STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676494	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Point Wellness	151 Heritage Springs Drive Bullard, TX 75757

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical and mental status that is, a deterioration in health, (mental, or psychosocial status in either life-threatening conditions or clinical complications) 1 of 7 (Resident #1) residents reviewed for notification of change. The facility did not notify the physician of Resident #1's fall on 1/9/25 when she hit her head. This failure could place residents at risk for physician intervention which could result in not receiving care and services to meet resident needs. Findings include: 1. Record review of the face sheet dated 1/22/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, anxiety, hemiplegia (muscle weakness or partial paralysis on one side of the body), cerebral infarction (ischemic stroke), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 11 and was moderately cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with toileting, bathing, and transfers. Record review of the care plan revised 12/15/24 indicated Resident #1 was at risk for falls related to actual continuous falls with a goal of the resident will not sustain serious injury through the review date. Record review of the incident report for Resident #1date 1/9/25 indicated, This RN found resident on the floor laying on her right her right side and head against the wall. Resident stated, I was trying to walk to the bathroom and fell . vital signs and neuro assessment done due to resident stating she hit her head on the wall, range of motion intact without pain . The incident report indicated the physician was not notified of Resident #1's fall. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Bluebonnet Point Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 151 Heritage Springs Drive Bullard, TX 75757	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 1:30 p.m. the Physician said he or his nurse practitioner were not notified on 1/9/25 of Resident #1 having a fall. The Physician said he found out about Resident #1's fall the week of January 13-17, 2025. During an interview on 1/23/25 on 2:06 p.m. RN B said she had a resident fall on 1/9/25. RN B said she thought it was Resident #1. RN B said Resident #1 was in the doorway lying on her side and Resident #1 stuck out in her mind because she was not aware she could move. RN B said she went to get help from another nurse, couldn't find another nurse to help her with the incident report, called the DON to assist with incident report, and completed the incident report. RN B said she did not notify the physician or the family because she was fairly new to the facility, did not know how to access the information, and could not get any other nurse to assist her. During an interview on 1/24/25 at 12:38 p.m. the Regional Compliance Nurse said she expected the physician to be notified immediately in the event of a change of condition including a fall or anything that seemed off/different from a resident's baseline. The Regional Compliance Nurse said the importance of physician notification was to address any issues in a timely manner. During an interview on 1/24/25 at 1:05 p.m. the Administrator said she expected staff to notify the physician any time a resident had a change in condition including a fall. The Administrator said the importance of physician notification was so the physician could order diagnostic testing if needed or advise staff to send the resident to the hospital for evaluation. Record review of the facility's Notifying the Physician of Changes in Status last revised 3/11/23 indicated, 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. The facility utilizes the INTERACT tool, Change in Condition-When to Notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires immediate notification of the physician or non-immediate/Report on Next Work day notification of the physician. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to the physician, and interventions that were implemented in the resident's clinical record .The nurse will monitor and reassess the resident's status and response of interventions. Physicians should develop a working diagnosis and guide nurse staff in what to monitor, and when to notify the physician if the resident's condition does not improve .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury for 1 of 7 (Resident #1) residents reviewed for abuse and neglect. The facility did not report to the state agency Resident #1's subdural hematoma (brain bleed) that was discovered during hospitalization admitted [DATE]. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings Include: 1. Record review of the face sheet dated 1/22/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, anxiety, hemiplegia (muscle weakness or partial paralysis on one side of the body), cerebral infarction (ischemic stroke), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 11 and was moderately cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with toileting, bathing, and transfers. Record review of the care plan revised 12/15/24 indicated Resident #1 was at risk for falls related to actual continuous falls with a goal of the resident will not sustain serious injury through the review date. Record review of the incident report for Resident #1 date 1/9/25 indicated, This RN found resident on the floor laying on her right her right side and head against the wall. Resident stated, I was trying to walk to the bathroom and fell . vital signs and neuro assessment done due to resident stating she hit her head on the wall, range of motion intact without pain . Record review of the nursing progress for Resident #1 note dated 1/12/25 written by LVN A indicated, family is requesting resident go to ER due to change in [level of consciousness] . Record review of the hospital records dated 1/14/25 indicated Resident #1 was admitted to the hospital on 1/12/25 with diagnoses including subacute subdural hematoma (brain bleed), metabolic encephalopathy (brain disorder that occurs when there is an imbalance of chemicals in the blood), probably secondary to subacute subdural hematoma vs urinary tract infection, and urinary tract infection. Record review of Resident #1's medical records indicated hospital records for her hospital admitted [DATE] were uploaded 1/14/25 and included the diagnosis of subacute subdural hematoma. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review in TULIP (an online system that is utilized for reporting facility incidents and complaints in nursing facilities to the state agency) indicated the subacute subdural hematoma was not reported until 1/16/25 to the state agency. During an interview on 1/23/25 at 1:44 p.m. the Administrator said she had a self-report to the state agency regarding Resident #1 having a subdural hematoma. The Administrator said she found out about the subdural hematoma on 1/16/25 the day she reported the injury to the state agency. When asked about the hospital documentation uploaded on 1/14/25 indicating Resident #1 had a subdural hematoma the Administrator said the paperwork must not have been reviewed by facility staff. The Administrator said they received hospital updates regarding a resident's status prior to accepting them back to the facility. The Administrator said the facility did not review the hospital updates daily. During an interview on 1/24/25 at 12:38 p.m. the Regional Compliance Nurse said the DON or ADON was responsible for reviewing any hospital updates on a resident. The Regional Compliance Nurse any hospital updates should be reviewed when they were received. The Regional Compliance Nurse said Resident #1's hospital records should have been reviewed when they were uploaded into the computer system on 1/14/25. The Regional Compliance Nurse said Resident #1's subdural hematoma should have been reported to the state agency within 2 hours of the facility receiving and reviewing the hospital updates. The Regional Compliance Nurse said the importance of reporting to the state agency in a timely manner was to ensure residents were safe from abuse and neglect. During an interview on 1/24/25 at 1:05 p.m. the Administrator said the DON or designee was responsible for reviewing hospital updates. The Administrator said the Admissions Coordinator and Marketing Coordinator would go see residents who were hospitalized and get updates. The Administrator said the Admissions Coordinator and Marketing Coordinator should update the DON and Administrator of changes in condition or diagnosis for a hospitalized resident. The Administrator said she did not realize the facility had hospital updates for Resident #1 which were uploaded into the electronic medical records on 1/14/25. The Administrator said she did not Resident #1 having a subdural hematoma until the hospital records were reviewed on 1/16/25. The Administrator said Resident #1's subdural hematoma should have been reported to the state agency prior to 1/16/25. The Administrator said when she reported the subdural hematoma, she knew it was being reported late, but knew it still needed to be reported to the state agency. Record review of the facility's Abuse/Neglect policy last revised 3/29/18 indicated, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart .The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility .Reporting .3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene were provided for 2 of 7 (Resident #1 and Resident #4) residents reviewed for ADL's. The facility did not ensure Resident #4 was cleaned up after having a liquid yellow substance covering his mouth, gown, sheets, and blanket. The facility did not provide scheduled showers for Resident #1 and Resident #4. These failures could place residents at risk of not receiving services/care, embarrassment, and decreased quality of life. Findings Include: 1. Record review of the face sheet dated 1/22/25 indicated Resident #4 was aa [AGE] year-old male, readmitted to the facility on [DATE] with diagnosis including age-related cognitive decline, dementia. Guillain-Barre Syndrome (a condition in which the body's immune system attacks the nerves and can cause weakness, numbness, or paralysis), and need for assistance with personal care. Record review of the MDS dated [DATE] indicated Resident #4 was usually understood by others and usually understood others. The MDS indicated Resident #4 had a BIMS of 13 and was cognitively intact. The MDS indicated Resident #4 was dependent for toileting, bathing, and personal care. Record review of the care plan last revised 11/05/24 indicated Resident #4 had an ADL self-care deficit with interventions including staff assistance of one for bathing, personal hygiene, and oral care. Record review of the Documentation Survey Report dated 1/22/25 indicated Resident #4 was scheduled to receive his showers on Mondays, Wednesdays, and Fridays. Record review of Resident #4's shower records indicated: November 2024 he was scheduled for 13 showers and received 8. December 2024 he was scheduled for 13 showers and received 8. During an observation on 1/22/25 at 10:23 a.m. Resident #4 was lying in bed. Resident #4 was observed to have a liquid yellow substance all over his sheets, blankets, gown, and mouth. Resident #4's breakfast tray was sitting on bedside table out of reach of the resident and untouched. During an observation on 1/22/25 at 10:47 a.m. Resident #4 had a liquid yellow substance on his mouth, sheets, gown, and blanket. Breakfast tray was not on his bedside table. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of the face sheet dated 1/22/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, anxiety, hemiplegia (muscle weakness or partial paralysis on one side of the body), cerebral infarction (ischemic stroke), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 11 and was moderately cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with toileting, bathing, and personal hygiene. Record review of the care plan revised 12/15/24 indicated Resident #1 had an ADL self-care deficit with interventions including staff assistance of one for bathing. Record review of a nursing progress note for Resident #1 indicated she was readmitted to the facility on [DATE]. Record review of the Documentation Survey Report dated 1/22/25 indicated Resident #1 was scheduled to receive her showers on Tuesday, Thursdays, and Saturdays. Record review of Resident #1's shower records indicated: January 2025 from January 1-January 12 there are no records of her receiving a shower and from her readmission on January 17-January 22 there were no records of her receiving a shower. During an interview on 1/24/25 at 12:15 pm CNA M said the CNAs were responsible for giving the residents their showers/bed baths and the nurses were responsible for ensuring the CNAs gave the showers/bed baths. CNA M said residents were scheduled for showers/bed baths 3 times a week. CNA M said if a CNA saw a resident was visibly dirty or had spilled something on themselves the CNA should clean the resident up immediately. CNA M said if a resident refused their shower/bed bath they should be reapproached at a later time, the refusal should be documented, and the nurse should be notified. CNA M said the importance of the residents getting cleaned up and receiving their showers/bed baths was for personal hygiene, to make them feel better about themselves, and for infection control. During an interview on 1/24/25 at 12:17 p.m. CNA X said the CNAs were responsible for giving the residents their showers/bed baths. CNA X said residents received showers every other day and as requested. CNA X said if a resident was found dirty or had a yellow liquid substance all over them they should be cleaned up immediately. CNA X said if a resident refused their shower/bed bath they should be reapproached at a later time and the nurse should be notified. CNA X said the importance of ensuring residents received their showers and were cleaned up when need was for hygiene and to better assess for skin issues. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/24/25 at 12:29 p.m. LVN Y said any nursing staff was responsible for giving the residents their showers including nurses and CNAs. LVN Y said the residents were scheduled for showers 3 times a week and received them as needed too. LVN Y said if a resident refused a shower the CNA should notify the nurse, the resident should be reapproached, and if the resident still refused the family and physician should be notified. LVN Y said if a resident was found with a liquid yellow substance all over them the CNA should report it to the nurse as it could be vomit and then clean the resident up. LVN Y said if meal trays were being picked up and a resident was dirty or covered with a liquid substance the resident should be cleaned up before the meal tray was removed. LVN Y said the importance of ensuring residents were cleaned in a timely manner and received their showers was to prevent skin issues. During an interview on 1/24/25 at 12:38 p.m. the Regional Compliance Nurse said she expected residents to receive showers 3 times a week unless they refused. The Regional Compliance Nurse said the CNAs were responsible for giving the showers and the charge nurses were responsible for verifying the showers were given. The Regional Compliance Nurse said if a shower was refused it should be documented. The Regional Compliance Nurse said if a resident was found by a CNA covered in a liquid yellow substance she expected the CNA to report it to the nurse so the nurse could assess the resident and then clean the resident up. The Regional Compliance Nurse said the importance of ensuring residents were clean and received their showers was quality of life. During an interview on 1/24/25 at 1:05 p.m. the Administrator said she expected residents to receive showers 3 times a week and as needed. The Administrator said the importance of residents receiving their showers was for infection control, so the resident feels better, and for respect. Record review of the facility's Bath, Tub/Shower policy dated 2003 indicated, Bathing by tub or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation .The aging skin becomes dry, wrinkled, thinner, and blemished with various aging spots over time and is easily affected by environmental temperature and humidity, sun exposure, soaps, and clothing fabrics. The frequency and type of bathing depends on resident preference, skin condition, tolerance, and energy levels. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 7 (Resident #1) residents reviewed for quality of care. The facility failed to perform neurological assessments following an incident report dated 1/9/25 indicating Resident #1 had a fall and hit her head resulting in her being hospitalized with a subdural hematoma. The facility failed to recognize a change in Resident #1's level of consciousness resulting in the family requesting for Resident #1 to be sent to the hospital and Resident #1 being admitted to the hospital with a diagnosis of a subdural hematoma. The failures resulted in an identification of an Immediate Jeopardy (IJ) at 11:00 a.m. on 1/23/25. While the IJ was removed on 1/24/25, the facility remained out of compliance with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could result in residents with falls not being monitored appropriately or residents a change in condition not being recognized leading to further resident decline, residents not receiving timely treatment, and death. Findings Included: 1. Record review of the face sheet dated 1/22/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, anxiety, hemiplegia (muscle weakness or partial paralysis on one side of the body), cerebral infarction (ischemic stroke), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 11 and was moderately cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with toileting, bathing, and transfers. Record review of the care plan revised 12/15/24 indicated Resident #1 was at risk for falls related to actual continuous falls with a goal of the resident will not sustain serious injury through the review date. Record review of the incident report for Resident #1 date 1/9/25 indicated, This RN found resident on the floor laying on her right her right side and head against the wall. Resident stated, I was trying to walk to the bathroom and fell . vital signs and neuro assessment done due to resident stating she hit her head on the wall, range of motion intact without pain . Record review of the nursing progress note for Resident #1 dated 1/12/25 written by LVN A indicated, family is requesting resident go to ER due to change in [level of consciousness . (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the hospital records dated 1/14/25 indicated Resident #1 was admitted to the hospital on 1/12/25 with diagnoses including subacute subdural hematoma (brain bleed), metabolic encephalopathy (brain disorder that occurs when there is an imbalance of chemicals in the blood), probably secondary to subacute subdural hematoma vs urinary tract infection, and urinary tract infection. During an interview on 1/22/25 at 1:39 p.m. the Regional Compliance Nurse said the facility did not have neuro assessments for Resident #1's fall on 1/9/25. The Regional Compliance Nurse said the nurse who entered the incident report did so incorrectly and the EMR system did not generate for neuro assessments to be completed. The Regional Compliance Nurse said RN B no longer was employed at the facility. The Regional Compliance Nurse said RN B quit after they were questioning her regarding Resident #1's fall on 1/9/25. The Regional Compliance Nurse said RN B was confused about the process of entering the incident report, at first claimed Resident #1 fell , then said it was another resident, and then corrected herself again stating Resident #1 was the resident who had fell . The Regional Compliance Nurse said CNA C was working with RN B on 1/9/25 and was questioned regarding the fall. The Regional Compliance Nurse said CNA C said Resident #1 had a fall and she assisted RN B in getting Resident #1 off the floor. During an interview on 1/22/25 at 2:06 p.m. RN B said she had not been employed at the facility since 1/17/25. RN B said she had resigned from the facility. RN B said she had worked on 1/9/25. RN B said she had a resident fall on 1/9/25. RN B said she thought it was Resident #1. RN B said Resident #1 was in the doorway lying on her right side and Resident #1 stuck out in her mind because she was not aware Resident #1 could move. During an interview on 1/22/25 at 2:12 p.m. the DON said the incident on 1/9/25 was confusing. The DON said she had called RN B regarding the fall. The DON said RN B at first said Resident #1 fell , then said it was the resident across the hall from Resident #1, and then said no, it was Resident #1. During an interview attempt on 1/22/25 at 2:53 p.m. CNA C did not answer the phone and a voicemail was left for her. During an interview on 1/23/25 at 10:10 am the DON said she expected nurses to perform neurological assessments after any head injury, any fall where the resident hit their head or may have hit their head, when a resident had a change in condition not related to their diagnosis that would indicated a neurological issue such as change in behavior or speech. The DON said neurological checks were performed every 15 minutes for an hour, every 30 minutes for an hour, every hour for two hours, every 2 hours for four hours, and then every shift for 48 hours to total 72 hours. During an interview on 1/23/25 at 5:04 p.m. LVN D said she had worked on 1/11/25 and 1/12/25. LVN D said she had assisted in taking care of Resident #1 on 1/11/25. LVN D said she was being trained by LVN A on 1/12/25. LVN D said she had noticed Resident #1 was not responding to her on 1/12/25 the same way she had been on 1/11/25. LVN D said she told LVN A she believed Resident #1 had a change in condition as she was not responding the same way or talking as much. LVN D said LVN A told her Resident #1 did that sometimes and they did not worry about it. LVN D said later in the day on 1/12/25 Resident #1's family came in and were concerned about her change in condition and not happy it had not been addressed. LVN D said Resident #1's family requested she be sent to the hospital. LVN D said at that time Resident #1 was sent to the hospital for evaluation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview attempt on 1/24/25 at 12:05 pm LVN A did not answer the phone and the surveyor was unable to leave a message. Record review of the facility's Neurologic Checks policy last revised May 2016 indicated, Neurologic checks are a combination of objective observations and measurements done to evaluate neurologic status. The results of the checks assist to determine nervous system damage and/or deterioration. The caregiver will identify changes indicating progressive improvement or deterioration in neurologic status. The resident will be free from energy. Procedure 1. Perform handwashing 2. Explain the procedure to the resident based on the ability of the resident to understand the procedure. 3. Become familiar with general physical assessment and history of neurological disorders and conditions affecting mental status. 4. Assess vital signs .5. Asses best eye response .6. Assess best verbal response .7. Assess best motor response .8. Use penlight to check response of pupils to light .9. Check grip of the hand and ability to squeeze hand. Compare grip strength in both hands. 10. Frequency of checks after initial neuro check: every 15 minutes times four, every 30 minutes times two, one-hour times two, every two hours times two, then every shift times 48 hours. 11. All deterioration in neurologic status will be immediately reported to the physician. The nurse will document assessment and the time of physician notification in the clinical record. The Administrator was notified on 1/23/25 at 11:22 a.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 1/23/25 at 11:27 a.m. The facility's Plan of Removal was accepted on 1/23/25 at 2:41 p.m. and included: Plan of Removal On 1/23/25 Resident #1 had a head to toe and neurological assessment completed by the charge nurse. No change in condition noted. Completed 1/23/25. As of 1/23/25 Resident #1's nurse from 1/9/25 is no longer employed with the facility. As of 1/23/25 a neurological assessment was completed on all residents that had an unwitnessed fall or hit their heads within the last 30 days. No changes in condition were identified. This was completed on 1/23/25. The Administrator, DON, ADON, or designee will review all falls during the morning clinical meeting to ensure that all neuro assessments have been completed for all unwitnessed falls or residents who hit their heads. This will start 1/23/25 and continue indefinitely. The Medical Director was notified of the immediate jeopardy on 1/23/25. An ADHOC QAPI was completed on 1/23/25 with medical director and interdisciplinary team to discuss the immediate jeopardy and plan of removal. The Compliance Nurse in-serviced the Administrator, DON, and ADON 1:1 on the following topics below. This was completed on 1/23/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Point Wellness	151 Heritage Springs Drive Bullard, TX 75757

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Abuse and Neglect Policy- failure to complete neurological assessment on residents that suffer an unwitnessed fall or hit their head could be considered neglect. o Fall Prevention Policy- to include neurological assessment for unwitnessed falls or resident who it their head. o Neurological Assessment Policy. o Incident reporting - how and when to complete an incident report with the post assessments to include fall notes and neuro assessments. o Notification of Change in Condition Policy to physician and responsible part for any change in condition. o Documentation - to include User Defined Assessments (UDA), progress notes, 24-hour report, etc. and follow-up for incidents and post incident assessments. The following in-services were initiated by the Regional Compliance nurse, Administrator, DON, and ADON on 1/23/25. Any staff member not present or in-serviced on 1/23/25 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All PRN staff will in-serviced prior to start of their next shift. All agency staff will in-serviced prior to their assignment. All Staff o Abuse and Neglect- failure to complete neurological on residents that suffer an unwitnessed fall could be considered neglect. o Notification of Change in Condition Policy report to a charge nurse for any resident that suffers a fall or change in condition immediately. Licensed Nurses: o Abuse and Neglect Policy- failure to complete neurological on residents that suffer an unwitnessed fall could be considered neglect o Fall Prevention Policy- to include neurological assessment for unwitnessed falls or resident who it their head. o Incident reporting - how and when to complete an incident report with the post assessments to include fall notes and neuro assessments. o Neuros Assessment Policy o Notification of Change in Condition Policy to physician and responsible part for any change in condition. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Documentation - to include UDAs, progress notes, 24-hour report, incident reports, and post incident assessments. On 1/24/25 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review on 1/23/24 of Resident #1's neurologic assessment. Record review of 14 out of 18 residents with unwitnessed falls or that hit their heads in the past 30 days neurologic assessments indicated all neurological exams did not indicate any change in the residents' current condition. Record review of the sign-in sheet for the ADHOC QAPI meeting dated 1/23/25 indicated the facility had a QAPI meeting regarding the above failure. Record review of an undated Payroll Input/Personnel Action Form indicated RN B's last date worked at the facility was 1/15/25. The Payroll Input/Personnel Action Form indicated RN B quit/walked of the job on 1/16/25. During interviews with licensed nurse (the Treatment Nurse, ADON E, LVN F, LVN G, LVN H, RN J, RN K, and LVN D) on 1/23/25 and 1/24/25 between 7:15 a.m. and 4:04 p.m. staff were able to name all types of abuse including physical, verbal, sexual, misappropriation of property, and neglect. Staff interviewed said in the case of reported abuse they would notify the abuse coordinator immediately. Staff interviewed said the abuse coordinator was the Administrator. Staff interviewed said if a resident had a change in condition including a fall the physician should be notified immediately. Staff interviewed said in the event of an unwitnessed fall the resident should be assessed and neuro checks initiated, the physician should be notified, and an incident report should be accessed through the risk management tab in the electronic medical records and completed. Staff interviewed said accessing the incident report through the risk management tab resulted in all necessary UDAs including neuro checks being automatically populated. Staff interviewed said all assessments should be documented in the electronic medical record and all changes in condition, medication, etc. should be documented on the 24-hour report. Staff interviewed said neurological assessments consisted of assessing vital signs, assessing best eye response, assessing best verbal response, assessing best motor response, using a penlight to check response of pupils to light, and checking grip of the hand and ability to squeeze hand including comparing grip strength in both hands. Staff interviewed said frequency of neurologic assessment should be as follows: after initial neuro check: every 15 minutes times four, every 30 minutes times two, one-hour times two, every two hours times two, then every shift times 48 hours. During interviews with staff (CNA M, CNA N, CNA P, CNA R, CNA S, CNA T, CNA V, the Admissions Director, Housekeeper W, and the Social Worker) on 1/24/25 between 10:21 a.m. and 10:45 a.m. staff were able to name all types of abuse including physical, verbal, sexual, misappropriation of property, and neglect. Staff interviewed said in the case of reported abuse they would notify the abuse coordinator immediately. Staff interviewed said the abuse coordinator was the Administrator. Staff said if they noticed a change in condition in a resident, they would report it to the nurse immediately and fill out a Stop and Watch Form (a form used by the facility uses to determine what type of change in condition was observed, who the resident was, who reported the change in condition, and who the change of condition was reported to. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bluebonnet Point Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 151 Heritage Springs Drive Bullard, TX 75757	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/24/25 at 10:45 a.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance the facility remained out of compliance with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

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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 diseases and infections for 2 of 4 staff (CNA M and CNA X) observed for infection control.

The facility failed to ensure CNA M performed hand hygiene between glove changes.

The facility failed to ensure CNA M changed her gloves and performed hand hygiene after picking barrier cream up off the floor and continuing incontinent care.

The facility failed to ensure CNA M did not touch Resident #2's face or swab her mouth after performing incontinent care, not changing gloves, and picking up the trash bag containing the dirty brief and wipes.

The facility failed to ensure CNA X used each disposable wipe only once while providing incontinent care.

The facility failed to ensure CNA X did not put the dirty brief, wipes, and gloves at the end of Resident #3's bed on top of the sheets while performing incontinent care.

The facility failed to ensure CNA X changed gloves and performed hand hygiene after touching the dirty diaper and wipes and then applying barrier cream to Resident #3's vaginal area.

These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building.

Findings Include:

1. During an observation on 1/23/25 at 2:00 p.m. CNA M perform incontinent care on Resident #2. CNA M performed hand hygiene and donned gloves. CNA M gathered a clean brief and wipes. CNA M unfastened and rolled down Resident #2's wet brief, did not change gloves or perform hand hygiene. CNA M cleaned Resident #2's vaginal area with disposable wipes. CNA M rolled Resident #2 to her side, removed the dirty brief, did not change gloves or perform hand hygiene, and cleansed Resident #2's bottom with clean wipes. CNA M retrieved barrier cream from Resident #2's dresser, applied cream to her bottom, then dropped the cream tube in the floor. CNA M removed her gloves, retrieved a clean pair of gloves from Resident #2's dresser drawer, did not perform hand hygiene, picked the barrier cream up off the floor, and donned the clean gloves. CNA M put a clean brief on Resident #2, did not change gloves or perform hand hygiene, adjusted the bed position, touched Resident #2's face with her gloved hand, moved the trash bag containing the dirty brief and wipes, and then swabbed Resident #2's mouth with a moistened sponge swab. CNA M removed her gloves, picked up the trash, exited the room, disposed of the trash, and then performed hand hygiene.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/23/25 at 2:12 p.m. CNA M said hand hygiene should be performed before and after performing care on a resident. CNA M said if something was picked up off the floor hand hygiene should be performed prior to resuming care. CNA M said she did pick up the barrier cream off the floor and did not perform hand hygiene afterwards. CNA M said she did not perform hand hygiene because she was not thinking and was nervous being observed by the surveyor. CNA M said gloves should be changed when they were visibly dirty. CNA M said the importance of proper hand hygiene and changing gloves was infection control. 2. During an observation on 1/24/25 at 10:51 a.m. CNA X performed incontinent care on Resident #3. CNA X provided privacy and explained the procedure prior to beginning incontinent care. CNA X removed tissues from around Resident #3's colostomy bag (a waterproof pouch that collects fecal waste from the body after a surgical procedure called a colostomy). The tissues were observed to have a small amount of brown substance on them. CNA X opened the wet brief. CNA X wiped between the vaginal area and leg with the same wipe twice. CNA X wiped Resident #3's vaginal area with the same wipe 3 times. CNA X wiped Resident #3's vaginal area twice with another wipe. CNA X wrapped the dirty tissues and dirty wipes into the dirty brief and placed the dirty brief on the end of Resident #3's bed. CNA X did not change her gloves or perform hand hygiene. CNA X applied barrier cream to Resident #3's bottom, touched the dirty brief with her gloved hand, and then applied barrier cream to her vaginal area. CNA X put a clean brief on Resident #3, removed her gloves, placed the dirty gloves next to the dirty brief on the end of the bed, and washed her hands. CNA X donned clean gloves and put the dirty brief and dirty gloves in a trash bag to remove from the room. During an interview on 1/24/25 at 11:05 a.m. CNA X said she did not notice if the tissues she removed from around Resident #3's colostomy bag were dirty or not. CNA X said wipes were not supposed to be used more than once. CNA X said she did not know why she used the wipes more than once while providing incontinent care. CNA X the importance of only using each wipe once was to prevent the spread of dirty substances to clean areas. CNA X said hand hygiene should be performed before and after providing care. CNA X said the importance of proper hand hygiene was to prevent spreading germs. CNA X said a dirty brief or dirty gloves should not be left on a resident's bed during care. CNA X said she did not know why she left the dirty brief or dirty gloves on the bed. During an interview on 1/24/25 at 12:26 p.m. the Regional Compliance Nurse said the facility did not have incontinent care or CNA checkoffs for CNA M or CNA X. During an interview on 1/24/25 at 12:38 p.m. the Regional Compliance Nurse said during incontinent care she expected staff to change their gloves and perform hand hygiene when going from dirty to clean. The Regional Compliance Nurse said disposable wipes were not designed to be used more than once during incontinent care. The Regional Compliance Nurse said she expected dirty briefs, dirty wipes, and dirty gloves to be placed in a trash bag and not a resident's bed. The Regional Compliance Nurse said the importance of proper hand hygiene, ensuring dirty supplies were put in a trash bag, and only utilizing disposable wipes once was to prevent cross contamination and for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's Fundamentals of Infection Control Policy dated 2019 indicated, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection and control precautions. 1. Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following list is a list of some situations that require hand hygiene: .Before and after assisting a resident with personal care . Upon and after coming in contact with a resident's intact skin .Before and after assisting a resident with toileting .After contact with a resident's mucous membranes and body fluids or excretions. After handling soiled or used linens, dressing, bedpans, catheters, and urinals .After removing gloves or aprons .Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections . Gloves are worn for three importance reasons. 1. To provide protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and on intact skin .2. To reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident care procedures that involve touching a resident's mucous membranes or nonintact skin. 3. To reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite can transmit these microorganisms to another resident; in the situation, gloves must be changed between resident contacts, and hands washed after gloves are removed. Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves .