for daily decision making was severely impaired. Further review of the document revealed Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's Care Plan, initiated 1/27/23, revealed: .The resident has bladder incontinence .INCONTINENT care at least q2h .The resident has bowel incontinence .Provide pericare after each incontinent episode . (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of perineal care for Resident #2, on 11/26/24 beginning at 2:18 pm, revealed CNA B washed her hands for 10 seconds prior to providing perineal care. Further observation revealed CNA B wiped Resident #2, removed her gloves, and put on clean gloves, without performing hand hygiene. CNA B left the room to get more gloves, without performing hand hygiene. Further observation revealed CNA B washed her hands for 5 seconds. Resident #2 was turned on her side and wiped the resident and the clean brief fell on the floor. CNA B picked up a pair of clean gloves without removing the contaminated gloves or performing hand hygiene, set the gloves back down, removed her gloves, sanitized her hands, and donned the pair of gloves she previously picked up and set back down. CNA B picked up the brief off the floor and placed it on Resident #2. CNA B removed her gloves, removed a pair of pants from Resident #2's dresser drawer, without performing hand hygiene, then sanitized her hands and donned new gloves. Further observation revealed CNA B disposed of the trash, removed her gloves, and donned clean gloves, without performing hand hygiene. 2. Record review of Resident #4's Admission Record, dated 11/27/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning), Cognitive Communication Deficit (difficulty with thinking and language), UTI, and Hemiplegia (paralysis of one side of the body). Record review of Resident #4's quarterly MDS assessment, dated 10/12/24, revealed the resident's BIMS score was 1, suggesting severely impaired cognition. Further review of the document revealed Resident #4 was always incontinent of bladder and occasionally incontinent of bowel. Record review of Resident #4's Care Plan, initiated 4/1/22, revealed: .The resident has bladder incontinence . INCONTINENT care at least q2h .The resident has bowel incontinence .Provide pericare after each incontinent episode . Observation of incontinent care for Resident #4, on 11/26/24 beginning at 1:43 pm, revealed CNA B washed her hands for 13 seconds prior to providing perineal care. Further observation revealed after CNA B wiped Resident #4's buttocks, she removed her gloves, sanitized her hands for 4 sec without allowing the ABHR to dry and donned clean gloves. 3. Record review of Resident #5's Admission Record, dated 11/27/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Cognitive Communication Deficit (difficulty with thinking and language), Dementia (group of thinking and social symptoms that interferes with daily functioning), and Muscle Weakness. Record review of Resident #5's quarterly MDS assessment, dated 11/5/24, revealed the resident's BIMS score was 4, suggesting severely impaired cognition. Further review of the document revealed Resident #5 was always incontinent of bladder. Record review of Resident #5's Care Plan, initiated 11/19/24, revealed: .The resident has bladder incontinence . INCONTINENT care at least q2h . Observation of incontinent care for Resident #5, on 11/26/24 beginning at 3:21 pm, revealed CNA B washed her hands for 10 seconds prior to assisting with perineal care. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation during tour of facility and interview on 11/25/24 beginning at 11:34 pm, revealed the linen cart on A hall was uncovered. LVN D said the linen carts were supposed to be covered and in the linen closet when not in use. 5. Observation and interview on 11/25/24 beginning at 12:12 am, revealed the linen carton D hall was uncovered. CNA E said the linen carts should always be covered to prevent the residents from getting anything inside, such as, briefs, wipes, sanitizing wipes, or anti-fungal powder. CNA E said the CNAs and nurses were responsible for ensuring the linen carts were covered because linens could become cross contaminated. Further observation at 12:16 am revealed CNA E walked away from the linen cart and left it uncovered. During an interview on 11/26/24 at 2:45 pm CNA B said she thought she should sing Happy Birthday once, approximately one minute or two. CNA B further stated she was expected to perform hand hygiene before and after care was provided. CNA B said when perineal care was provided, gloves should be removed after cleaning the front area hands sanitized, new gloves donned, and then the buttock area was cleaned. CNA B said hands were to be sanitized between glove changes to avoid cross contamination from one area to another and the spread of infections. CNA B said ABHR should be rubbed for one minute and hands held up in the air until the hands dried instead of waving them. CNA B it was important to use ABHR as recommended so that the ABHR did not get on the resident or into their eyes, she said she guessed but did not know. CNA B further stated ABHR should be allowed to dry to be able to put gloves on properly. CNA B said she did not think not using ABHR as recommended could result in negative outcomes for the residents because she wore gloves so they were protected, adding she did not think anything would come out of the gloves. CNA B said when the brief fell on the floor, she should have picked it up, disposed it and washed her hands. CNA B further stated if a brief fell on the floor, she could not place it on the resident, but the brief that fell on the floor was folded and fell on the mat. CNA B said there were no fluids around that could contaminate the brief. CNA B said she had washed her hands, donned new gloves, and did not go far or touch anything before reaching into Resident #2's dresser drawer to retrieve a pair of pants. During an interview on 11/26/24 at 4:20 pm, CNA A said she did not know how long it was recommended to rub her hands when using ABHR. CNA A further stated she had not been told that ABHR should be allowed to dry. CNA A said she could not remember why it was important to use ABHR as recommended. CNA A further stated it was important to use ABHR as recommended to avoid cross contamination. (continued on next page)		

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Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Fundamentals of Infection Control Precautions, updated 03/2024, revealed: .Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . o Before and after assisting a resident with personal care (e.g., oral care, bathing) . After removing gloves . Recommended techniques for washing hands with soap and water include . rubbing hands together vigorously for at least 20 seconds covering all surfaces . Recommended techniques for performing hand hygiene with an ABHR: Include applying product to the palm of one hand and rubbing hands together, covering all surfaces of hands and fingers, until the hands are dry .		