

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER Bluebonnet Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on observation, interview, and record review, the facility failed to promote and protect the resident's right to a dignified existence for 1 (Resident #13) of 40 residents reviewed for dignity, in that: Resident #13 was dependent upon staff to perform all activities of daily living and was observed with hair on her chin. This deficient practice could lead to diminished quality of life and psychosocial harm due to feelings of shame or embarrassment. The findings were: Record review of Resident #13's face sheet, dated 07/18/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Vascular Dementia, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Muscle Weakness. Record review of Resident #13's Quarterly MDS assessment, dated 06/12/2024, revealed a BIMS score of 9 which indicated moderate cognitive impairment. Further review revealed Resident #13 had limited range of motion with impairment on both sides of her upper extremities (shoulder, elbow, wrist, and hand). Further review revealed Resident #13 was wholly dependent upon staff to perform all activities of daily living, including maintaining personal hygiene. Record review of Resident #13's Visual/Bedside Kardex Report, as of 07/19/2024, revealed, Personal Hygiene/Oral Care. Personal Hygiene/Oral Care: the resident requires x 1 staff participation with personal hygiene and oral care. Personal Hygiene/Oral Care: the resident requires total assistance with personal hygiene care. Record review of Resident #13's care plan, revised 03/01/2022, revealed a focus: [Resident #13] has Hemiplegia/Hemiparesis [related to] affects from cerebral infarction and interventions, Assist with ADLs [activities of daily living] /Mobility as needed. Further review revealed an additional focus, [Resident #13] has an ADL [activities of daily living] Self Care Performance Deficit related to dementia, hemiplegia, limited mobility, and stroke and Personal Hygiene: the resident requires total assistance with personal hygiene care. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675306	Facility ID: 675306 If continuation sheet Page 1 of 7

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/18/2024 at 2:09 p.m. revealed Resident #13 had chin hair approximately two inches in length. During an interview with Resident #13 on 07/18/2024 at 2:09 p.m., Resident #13 stated that she dislikes having chin hair and feels embarrassed by it. During an interview with CNA C on 07/18/2024 at 2:14 p.m., CNA C confirmed she cared for Resident #13, stated she had not noticed the resident's chin hair, and stated she had been directed to shave both male and female residents. During an interview with CNA D on 07/19/2024 at 9:38 a.m., CNA D stated Resident #13 will allow CNAs to shave her chin hair and sometimes asks that her hair be tweezed. During an interview with the DON on 07/19/2024 at 10:30 a.m., the DON confirmed that ADL care included shaving residents who wished to be clean-shaven. Record review of the facility policy, Resident Rights, undated, revealed, The resident has a right to a dignified existence .		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41651 Based on observation, interview, and record review, the facility failed to ensure the resident environment was safe, clean, comfortable, and homelike for 2 of 3 shower rooms reviewed for environment, in that: The A and D hall shower rooms contained barrels with soiled linen and trash including soiled briefs. This deficient practice could place residents at risk of living in an unsanitary environment, and psychosocial harm due to diminished quality of life. The findings were: Observation on 07/19/2024 at 9:32 a.m. revealed a barrel with soiled linen and a barrel with trash (including soiled briefs) were located in the A hall shower room. Observation on 07/19/2024 at 9:36 a.m. revealed a barrel with soiled linen and a barrel with trash (including soiled briefs) were located in the D hall shower room. During an interview with CNA D on 07/19/2024 at 9:52 a.m., CNA D stated that the normal facility procedure was to keep a barrel with soiled linen and a barrel with trash (including soiled briefs) in the shower room, including while residents were receiving showers. During an interview with Resident #4 on 07/19/2024 at 9:45 a.m., Resident #4 stated that she dislikes having a shower in a space that contains other residents' soiled clothing and soiled briefs. Record review of the facility policy, Resident Rights, undated, revealed, The resident has a right to a dignified existence .a facility must treat each resident 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 .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 8 residents (Residents #21, #30 and, #40) reviewed for infection control, in that: 1. Medication Aide A did not sanitize the blood pressure cuff between Residents #30 and #21. 2. While providing incontinent care for Resident #40, CNA B and CNA C did not change their gloves or wash her hands after touching the privacy curtain and bed remote. These deficient practices could place residents at-risk for infection due to improper care practices. The findings include: 1. Record review of Resident #30's face sheet, dated 07/19/2024, revealed an admitted [DATE] with diagnoses which included: Dysphagia (Difficulty swallowing), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Anxiety (A group of mental illnesses that cause constant fear and worry), Hypertension (High blood pressure) and, Retinopathy (Damage to the retina which may cause vision impairment). Record review of Resident #30's physician's orders for July 2024 revealed an order for. Amiodarone HCl Tablet 100 MG Give 1 tablet by mouth one time a day related to Unspecified Atrial fibrillation hold for Systolic Blood Pressure <100 OR Diastolic Blood Pressure <60. Record review of Resident #21's face sheet, dated 07/19/2024, revealed an admitted [DATE] with diagnoses which included: Major depression disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Retinopathy (Damage to the retina which may cause vision impairment), Hypothyroidism (under active thyroid), Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood) and, Hypertension (High blood pressure). Record review of Resident #21's physicians' orders for July 2024 revealed an order for, Lisinopril Tablet 10 MG Give 1 tablet by mouth one time a day related to Essential (primary) hypertension. Hold if Systolic Blood Pressure<100, Diastolic Blood Pressure <60 or Heart Rate<60. Observation on 07/19/2024 at 9:08 a.m. revealed, while administering medications, Medication Aide A took the blood pressure and pulse of Residents #30, and #21 with the same blood pressure/pulse cuff. Medication Aide A did not sanitize the blood pressure/pulse cuff in between the residents. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Medication Aide A on 07/19/2024 at 9:12 a.m., Medication Aide A confirmed she used the blood pressure cuff on the 2 residents to measure their blood pressure. Medication Aide A confirmed she forgot to use a disinfecting wipe to disinfect the blood pressure cuff in between each resident but should have done it to avoid risk of cross contamination. Medication Aide A confirmed receiving infection control within the year. During an interview on 07/19/2024 at 10:50 a.m., the DON confirmed the medication aide should have sanitized the blood pressure/pulse cuff in between the residents to avoid cross contamination. The DON revealed infection control training was provided to the staff multiple times a year. The DON revealed the staff's skills were checked annually. The DON further stated the ADONs did spot check of the staff for skills and infection control knowledge. Review of facility policy, titled Fundamentals of infection control precaution, dated 03/2023, revealed Non invasive resident care equipment is cleaned daily or as needed between use 2. Record review of Resident #40's face sheet, dated 07/19/2024, revealed an admitted [DATE] with diagnoses which included: Parkinson's disease (progressive disorder that affects the nervous system and causes tremors and slow movements), (Hyperlipidemia Elevated level of any or all lipids(fat) in the blood), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions.), Dementia (decline in cognitive abilities)and, Retention of urine. Record review of Resident #40's MDS Quarterly assessment, dated 06/22/2024, revealed the resident had a BIMS score of 3, indicating severe impairment. Resident #40 required extensive assistance, had an indwelling catheter and, was always incontinent of bowel. Record review of Resident #40's care plan revealed a care plan initiated 03/29/2024 with a problem of Resident is on enhanced barrier precautions. with a goal of will not have any transmission of infection from or to others through the next review date. Observation on 07/18/24 10:54 a.m., revealed while providing incontinent care for Resident #40, CNA B touched the privacy curtain with her gloved hands. She did not change her gloves or wash her hands, then, placed her hands on the hip of the resident to keep him in place. CNA B touched the privacy curtain with her gloved hands. CNA B touched the resident's bed remote to raise the bed. She did not change her gloves or sanitize her hands and touched the wet wipes, she, then, used to clean Resident #40. During an interview on 07/18/2024 at 11:05 a.m., CNA B and CNA C confirmed they touched the privacy curtain and bed remotes after washing their hands and putting their gloves on. CNAs B and C confirmed the environment around the resident was considered dirty and they should have changed their gloves and sanitized their hands. CNA B and CNA C confirmed receiving infection control training within the year. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/19/2024 at 10:50 a.m., the DON confirmed the environment around the residents was considered contaminated and the staff should have changed gloves and wash their hands after touching the privacy curtain and the bed remote prior to touching the resident and the wet wipes. The DON revealed infection control training was provided to the staff multiple times a year. The DON revealed the staff's skills were checked annually and sport checked by the ADONs. Review of facility policy, titled Fundamentals of infection control precaution, dated 03/2023, revealed, The following is a list of some situations that require hand hygiene [.] after handling soiled equipment or utensils.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41651 Based on observation, interview, and record review, the facility failed to ensure the resident environment was safe, functional, sanitary, and comfortable for residents, staff, and visitors for 1 of 3 halls reviewed for environment, in that: The facility beauty shop on D Hall was unlocked and contained potentially dangerous materials. This deficient practice could result in accidents and/or injury. The findings were: Observation on 07/16/2024 at 12:55 p.m. revealed the facility beauty shop was unlocked. Further observation revealed an unlocked cabinet containing hairspray, hair mousse, and hair dye - on which all were printed warning, danger, flammable, keep out of reach of children and harmful if swallowed. During an interview with CNA F on 07/16/2024 at 12:55 p.m., CNA F confirmed the facility beauty shop was unlocked and contained hairspray, hair mousse, and hair dye - on which all were printed warning, danger, flammable, keep out of reach of children and harmful if swallowed. During an interview with the DON on 07/19/2024 at 10:30 a.m., the DON stated that a lock had been installed on the beauty shop and staff had been trained to ensure that the beauty shop was secured when not in use. Record review of the facility policy, Resident Rights, undated, revealed, .a facility must treat each resident 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 .		