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	08/06/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure that each resident is treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 6 (Resident #3) residents in that: Resident #3 did not get his preference of being cleaned shaven. Resident #3 had a full/thick mustache and thin haired goatee. This failure could place residents at risk of not being provided grooming as needed. The Findings include: Record review of Resident #3's admission Record, dated 8/05/2025, revealed the resident was admitted to the facility on [DATE], with diagnoses of encephalopathy, Alzheimer's disease, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit, malignant neoplasm of brain, seizures and pain. Further review revealed the resident's POA was his family members. Record review of Resident #3's of Quarterly MDS dated [DATE] documented a BIMS score of 7/15 (severe cognitive impairment), he required a wheelchair to mobilize, ADL he required partial moderate assistance for toileting, showers, upper/lower body dressing putting on/taking of footwear, and personal hygiene. Resident #3 was independent with eating and oral hygiene, and his height was 73 inches and weighted 222. Record review of Resident #3's Care Plan dated 7/30/2025 documented he had seizures related to malignancy in brain, encephalopathy, ADL self-care performance included bathing , bed mobility, dressing, toilet use he required 1 person assistance, eating he required supervision, resident use a wheelchair and personal hygiene he required set up and supervision with rinse, and spit and brush tee and bathing check nail length and trim. The care plan did not include shaving and his preference. Observation on 8/5/2025 at 10:57 AM in Resident #3's room with his POA revealed he had a full/thick unkept mustache and a thin goatee, his hair was coarse. Interview on 8/5/2025 at 10:58 AM with Resident #3 and his POA stated he was used to being clean shaven and had a full unkept mustache and a thin goatee. The POA stated his mustache gets long and gets food stuck in his mustache. Interview on 8/5/2025 at 11:09 AM Resident #3 stated he wanted to be clean shaven with no mustache or goatee. Resident #3 stated he preferred his POA to shave him because she used an electric shaver and did not hurt. Resident #3 stated he did not like the staff to shave him because they used disposable single blade. Observation on 8/6/2025 at 11:439 AM he was in dining area, he had a full/thick unkept mustache and a thin goatee, his hair was coarse. Interview on 8/6/2025 at 11:40 AM with Resident #3 he stated he would like to be clean shaven. Interview on 8/6/2025 at 12:35 PM with CNA C stated she had worked at the facility for 6 years and stated Resident #3 liked to shower and he had facial hair that aides shaved while in the shower. Interview with CNA C sated she had to use 2-3 disposable razors for Resident #3's facial hair. Interview on 8/6/2025 at 2:18 PM with PTA D, stated the POA of Resident #3 had complained about his facial hair not fully shaven by the staff in the past. PTA D stated Resident #3 did not like his facial hair to be shaven by the staff because it hurts. PTA D stated Resident #3 had facial dryness and could get stuck on facial hair. Interview on 8/6/2025 at 2:53 PM the MDS Nurse stated she has worked at the facility since 2021 and used to be a certified nurse aide. The MDS Nurse stated she was not aware Resident #3 did not like to have his facial hair shaven by aides. The MDS did not have any further response. Interview on 8/6/2025 at 6:08 PM with CNA E stated she did take Resident #3 to shower yesterday, and he did not want her to shave his face. CNA E stated she tried to quickly shave the side of his face with a disposable single razor. Interview on 8/6/2025 at 3:59 PM with the Administrator and the DON revealed they had no response and stated they were not aware Resident #2 preferred to be clean shaven with no mustache or goatee, and preferred to be shaved with an electric razor instead of with a disposable razor like the staff always used because it hurt his face. Record review of policy, Resident Rights, dated 11/28/2016 was documented, The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. Respect and Dignity-3. the right to reside and receive services in a facility with reasonable accommodation of resident needs and preferences .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 2 of 3 residents (Residents #1 and #2) reviewed for tube feeding management, in that: 1.The facility failed to follow physician's orders for Resident #1 to cleanse g-tube (gastrostomy tube, a small flexible tube surgically inserted through the abdomen to deliver nutrition, fluids and medication directly to the stomach) site with normal saline and apply split sponge every shift. 2.The facility failed to follow physician's orders for Resident #2 to cleanse g-tube site every day shift. These failures could place resident at risk for not receiving appropriate care and treatment and/or a decline in their health. Findings included: 1.Record review of Resident #1's admission Record dated 8/5/25 revealed an [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE]. Diagnoses listing revealed dementia (a group of conditions categorized by impairment of brain function), atherosclerosis (hardening of the arteries), Vitamin B12 Deficiency, anxiety, cerebral infarction (a condition where brain tissues dies due to lac of blood supply) with right sided hemi-paresis, atrial fibrillation (irregular heartbeat), congestive heart failure (chronic condition in which the heart does not pump blood as well as it should), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wears down), schizoaffective disorder (a mental health condition / mood disorder). Record review of Resident #1's BIMS assessment revealed a score of 9 indicating moderate cognitive impairment. Record review of Resident #1's MDS dated [DATE] revealed Resident #1 presented with functional limitations to upper and lower extremities, was dependent in eating, toileting, bathing, dressing, transfers and mobility. Record review of Resident #1's physicians orders revealed an order dated 5/29/24 to Cleanse g-tube site with NS (normal saline), pat dry and apply split sponge Q (every) shift. Record review of Resident #1's Medication Administration Record dated August 2025 revealed nursing staff were signing off on day shift and night shift from 8/1/25-8/4/25 that they provided stoma site care per physician's order. Observation of Resident #1 on 8/5/25 at 10:05 a.m. revealed multiple (6) brown colored dried substances around stoma (surgically created opening) site. No split drain sponge was observed. 2. Record review of Resident #2's admission record dated 8/5/25 revealed a [AGE] year-old female admitted [DATE]. Diagnoses listing revealed [NAME]-[NAME] syndrome (a disorder of the skin and mucous membranes), hypertension (high blood pressure), diabetes type II, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), hyperlipidemia (high cholesterol), and intracerebral hemorrhage (bleeding in the brain) with left sided hemiplegia (paralysis) and dysphagia (difficulty swallowing). Record review of Resident #2's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Further record review of MDS dated [DATE] revealed Resident #2 had limited range of motion to upper and lower extremity, required set-up assistance with eating; maximum assistance in bathing and upper body dressing; and required total assistance in toileting, bed mobility, lower body dressing, transfers and mobility. Record review of Resident #2's physicians orders revealed an order dated 5/15/25 to cleanse g-tube site very day shift. Record review of Resident #2's care plan revealed intervention for tube feeding included clean insertion site daily as ordered. Observation of Resident #2's stoma site revealed multiple (5) brown colored dried substance around the stoma site. During an interview on 8/5/25 at 10:05 am with LVN A regarding stoma site care for Resident #1, LVN A stated that she would normally utilize a drainage sponge, but up until about a week ago, this resident's tube was sewn in and secured to her skin. LVN A stated that resident's order does indicate to clean stoma site daily and apply drain split sponge. LVN A acknowledged that dried substance surrounding stoma site. During an interview on 8/5/25 at 10:05 am with LVN A regarding stoma site care for Resident #2, LVN A stated that we clean her stoma site every shift. LVN A stated she had not provided stoma care yet for this resident today. LVN A acknowledged dried substance surrounding stoma site. During an interview on 8/5/25 at 1:00 pm with LVN C regarding stoma site care for Resident # 1 and Resident #2, LVN C stated she only works 1 day a week, but when she does work, she clean[s] both sites with normal saline and replaces split drain gauze. During an interview on 8/5/25 with Resident #2, Resident #2 stated, they clean it (stoma site) at night. During an interview on 8/6/25 with the DON, the DON stated that she expects nursing staff to follow physicians' orders