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	04/09/2026

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 interview and record review, 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 (Residents #1) reviewed for care plans: The facility failed to ensure Resident #1 comprehensive care plan included a plan with interventions to address her recent fall 3/14/2026 and post-surgical right arm care. This failure could place residents at risk of receiving improper care and services. The findings were:Record review of Resident #1's face sheet dated 4/08/2026 revealed an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: unspecified fracture of upper end of right humerus subsequent encounter for fracture with routine healing (fracture or break in the bone of the upper arm near the shoulder), dementia, and Parkinsons disease without dyskinesia with fluctuations (neurological disorder that affects movement without tremor). Record review of Resident #1's re-admission MDS dated [DATE] revealed a BIMS score of 10 which indicated a moderate cognitive impairment. Her ADL functioning was scored as non-ambulatory and dependent on staff for movement and dressing. The assessment indicated she had no fall history. Record review of Resident #1's progress notes dated 3/14/2026 revealed she sustained a fall from leaning forward in her wheelchair while in the hallway. An assessment was performed and Resident #1 complained of discomfort to upper right extremity. The MD was notified of the fall and ordered an x-ray. Documented by the DON. Record review of Resident #1's progress notes dated 3/16/2026 revealed the resident was transferred to the hospital related to the fall on 3/14/2026 due to pain of right elbow and x-ray not done. Record review of Resident #1's hospital records dated 3/16/2026 revealed the resident had surgery on her right humerus and received discharge instructions on post-surgical care for a fracture due to a fall. The instructions included activity guidelines, and sling use. She also received fall precaution discharge instructions. Record review of Resident #1's re-admission progress note dated 3/19/2025 revealed she was scheduled for a follow up with her surgeon on 3/31/2026 and she had a surgical dressing to right arm which was in a sling. Record review of Resident #1's comprehensive care plan indicated:-she was at risk for falls related to prior function and poor safety awareness which was last revised dated 8/11/2025 and had not been revised with any new interventions post fall on 3/14/2026. -the care plan did not include any problems or interventions related to her fractured right humorous, post-surgical care or use of a sling. During an interview on 4/08/2026 at 1:21 p.m., the MDS Coordinator stated she was aware of Resident #1's fall on 3/14/2026 with significant injury because she had coded in on Resident #1's revised discharge MDS assessment. She stated she had also completed Resident #1's 5-day admission assessment post hospitalization. The MDS Coordinator stated she reviews progress notes and hospital records as part of information gathering. The MDS Coordinator stated she was responsible for care plans associated with MDS assessments. She stated acute care plans were the responsibility of nursing. She stated she was aware of the fall. She was running late and had not had (continued on next page)

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	a chance to change Resident #1's care plan to reflect her current status. The MDS Coordinator stated the current care plan did not include revisions from her fall on 3/14/2026 or a plan of care for her broken arm or use of a sling. She stated this was something nursing could have put into the care plan. She stated the facility management reviewed residents during morning meetings. The MDS Coordinator stated it was important to have an acute care plan because it was where everyone goes to review what was relevant to the patient's care. During an interview on 4/08/2026 at 1:49 p.m., the DON stated she was the nurse on duty when Resident #1 had the fall on 3/14/2026. The DON stated she was new to the facility by 45 days and had been working as a charge nurse due to staffing issues. The DON stated the nursing staff was responsible for acute changes to the care plan, The DON stated the MDS Coordinator was responsible for the care plan for falls, incidents and anything related to MDS assessment. The DON stated she was not used to having to update a care plan as required by this organization. She stated she was still learning due to new DON status. She stated an acute care plan was important because it had to do with resident care. Record review of the facility policy titled Comprehensive Care Planning undated, revealed: The facility will 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. The comprehensive care plan will describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. A comprehensive care plan will be developed within 7 days after completion of the comprehensive assessment. The resident's care plan will be reviewed after each admission .or significant change MDS assessment, and revised based on changing goals, preferences and needs of the resident or in response to current interventions.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices for 1 of 3 residents (Resident #1) reviewed for falls, in that: The facility failed to ensure Resident #1 received a STAT x-ray of her right elbow after a fall on the evening of 3/14/2026 until she was discharged to the hospital on 3/16/2026, creating a delay in care. This failure could place residents at risk for missed injuries and a delay in care and harm. The findings were:Record review of Resident #1's face sheet dated 4/08/2026 revealed an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: unspecified fracture of upper end of right humerus subsequent encounter for fracture with routine healing (fracture or break in the bone of the upper arm near the shoulder), dementia, and Parkinsons disease without dyskinesia with fluctuations (neurological disorder that affects movement without tremor). Record review of Resident #1's MDS assessment (other) dated 3/03/2026 revealed a BIMS score of 13 requiring maximal assistance for movement and walking. The assessment indicated a history of one fall 2-6 months prior. Record review of Resident #1's re-admission MDS dated [DATE] revealed a BIMS score of 10 which indicated a moderate cognitive impairment. Her ADL functioning was scored as non-ambulatory and dependent on staff for movement and dressing. Record review of Resident #1's comprehensive care plan indicated initiated 8/11/2025 revealed-she was at risk for falls related to prior function and poor safety awareness had not been revised with any new interventions post fall on 3/14/2026. The care plan included interventions to prevent falls that included: anticipate and meet resident needs, educate the resident about safety reminders, call light within reach and encourage the resident to use it, encourage resident to participate in activities that promote exercise, and strengthening, appropriate footwear when ambulating or mobilizing in wheelchair for protection and traction, keep needed items in reach, and keep furniture in locked position. Record review of Resident #1's Fall Risk assessment dated [DATE] revealed she was at high risk for falls. Record review of Resident #1's Fall Event Note, effective date 3/14/2025 at 8:05 p.m. revealed Resident #1 had an unwitnessed fall in the hallway from bending over and sliding out of the chair. An assessment was performed. The resident was described as having an injury of a skin tear or laceration to her right cheek bone area 1 cm x 1 cm where her glasses cut her cheek when she landed on them, a bruise to the forehead 4 cm x 4 cm. The resident had unequal hand grip and stated she had pain in the right elbow. First aid was provided. The laceration was cleaned and ice pack was applied to the forehead. The resident had no pain or discomfort voiced after first aid was provided. The physician was notified of the fall at 8:30 p.m. and gave orders for an x-ray to the right elbow. Documented by the DON. Record review of Resident #1's physician orders as entered into the x-ray company portal revealed: Right elbow x-ray dated 3/14/2026 STAT. Order placed 3/14/2026 at 8:47 pm by phone. Record review of Resident #1's progress notes dated 3/15/2026 at 1050 am revealed a fall follow up note with vitals sign WNL, swelling to cheek and forehead and right elbow pain. The pain was described as intermittent pain. Documented by LVN A. Record review of Resident #1's progress note dated 3/15/2026 at 10:58 am revealed a pain assessment score of 0 (which indicated no current pain (at time of assessment), with intermittent pain at times at 4 (on a scale of 1-10). Documented by LVN A. Record review of Resident #1's progress note dated 3/15/2026 at 8:28 p.m. revealed acetaminophen 650 mg was administered for pain scale of 1-3 as needed. Documented by LVN B. Record review of Resident #1's progress note dated 3/16/2026 revealed follow up pain scale of 1 post administration of acetaminophen. Documented by LVN B. Record review of Resident #1's progress note dated 3/16/2026 at 5:40 a.m. revealed: Still pending on tech to perform x-ray to right elbow due to pain/swelling/bruising from previous fall on 3/14. Called [name of radiology company], stated they were unsure when tech would arrive, they were behind on orders but will be here as soon (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	as possible. During the night, resident would complain of right arm hurting the CNAs would touch it or provide peri care. PRN pain medication was given. This nurse notified DON, to see if resident could be sent out. DON stated to get an order from MD to send to ER. This nurse call PCP. Unable to reach PCP. Called [name of radiology company] again to get an ETA. Tech coming from [name of different city] and should be at facility in a few hours, late morning. DON notified of PCP not answering. Documented by LVN B. Record review of Resident #1's progress note dated 3/16/2026 at 5:53 a.m. revealed: This nurse asked resident if she needed any pain medication. Resident stated no, she felt okay right now. Documented by LVN B. Record review of Resident #1's progress note dated 3/16/2026 at 8:15 a.m. revealed: Resident fell the night of 3/14. Resident had been complaining of right elbow pain since the fall with movement/repositioning .denied headache or any other pain. VS within normal limits for resident. Resident in bed with eyes closed resting, responded well to questions and verbalized understanding to being sent out to ER. EMS took resident to [name of local hospital], PCP and RP notified of transfer. Documented by LVN A. Record review of Resident #1's Transfer Notification dated 3/16/2026 at 8:15 a.m. revealed: Resident #1 was transferred to a hospital on 3/16/2026 at 8:15 am related to fall on 3/14. Resident is complaining of right elbow pain, x-ray not done . Documented by LVN A. Record review of Resident #1's hospital records dated 3/16/2026 revealed the resident was admitted on [DATE] and had surgery on her right humerus for open reduction internal fixation of] distal humorous fracture (surgical repair with hardware for a fracture of the elbow). During an observation and interview on 4/08/2026 at 12:35 p.m., Resident #1 was observed seated in her wheelchair in her room. A personal care giver was in attendance. Resident #1's right arm was in a sling. The resident was awake, alert, without distress and talkative but confused. She stated she fell and broke her arm while closing gates at the ranch. She was unable to remember the details of the fall. During an interview on 4/08/2026 at 12:42 p.m., Resident #1's care giver stated she worked for the family and stayed with the resident Monday through Friday from 8 am to 2 pm. The Care giver stated the resident uses the toilet and does ask for help when needed. She stated she was not in the facility when the fall occurred and did not see the resident until Monday 3/16/2026 when she was already in the ambulance. During an interview on 4/08/2026 at 12:52 p.m., LVN A stated she was not in the facility on 3/14/2026 when the resident fell at approximately 9:00 p.m. LVN A stated when she came to work the next day, on 3/15/2026 Resident #1 was complaining of right elbow pain. She stated the DON told her a STAT x-ray had been ordered. LVN A stated the x-ray company did come to the facility on 3/15/2026 to do x-rays and completed an x-ray for another patient. LVN A stated she assumed one was done for Resident #1 as well but did not follow up on it at the time or direct the x-ray company to Resident #1. LVN A stated when she realized the order was missed, she put in another order and called the x-ray company a few times. LVN A stated the x-ray company kept saying they would be there at noon. then 1:00 p.m., etc. LVN B stated she did a pain assessment on 3/15/2026. She stated the resident was having intermittent pain to the arm when moved. She stated she tried to keep the resident as comfortable as possible and administered PRN pain medication. She stated she kept the residents arm elevated and just kept checking on her. LVN A stated there was swelling and bruising from her elbow down 3/4 down her arm toward her wrist. She stated the resident was babying the arm but only complained of pain with movement of the arm. LVN A stated the resident did have pain medications that was given. LVN A stated she continued to call the x-ray company multiple times, and they kept giving her different ETA's. She stated she notified the DON that the x-ray was not done. She stated the DON asked why. LVN A stated she told her she was not sure why it was not done, they (x-ray company) missed it, and she had not been able to get ahold of a tech and they got excuses. LVN A stated she did not notify the doctor that the x-ray was not done. She stated the facility policy indicated that normally if they could not get something right away, they should notify the doctor. LVN A stated on 3/16/2026, LVN B talked to the DON who told LVN to send the resident to the hospital because of pain. LVN A stated when she learned that from LVN B, she called EMS on 3/16/2026. LVN A since the incident she had received training and a new (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	log in for the x-ray company portal use. She stated she did not know how to use it prior to the incident. She stated she was a new nurse and relied on the other nurses and DON for guidance. She stated she had received in-service training to call the DON if services were not provided by the end of the shift. During an interview on 4/08/2026 at 12:59 p.m., Resident #1's RP stated she was upset that Resident #1 was not sent to the ER immediately after the fall for care. She stated Resident #1 needed a surgical repair for a fracture to her right arm. The RP stated she was initially notified by the DON that the fall had occurred. She stated the DON indicated Resident #1 had full range of motion. The RP stated she was not happy with the way the fall was handled. She stated she called after Resident #1 was admitted to the hospital to discuss with the DON her concerns about care. The RP stated the DON stated they had followed facility policy. The RP stated the resident did not have a history of falls. During an interview on 4/08/2026 at 1:49 p.m., the DON stated she was a new DON to the facility by 45 days. She stated the old DON took a bunch of the nursing staff with her when she left, leaving the facility short of staff. She stated she was having to work the floor as a charge nurse while the facility worked to find replacement staff. The DON stated on 3/14/2026 she was informed by an unknown staff member at an unknown time that Resident #1 had a fall. She stated she was lying on the floor in front of her wheelchair in the hallway. The DON stated she did an assessment of the resident. She stated the resident was able to move all extremities and was fine. The DON stated the resident had a small cut to her face from her glasses and her forehead had the start of a bump with discoloration. The DON stated she notified the RP and told her about the fall and that the resident was fine. The DON stated she then notified the physician. She stated she told the physician Resident #1 had a goose egg to her forehead, a laceration to her face and pain in her arm (right arm) but was able to move the arm. She stated she told the physician she ordered a skull x-ray, a face x-ray and an elbow x-ray but the physician disagreed. The DON stated the physician wanted only the elbow x-ray. She stated the resident was not ready for bed and stayed up for a while. She stated she provided ice to the resident's forehead. The DON stated they started neuro checks and there were no changes in neurological status. She stated the resident went to bed, slept through the night and had no complaints during the night. The DON stated she kept checking on the resident through the night and she was fine. The DON stated she was aware the x-ray had not been done on her shift and passed it on to the day shift nurse that it still needed to be done. The DON stated on the night of 3/15/2026 LVN B started texting her that the x-ray company had not come out. That something had happened to their driver, but they were sending another driver. The DON said she told LVN B not to wait to send Resident #1 out to the hospital. The DON stated when she arrived to the facility on 3/16/2026 Resident #1 was still there, and another nurse was sending her out (to the hospital). The DON stated later on 3/16/2026 the RP for Resident #1 came by the facility and was upset. The DON stated she told the RP the facility followed policy. The DON stated the RP was not happy because Resident #1's arm was broken. The DON stated she was not certain how soon a STAT x-ray should be completed without reviewing her contract with the company. She stated she did expect staff to notify the physician if an x-ray could not be completed but did not have a time frame. She stated it was best practice to let the physician know. She stated since the incident she has re-educated staff on proper procedures. She stated the in-service provided to staff included having the nurses call her by the time the shift was over if an x-ray had not been completed and getting hold of the doctor. She stated if staff was unable to reach the physician, they were to use nursing judgement and send the resident out to the hospital for care and let the doctor know afterwards. She stated timely x-rays were important so they could provide the correct care for the resident and prevent further injury. During an interview on 4/08/2026 at 2:44 p.m., Resident #1's physician stated on 3/14/2026 he received notification that Resident #1 had a fall with right elbow pain, a knot to the forehead and a cut to the cheek. He stated he ordered a STAT x-ray of her elbow. He stated his next notification came on 3/16/2026 that Resident #1's x-ray had not been done, that she was in a lot of pain and they were sending EMS to pick her up. He stated he would assume an x-ray should be completed within 24 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hours. He stated if he ordered a STAT x-ray, he expected STAT. He stated he was not getting information back from staff. He stated they could have communicated with her as he was expecting the x-ray right away. He stated most of the nursing homes he works with call him back and say they can't get it and they send them out to get it done. The physician stated he was expecting the x-ray would be there for him to review. He stated when he learned it had not been done; he told the staff to send her out (to the hospital). The physician stated the staff had asked for a skull x-ray and he said no. He said x-rays of her face and skull were not indicated and did not need to be done. During an attempted interview on 4/08/2026 at 2:51 p.m. a voicemail was left for a return call from the x-ray company. No return call was received. During an interview on 4/08/2026 at 3:47 p.m., the DON stated as a result of the incident with Resident #1 the facility did the following to correct: Educated staff that x-rays should be done by the end of their shift. If they cannot be completed, the resident should be sent out for imaging the local hospital and the physician should be notified. The DON stated she placed a sign at the nurses' station reminding staff of the training and that staff should notify the DON by the end of the shift if an x-ray could not be completed. The DON stated she re-educated staff that if a physician was not answering calls, they are to use nursing judgement and send the resident out to the hospital and notify the physician after. The DON stated the management is reviewing all labs and x-rays in morning meeting to ensure they are complete. She stated the Weekend Supervisor was reviewing on the weekends. During an interview on 4/08/2026 at 6:00 p.m., LVN B stated she was told in report that Resident #1 fell from her wheelchair and hurt her arm. She stated the ongoing care was that a STAT x-ray for the arm had been ordered. LVN B stated she was waiting for the tech to come in for the x-ray. She stated she was providing neuro checks and pain management with Tylenol and Norco as ordered. LVN B stated she checked on Resident #1 all during the night on 3/15/2026. She stated she did an assessment and vitals. She stated the resident refused all pain medication and complained of pain only with movement. She stated she told the aides to be very gentle with moving her for care. She stated she went in multiple times and pain meds were refused. LVN B stated she had redness like bruising to the back of her elbow and moderate swelling. LVN B stated she tried to call the physician at approximately 4:00 am and got no response. She stated she only tried to call him one time and just waited for a call back. LVN B stated she was not sure what the facility policy was at the time. LVN B stated she called the radiology company multiple times. She stated they told her a tech was assigned to come in the morning and they were behind. LVN B stated she was never told what an acceptable time was to wait for a STAT x-ray to be completed. LVN B stated she did call the DON and notified her but did not remember the response. LVN B stated she asked the Resident if she was okay being sent to the hospital and the resident said no. LVN B stated she was unsure how reliable Resident #1 was with responses and dementia, but she seemed pretty with it to her. LVN B stated she did not know how to access the facility policies. LVN B stated she had received in-service training since the incident. She stated they were to follow neuro checks for unwitnessed falls. And if a resident was unstable, had pain or was crying or their vitals are unstable to utilize nursing judgement. If the resident was uncomfortable and they had pain they could use their nursing judgement and call 911. During an interview on 4/09/2026 at 12:08 p.m., the DON stated the facility did not have a policy for radiology or STAT x-rays. During an interview on 4/09/2026 at 1:25 p.m., the DON stated she had only three fulltime licensed staff and a few PRN licensed staff. She stated all nursing staff had been retrained on x-rays. She stated the training included sending to the ER for immediate care by the end of the shift if an x-ray could not be promptly obtained. During interviews on 4/08/2026-4/09/2026 LVN C, LVN D and RN E confirmed they had received the in-service training for STAT radiology. They indicated the training indicated STAT x-rays should be obtained within 4-6 hours, if the x-rays cannot be obtained, they should notify the DON by the end of the shift. They stated a resident's pain should be assessed and treated. They stated they should call the physician to get an order to send to the hospital and if they could not get a hold of the physician to notify the DON immediately. Record review of a facility in-service dated 3/16/2026 titled Fall prevention revealed 27 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	staff completed the in-service training. Record review of a facility in-service dated 3/16/2026 titled Reporting Injuries, Physician/NP/PA Notifications revealed 9 nursing staff had completed the training. Record review of a facility in-service dated 3/16/2026 titled Abuse, Neglect, and Exploitation revealed 44 staff members had completed the training. Record review of the facility contract with the x-ray company dated 7/29/2025 revealed: 4.4 Company will use reasonable efforts to dispatch STAT x-ray services as soon as possible for receipt of the STAT order. Record review of the facility policy titled Fall Policy undated revealed: In instances where fall risk measures do not prevent a fall, the residents will be assessed immediately for injury. Vital signs and first aid measures will be completed immediately. The Charge Nurse will notify the attending physician and family member as soon as possible after the resident has been stabilized. Record review of a facility policy titled Notifying the Physician of Change in Status undated revealed: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention. 4. If the physician does not return the call within a reasonable amount of time, the nurse will attempt to contact the physician a second time. If the situation is an emergency, the physician does not call back within a reasonable amount of time, the nurse will contact the Medical Director or the nearest ambulance service for assistance. The nurse will document all attempts to contact the physician in the resident's clinical record. 11. Abnormal lab, x-ray and other diagnostic reports require physician notification.

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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 interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for medical records accuracy, in that: The facility failed to ensure Resident #1's medical record was free of erroneous information when the DON documented assessments and progress notes when the resident was not in the facility and was hospitalized . This failure could place residents at risk for an inaccurate clinical picture and errors in care and treatment. The findings were: Record review of Resident #1's face sheet dated 4/08/2026 revealed an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: unspecified fracture of upper end of right humerus subsequent encounter for fracture with routine healing (fracture or break in the bone of the upper arm near the shoulder), dementia, and Parkinsons disease without dyskinesia with fluctuations (neurological disorder that affects movement without tremor). Record review of Resident #1's progress notes dated 3/14/2026 revealed she sustained a fall from leaning forward in her wheelchair while in the hallway. An assessment was performed and Resident #1 complained of discomfort to upper right extremity. The MD was notified of the fall and ordered an x-ray. Documented by the DON. Record review of Resident #1's progress notes dated 3/14/2026 revealed she sustained a fall from leaning forward in her wheelchair while in the hallway. An assessment was performed and Resident #1 complained of discomfort to upper right extremity. The MD was notified of the fall and ordered an x-ray. Documented by the DON. Record review of Resident #1's progress notes dated 3/16/2026 revealed the resident was transferred to the hospital on 3/16/2026 related to the fall on 3/14/2026 due to pain of right elbow and x-ray not done. Record review of Resident #1's modified discharge MDS dated [DATE] revealed the resident had an unplanned discharge on [DATE] to an acute care hospital. Record review of Resident #1's hospital records dated 3/16/2026 revealed the resident was admitted on [DATE] for a fracture to the right humorous with surgical repair and was discharged back to the nursing facility on 3/19/2026 at 10:03 am. Record review of Resident #1's medical record in PCC revealed the following documentation while Resident #1 was hospitalized and not in the facility. Fall Nurses Note assessment dated [DATE] which included vital signs, documentation of a bruise to cheek, forehead and right arm, pain assessment and fall interventions of low bed with a note: monitoring every 2 hours and PRN. The assessment was documented by the DON and signed on 4/02/2026. Fall Nurses Note assessment dated [DATE] which included vital signs, documentation of a bruise to cheek, forehead and right arm, pain assessment and fall interventions of low bed with a note: monitoring every two hours and PRN. The assessment was documented by the DON and signed on 4/02/2026. a progress note dated 3/17/2026 at 3:51 pm noted as late entry for Fall Follow-up which indicated bruising that was blue, purple and painful to the cheek, forehead and right arm, with right intermittent elbow pain and low bed and vital signs documented by the DON. a progress note dated 3/18/2026 at 3:53 am with vital signs, location of bruise to cheek, forehead, and right arm that was blue/purple and painful and intermittent right elbow pain with low bed. documented by the DON. During an interview on 4/08/2026 at 1:49 p.m., the DON stated she was a new DON to the facility by 45 days. She stated she had been working as a charge nurse due to staffing issues. She stated she was the charge nurse on duty when Resident #1 fell on 3/14/2026. The DON stated Resident #1 left the faciity on 3/16/2026 to be treated at the hospital for right arm pain, post fall and did not return to the facility until 3/19/2026. The DON stated she did not know why she had documented assessments, vital signs and progress notes on Resident #1 on 3/17/2026 and 3/18/2026 when the resident was not in the facility and was hospitalized . She stated she did not know why the assessments were dated 3/17/2026 and 3/18/2026 but were not signed until 4/02/2026. She stated it had to be an error. The DON stated the progress notes were (continued on next page)

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	04/09/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	generated from the assessments. The DON stated she was not aware of the facility policy on documentation as she was still new to the organization and still learning. The DON stated medical records should have accurate documentation to ensure proper care for the resident. Record review of the facility policy titled Documentation undated, revealed: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Documentation also occurs in the clinical software Point Click Care (PCC).