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	06/07/2025

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 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 observation, interview, and record review, the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for accuracy of records. The facility failed to ensure Resident #1's bath or shower was documented as given or as refused 9 times in May and June 2025. These failures could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #1's admission Record (face sheet) dated 06/07/2025 revealed she was admitted to the facility on [DATE] with diagnoses which included Schizoaffective disorder (is a mental health condition that is marked by hallucinations and delusions),anxiety disorder (disorder involving feelings of nervousness, panic and fear) and hypertension (condition in which the force of the blood against the artery walls is too high) . Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 15 out of 15, indication her cognitive skills for daily decision making were intact; and the resident was dependent on staff to be showered or bath Record review of Resident #1's Care Plan for Self-Care performance deficit, initiated on 01/05/2021 and revised on 03/07/2022, revealed under interventions assist with personal hygiene . Record review of Resident #1's undated Kardex revealed the resident preferred to be bathed 2-3 times a week. Record review of Resident #1's nurses' notes from 05/01/2025 to 06/01/2025 revealed no notation of Resident #1 had refused to be bathed. Record review of the undated Shower Schedule revealed Resident #1 was to be bathed on Monday, Wednesday, and Friday on the 6 am - 2 pm shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Record review of Resident #1's electronic clinical record for the Bathing Task from 05/01/2025 to 06/03/2025 revealed Resident #1 had only been bathed 6 times on: 05/02/2025, 05/05/2025, 05/05/2025, 05/07/2025, 05/09/2025, and 05/12/2025; there was no documentation the resident had refused to be bathed; and there was no documentation if Resident #1 was bathed or refused on her scheduled shower days on 05/14/2025, 05/16/2025, 05/19/2025, 05/21/2025, 05/23/2025, 05/26/2025, 05/28/2025, 05/30/2025, and 06/02/2025. Observation on 6/7/2025 from 11:00 AM - 11:05 AM revealed the Regional Compliance Nurse completing a shower for Resident #1 and making beds throughout the facility. Interview on 6/7/2025 at 11:08 AM, the Regional compliance nurse stated that she had spoken with the CNA's who were responsible for bathing Resident #1 on the following dates: 5/19/2025, 5/21/2025, 5/23/2025, 5/26/2025, 5/28/2025, 5/30/2025, and 6/2/2025. Resident #1 was bathed on 5/14/2025 and 5/16/2025 but refused to be bathed on the following dates: 5/19/2025, 5/21/2025, 5/23/2025, 5/26/2025, 5/28/2025, 5/30/2025, and 6/2/2025. The Regional Compliance Nurse indicated that if a resident refused to bathe, the CNA should document this refusal in the Point of Contact Tasks and inform the charge nurse. Interview with Resident #1 on 6/7/2025 at 1:30 PM, revealed she had refused some shower days but could not recall which days. In a subsequent interview on 6/7/2025 at 1:13 PM, the Regional Compliance Nurse reiterated that nursing staff should also document in the nurses' progress notes if a resident had refused to be bathed. She emphasized that if the resident's bathing status was not recorded in their clinical record-indicating whether the resident had been bathed or had refused to be bathed-it would lead to inaccurate documentation. However, she did not foresee any harm to the resident resulting from this issue. Record review of the undated, facility Documentation policy revealed, complete documentation as needed promptly, document or check information on flow sheets each shift or as appropriate for the care or treatment being monitored.