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	03/25/2026

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 3 residents (Resident #1) reviewed for care plans: 1. The facility failed to ensure Resident #1's comprehensive care plan included his pain related to gangrene (death of body tissue due to lack of blood flow or serious infection). 2. The facility failed to ensure Resident #1's comprehensive care plan included hospice services. This deficient practice could place residents at risk of receiving improper care and services.The findings included: Record review of Resident #1's admission record, dated 3/25/26, revealed an [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (a group of conditions affecting blood flow and blood vessels in the brain, which can lead to stroke), gangrene, pain unspecified knee (knee pain without a clearly identified cause or specific diagnosis), and osteoarthritis (a degenerative joint disease characterized by the breakdown of cartilage causing pain, stiffness, and decreased mobility). Record review of Resident #1's significant change MDS assessment, dated 2/18/26, revealed Resident #1's cognition was severely impaired for daily decision making. The MDS revealed the resident received PRN pain medication and experienced pain which frequently limited his day-to-day activities. The MDS revealed he received hospice services while a resident. The Care Area Assessment (CAA) Summary revealed under Section V, Care Area Assessments, Care Area #19 (Pain) was triggered; however, the corresponding care planning decision box was not selected, indicating the triggered care area for pain was not care planned. The CAA documentation indicated CAA WS dated 3/5/2026. The form further revealed the CAA process and care planning decision was signed by Corporate Compliance Nurse, on 3/5/2026. Record review of Resident #1's care plan, last revised 3/11/26, did not reflect he had pain related to gangrene, knee pain, osteoarthritis, or received hospice services. Record review of Resident #1's physician orders, dated 3/25/26, revealed an order for:-hydrocodone-acetaminophen oral tablet 10-325 mg, give 1 tablet by mouth every 6 hours for pain related to gangrene, with a start date of 3/9/26, and no end date.-morphine sulfate oral solution 20mg/5mL, give 0.25 mL by mouth every 2 hours as needed for pain/SOB related to gangrene, give 0.25 mL-1mL every 2 hours as needed for pain, with a start date of 2/17/26, and no end date.-Admit to hospice, hospice to pronounce at time of death, with a start date of 2/18/26, and no end date. During an interview on 3/24/26 at 10:40a.m., Resident #1 was lying in bed, and his family member was also in the room with him. Resident #1 had a bandage visible to one hand and stated he had another one on his foot. He stated he had pain because he had gangrene. Resident #1 stated he was unsure if he received his pain medication. The resident's family members stated sometimes nursing staff were not around when his pain medications were due but overall, they were good about getting his pain medications when he had pain. The family member stated hospice had spoken to the facility about making sure he received his pain medications. During an observation and interview on 3/25/26 at 2:10 p.m. the Corporate (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compliance Nurse accessed the resident's care plan in edit view and indicated that the area for potential uncontrolled pain did not have a selectable box, which she stated meant the area had already been triggered, and added to the care plan. She selected intervention boxes and navigated within the care plan, stating she had added interventions under a different section rather than under pain. When shown a previously saved copy of the care plan that did not include pain, she reviewed the most recent version and stated the care plan now reflected a care area for pain with a date initiated of 3/25/26, but reported that was not the correct date as the issue had already been triggered and added to the care plan. She stated she knew this because there was no box available to select next to pain, which indicated it was already included in the care plan. She further stated she assists with care plans at the facility as needed and would have the MDS nurse speak with the surveyor. During an interview on 3/25/26 at 2:20 p.m., the MDS nurse stated when she completed Resident #1's last MDS the area where it asked if the resident had pain was not selected and should have been. The MDS nurse stated if it was selected it would have triggered them to add pain to the resident's care plan. The MDS nurse stated due to the resident's memory issues he would sometimes tell you he was not in pain when he was in pain. The MDS nurse stated pain was not on the care plan and should have been so staff knew how to plan, treat, and monitor the residents for pain. During an interview on 3/25/26 at 2:34 p.m. the DON stated pain should be on Resident #1's care plan because it affected his daily care, activities, and eating habits. The DON stated the resident was receiving hospice services and she had communicated with hospice the resident was not always able to verbalize when he was in pain. The DON stated they then updated his hydrocodone order to be every 6 hours instead of as needed. The DON stated she was unsure if hospice was on his care plan but should be if it is a comprehensive care plan. Record review of the facility's policy titled Comprehensive Care Planning, no date, stated The facility will develop and implement a comprehensive person-centered care plan for each resident.that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives.When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition.If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident.Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered will be recorded in the medical record.If the decision to proceed to care planning is made, the interdisciplinary team (IDT).will develop and implement the comprehensive care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 4 of 4 medication carts (A hall/C hall left side medication cart (1), A hall/ C hall left side nurse cart (2), D hall/C hall right side nurse cart (3), and D hall/C hall right side medication cart (4)), reviewed for medications and pharmacy services, in that: 1. The facility failed to ensure the controlled drug count record was signed by oncoming staff for the medication cart 1. 2. The facility failed to ensure the controlled drug count record was signed by off-going staff for nurse cart 2. 3. The facility failed to ensure the controlled drug count record was completed at the time of shift change for nurse cart 3, as the record was pre-signed for the upcoming shift. 4. The facility failed to ensure the controlled drug count record was completed at the time of shift change for medication cart 4, as the record was pre-signed for the upcoming shift. This failure could place residents at risk for medication errors, not receiving therapeutic effects. and/or drug diversions. The findings included: 1. During an observation and record review on 3/25/26 at 10:18 a.m., the controlled drug audit record for medication cart 1 was missing a signature from the oncoming staff (6 a.m. to 6 p.m. shift). 2. During an observation and record review on 3/25/26 at 10:27 a.m., the controlled drug audit record for the nurse cart 2 was missing a signature from the off-going staff (overnight shift ending at 6 a.m.) for the 6 a.m. to 6 p.m. shift. 3. During an observation and record review on 3/25/26 at 10:28 a.m., the controlled drug audit record for nurse cart 3 contained a signature from the off-going nurse for the 6 p.m. shift prior to the end of the shift. 4. During an observation and record review on 3/25/26 at 10:29 a.m., the controlled drug audit record for medication cart 4 contained a signature from the off-going nurse for the 6 p.m. shift prior to the end of the shift. During an interview and record review on 3/25/26 at 10:15 a.m., LVN B stated she was using Nurse cart 2. LVN B stated she had not counted the cart medications, but LVN C was responsible for counting all the medications at the start of the shift for all the carts. LVN B stated she was a new employee of the facility and was unfamiliar with this practice of one nurse counting every cart. LVN B then showed this surveyor medication cart 1. LVN B stated MA D was passing medications from this cart but was on break. LVN B had the keys to the cart. Upon review of the narcotic log for medication cart 1 it was noted that the log was not signed for the beginning of the shift that day. LVN B again stated she had not counted the carts and was unsure why LVN C had not signed the log. During an interview and observation on 3/25/26 at 10:18 a.m., LVN C was called over to medication cart 1 by LVN B. This surveyor asked LVN C why the log was not signed for the narcotic count that morning by the on-coming nurse. LVN C stated she was responsible for counting all the carts in the morning at 6 a.m. when she arrived at work. LVN C stated she had counted the cart but forgot to sign the log. LVN C then signed the log for medication cart 1. LVN C stated counting the medication at the start of each shift ensured there were no missing medications and she should sign the log to prove she completed the count at shift change. During an interview on 3/25/26 at 10:20 a.m., MA D approached medication cart 1. MA D stated she was passing medications from medication cart 1 but was going on break. MA D stated she left the keys for the cart with the other nurses. MA D stated the narcotic counts were done at 6 a.m. by the nurse and her shift started at 7 a.m. before she arrived at work. MA D stated she never counts the medication carts because the nurses count them. MA D was asked by this surveyor how she could be sure all the medications in the cart could be accounted for and she stated she was present during the narcotic counts. MA D stated they handed over the keys to another staff when they went on break and did not complete a count prior to handing over the keys. During an interview on 3/25/26 at 10:34 a.m., the DON stated both the off-going and on-coming nurse should be counting all narcotics on the carts and signing the narcotic count record at that time. The DON stated she needed to check the policy to see if the morning shift nurse could (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pre-sign the narcotic count record prior to the end of shift count. The DON was asked by this surveyor if staff were able to hand off keys and take possession of the carts without counting the narcotics. The DON stated she was unsure and needed to check the policy. During an interview on 3/25/26 at 11:23 a.m., the Corporate Compliance Nurse stated staff should not pre-sign the narcotic count logs and should sign them at the time the cart is counted at shift change. The Corporate Compliance Nurse stated staff were going to be in serviced on how to complete the logs because they had already been trained but were not doing it correctly. During a follow-up interview on 3/25/26 at 2:55 p.m. the DON stated the corporate compliance nurse stated the facility's policy stated the staff only needed to count the carts at shift changes and before or after breaks when they give the keys to other staff to take possession of the carts. The DON stated she could see how this was an issue because they recently had a package of narcotics going missing and were unable to know what happened to them. Record review of facility policy titled Controlled Medications, dated 2025, revealed Only authorized licensed nursing and pharmacy personnel have access to controlled medications. The medication nurse on duty maintains possession of the key to controlled medication storage areas.A controlled medication accountability record is prepared when receiving or checking in a Schedule II, III, IV, and V medication.Name of person receiving medication supply.the licensed nurse administering the medication immediately enters all of the following information on the accountability record. Signature of the nurse administering the dose, completed after the medication is actually administered. The policy further stated, At each shift change, a physical inventory of all controlled medications is conducted. and is documented on an audit record.Any discrepancy in controlled substance medication counts is reported to the Director of Nursing immediately. [and] investigated.

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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 maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 3 residents (Residents #1) reviewed for medical records. The facility failed to ensure Resident #1's medication administration report did not contain blanks. The facility failed to ensure the paper MAR contained the required information to accurately capture if medications were administered, refused, held, or unavailable and which staff this information was documented by. This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records.The Findings include: Record review of Resident #1's admission record, dated 3/25/26, revealed an [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (a group of conditions affecting blood flow and blood vessels in the brain, which can lead to stroke), gangrene, pain unspecified knee (knee pain without a clearly identified cause or specific diagnosis), and osteoarthritis (a degenerative joint disease characterized by the breakdown of cartilage causing pain, stiffness, and decreased mobility). Record review of Resident #1's significant change MDS assessment, dated 2/18/26, revealed Resident #1's cognition was severely impaired for daily decision making. The MDS revealed the resident received PRN pain medication and experienced pain which frequently limited his day-to-day activities. Record review of Resident #1's care plan, last revised 3/11/26, did not reflect he had pain related to gangrene, knee pain, osteoarthritis, or received hospice services. Record review of Resident #1's physician orders, dated 3/25/26, revealed an order for:-hydrocodone-acetaminophen oral tablet 10-325 mg, give 1 tablet by mouth every 6 hours for pain related to gangrene, with a start date of 3/9/26, and no end date. Record review of Resident #1's March 2026 electronic MAR revealed an order for hydrocodone-acetaminophen 10-325 mg, give 1 tablet by mouth every 6 hours for pain related to gangrene. The order contained blanks on:-3/10/26 at 5:00 p.m.-3/13/26 at 5:00 p.m.-3/19/26 at 5:00 p.m. and 11:00 p.m.-3/20/26 at 5:00 a.m.Further review of the MAR revealed the scheduled medications were left blank with no coding, initials, or documentation to indicate whether the medications were administered, refused, held, or unavailable on 12/10/26, 12/13/26, and 12/20/26 for daily orders. Record review of Resident #1's paper MAR, dated March 19th, 2026, revealed an order for hydrocodone-acetaminophen 10-325 mg, give 1 tablet by mouth every 6 hours for pain related to gangrene. The paper MAR stated on:-3/19/26 at 5:00 p.m. ref and unknown staff initials.-3/19/26 at 11:00 p.m. LVN A signed the box with their initials, no documentation on whether the medication was administered, refused, held, or unavailable was noted.- 3/20/26 at 5:00 a.m. LVN A signed the box with their initials, no documentation on whether the medication was administered, refused, held, or unavailable was noted.Further review of the paper MAR revealed an area on the form below the order on the paper MAR had an area for staff to initial and write their name. Only LVN A filled out this portion, the unknown staff's initials information was missing from this area. During an interview on 3/24/26 at 10:40 a.m., Resident #1 was lying in bed, and his family member was also in the room with him. Resident #1 had a bandage visible to one hand and stated he had another one on his foot. He stated he had pain because he had gangrene. Resident #1 stated he was unsure if he received his pain medication. The resident's family members stated they were roommates and sometimes nursing staff were not around when his pain medications were due but overall, they were good about getting his pain medications when he had pain. The family member stated hospice had spoken to the facility about making sure he received his pain medications. During an interview on 3/25/26 at 2:34 p.m., the DON stated the resident was receiving hospice services and she had communicated with hospice the resident was not always able to verbalize when he was in pain. The DON stated they then updated his hydrocodone order to be every 6 hours instead of as needed. The DON reviewed Resident #1's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic MAR with this surveyor, the paper narcotic account sheet, and compared it to what was documented on the electronic MAR. The DON stated during the dates the electronic MAR contained blanks they may have been experiencing internet interruptions and she would need to look at the paper MAR. The DON stated staff should be documenting on the MAR and not leaving it blank. The DON stated the resident could refuse the medication but that it needed to be documented if it was refused. The DON stated they were able to locate the paper TAR but not the paper MAR at the time of the interview. The DON stated she would return with the with paper MAR. During an interview on 3/25/25 at 3:33 p.m., the administrator stated the internet at the facility may go down a couple times a month and sometimes there is a gap in electronic documentation and the staff has to use paper MARs. The Administrator stated however they recently had this issue fixed and the MARs would update once the EMR was back on the internet. The Administrator stated staff was expected to document a code on the MAR and not just leave it blank. The Administrator stated they spoke with the medical records personnel so far, the missing dates were not corresponding to what they had. Record review of the facility policy titled Medication Administration and General Guidelines, no date, stated Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications.Except for single unit dose packet distribution systems, only the licensed or legally authorized personnel who prepare a medication may administer it. This person then records the administration on the resident's MAR at the time the medication is given.At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that all necessary doses were administered and documented.The resident's MAR is initialed by the person administering a medication, in the space provided under the date and on the line for that specific medication dose administration.If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time.an explanatory note is entered on the record.