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	04/24/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 3 residents (Residents #2 and #3) reviewed for pressure ulcers.1. The facility failed to ensure Resident #2 receives necessary treatment and services when Resident #2's weekly skin assessments for the month of April reflected the resident did not have any pressure wounds.2. The facility failed to ensure Resident #3 received necessary treatment and services when Resident #3's skin assessments had not been completed since 3/24/26.These failures could place residents at risk of not receiving necessary monitoring and treatment for skin care breakdown and pressure wounds which can cause discomfort, pain, infection, and illness.Findings include:1. Record review of Resident #2's admission record, printed on 4/24/2026, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Active diagnoses included irritant contact dermatitis (itchy rash) due to fecal/urinary incontinence (loss of bowel/bladder control), Type 2 Diabetes Mellitus (insulin resistance and high blood sugar levels), and protein-calorie malnutrition (undernutrition caused by insufficient intake of protein and calories).Record review of Resident #2's MDS assessment dated [DATE] revealed a BIMS Summary Score of 15 indicating no cognitive impairment. Resident #2 was coded as always incontinent for bowel and bladder. Diagnoses included neurogenic bladder (nerve damage leading to incontinence), malnutrition, and Diabetes Mellitus. Resident #2 was at risk for developing pressure ulcers/injuries and had one unstageable pressure ulcer.Record review of Resident #2's Care Plan last completed on 4/22/2026 revealed Diabetes Mellitus type 2 was initiated on 1/5/2021 with interventions Check all of body for breaks in skin and treat promptly as ordered by doctor and notify the charge nurse for open areas, sores, pressure areas, blisters, edema or redness to the feet. It revealed actual impairment to skin integrity r/t gluteal dermatosis (brownish scaly plaque on skin) was initiated on 6/12/2025 with interventions identify/document potential causative factors and eliminate/resolve where possible and monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration (softened or worn away) etc. to MD. It revealed the resident has a pressure ulcer to left inner heal and right inner heal initiated on 9/29/2025 with interventions Assess/record/monitor wound healing at least weekly. Measure length, width depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD.Record review of Resident #2's Weekly Skin Assessments stated there were no pressure, venous, arterial, or diabetic ulcer noted on the 4/4/2026, 4/11/2026, and 4/18/2026 assessments signed by LVN A.Record review of Resident #2's TAR printed on 4/24/2026 revealed wound care treatment was provided for the right heel one time a day by the charge nurse from 4/1/2026 through 4/24/2026.During an observation and interview on 4/24/2026 at 3:45 PM, Resident #2 was observed sitting in the dining room in a wheelchair writing in a note pad. She revealed she received weekly skin assessments and currently has pressure wounds in her foot and bottom. She said she received wound care treatment for my foot once a day and my (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bottom every time they change me.2. Record review of Resident #3's admission record, printed on 4/24/2026, reflected an [AGE] year-old female, initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of cerebral infarction (blood flow disruption to the brain) due to embolism (formation of blood clots) of bilateral cerebral arteries (paired arteries that supply each hemisphere of the brain), protein-calorie malnutrition, and enterocolitis (inflammation of small and large intestine) due to clostridium Difficile (bacterium that causes infection of the colon).Record review of Resident #3's MDS assessment dated [DATE] revealed a BIMS Summary Score of 12 indicating moderate cognitive impairment. Resident #3 was coded as always incontinent for bowel and bladder. Active diagnoses included malnutrition. Resident #3 was at risk for developing pressure ulcers/injuries and had one unstageable pressure ulcer.Record review of Resident #3's CP last completed on 4/21/2026 revealed ?the resident has potential/actual impairment to skin integrity r/t edema with interventions Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. It revealed The resident has a stage II pressure ulcer to left buttock with intervention Assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD. It revealed ?the resident has a DTI pressure ulcer to right heel with interventions assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD.Record review of Resident #3's Weekly Skin Assessments revealed that the last assessment was completed on 3/24/2026 with a red note stating, Weekly Skin Assessment - 24 days overdue - 3/31/2026.Record review of Resident #3's April TAR printed on 4/24/2026 revealed wound care treatment was provided for the right heel daily and sacral area daily and three times a week.During an observation and interview on 4/24/2026 at 3:30 PM, Resident #3 was observed lying in bed with the television on. She revealed she currently has pressure wounds and receives daily wound care treatment for my heels and butt tailbone.An interview on 4/24/26 at 5:24 PM, LVN A revealed that Resident #2 has a pressure wound that she treats. She confirmed that she had signed the skin assessments completed and stated that the reason the skin assessment was not accurate based on treatment care provided for wounds was I over-looked it. She stated that the impact of an inaccurate assessment was something could get missed. LVN A revealed that she was not the nurse for Resident #3 and was not sure why the assessments had not been completed since 3/24/2026.An interview on 4/24/26 at 5:46 PM with the DON revealed that residents were required to receive weekly skin assessments and wounds should be documented if observed. She stated that prior to her role as DON someone was doing the assessments for the nurses. I am reeducating the nurses on how to perform the assessments. She stated that the impact of an inaccurate or missed assessment was we wound not know what their skin's condition would be and we wouldn't be able to provide them proper care.An interview on 4/24/26 at 5:56 PM with the ADMIN revealed that her understanding was residents were required to receive weekly skin assessments. She stated the impact of an assessment that did not show observed wounds was not accurate and not helpful. She said the impact of not receiving the required weekly skin assessment was if they have skin breakdown, we wouldn't know about it.Record review of the facility's Skin Assessment policy with a revision date of 12/24 stated the following: It is the policy of this facility to establish a method whereby nursing can assess a resident's skin integrity to allow of appropriate intervention be initiated in a timely manner.Procedure:I.If the Treatment nurse/designee isn't available then the charge nurse should complete the assessment within four (4) hours of the resident's arrival at the facility. The charge nurse will then notify the Treatment Nurse/designee of any skin problems noted. Complete the appropriate attachments/assessments. The DON or designee, along with the Treatment Nurse/designee and other team members will review for the follow-up assessment and recommendations. Any pressure ulcer should also be care planned. Any alterations in skin integrity will be treated according to physician orders. Notify DON and responsible family member. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation will then be entered into the resident's chart with the following information.2. All residents should have a skin assessment on a weekly basis completed in [EMR]3. If the resident has any type of ulcer(pressure injury, arterial, venous, diabetic) an ulcer assessment should be completed at least weekly.Record review of the facility's Documentation undated policy reflected the following: 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. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software Point Click Care(PCC).GoalThe facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.