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	04/08/2025

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 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** 44637 Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical needs for 1 of 6 residents (Resident #2) reviewed for comprehensive resident centered care plan. The facility failed to ensure Resident #2 was not care planned for a secured unit when the facility did not have a secured unit. This failure could place the residents at increased risk of not having their individual needs met and a decreased quality of life. Findings Included: 1. Record review of the face sheet dated 4/5/25 indicated Resident #2 admitted to the facility on [DATE] with diagnoses including second cervical vertebrae (the second vertebrae in the spinal column, located in the neck region) with routine healing, surgical aftercare, seizures, hypertension (elevate blood pressure), and shortness of breath. Record review of the MDS dated [DATE] indicated Resident #2 understood others and was understood by others. The MDS indicated Resident #2 had a BIMS score of 15 and was cognitively intact. Record review of the care plan revised 2/27/25 indicated Resident #2 resided in the Secure Care Unit, related to diagnosis of dementia (or related diagnosis) and risk for elopement. During an interview on 4/5/25 at 6:54 a.m. the Regional Nurse said the facility did not have a secured unit. The Regional Nurse said the facility did not have any residents that required a secured unit at this time. During an interview on 4/7/25 at 11:29 am the DON said she was ultimately responsible for ensuring care plans were correct. The DON said the facility did not have a secure unit in the facility. The DON she was not aware of any residents that had a care plan to be in a secured unit. The DON said secured units being care planned was not something she had looked at on the care plans as the facility did not have a secured unit. The DON said the importance of the care plans being accurate were so the facility staff knew how to take care of the residents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated Comprehensive Care Planning policy indicated, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with 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 .

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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 - Few	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 observations, interviews, 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 1 of 7 (Resident #1) residents reviewed for ADLs. The facility failed to ensure Resident #1 received incontinent care for an episode of urine incontinence on 4/5/25. These failures could place residents at risk of not receiving services/care and decreased quality of life. Findings Included: 1. Record review of the face sheet dated 4/7/25 indicated Resident #1 was admitted to the facility on [DATE] with diagnoses including overactive bladder, urinary incontinence, muscle weakness, unsteadiness on feet, and difficulty walking. Record review of the quarterly MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 11 and was moderately cognitively impaired. The MDS indicated Resident #1 required substantial/maximum assistance with toileting. The MDS indicated Resident #1 required partial/moderate assistance with transfers. The MDS indicated Resident #1 was occasionally incontinent of urine and frequently incontinent of bowel. Record review of the care plan updated 1/29/25 indicated Resident #1 had ADL self-care performance deficit with interventions including supervision with toileting as needed. During an interview on 4/4/25 at 10:42 a.m. Resident #1 said she was always waiting to get changed. Resident #1 said today was the first time in a while she had breakfast and was not wet from urine. During an interview and observation on 4/5/25 at 8:28 a.m. Resident #1's breakfast tray was sitting on her bedside table. Resident #1 said she was wet all over from an incontinent episode. Resident #1's nightgown was observed being wet in the front. During an observation on 4/5/25 at 8:33 a.m. CNA C assisted Resident #1 out of bed. Resident #1's gown was observed to be wet up to the middle of her back. During an interview on 4/5/25 at 8:49 a.m. CNA C said she did rounds at approximately 6:00 a.m.-6:15 a.m. to check on the residents and ensure they were ok and not on the floor. CNA C said after her first round, she got the residents up who needed to be up for breakfast. CNA C said then she would start her first round before the breakfast trays came out. CNA C said the last time she had checked on Resident #1 was between 6:00 a.m. and 6:15 a.m. CNA C said she had the back half of the hall today and she did not check to see if Resident #1 was wet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/25 at 8:54 a.m. NA D said she did rounds every 2 hours. NA D said when she made rounds, she ensured people were dry, and comfortably positioned. NA D said she did not check to see if Resident #1 was wet when she checked on Resident #1's roommate. NA D said she did not check on Resident #1 because Resident #1 got up and went to the bathroom on her own. During an interview on 4/7/25 at 11:29 am the DON said she expected residents to be checked for incontinent episodes by staff even if the resident was only occasionally incontinent. The DON said the importance of staff checking residents for incontinent episodes was to aide in preventing skin breakdown, for the residents' comfort, and for infection prevention. During an interview on 4/7/25 at 11:45 a.m. the Divisional Director said the facility did not have a specific policy regarding incontinent care. Record review of the facility's Skin Integrity Management dated 2003 indicated, .Skin should be cleansed at the time of soiling and at routine intervals. The frequency of skin cleansing should be individualized according to need and/or resident preference .

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observations, interviews, and record review, the facility failed to ensure necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new pressure injuries from developing was provided for 1 of 4 residents reviewed for pressure injuries (Resident #3). The facility failed to ensure Resident #3 did not develop a stage II pressure injury to the right heel on 3/25/25 and a stage III pressure injury to the right buttock on 4/8/25 that were not present on her admission to the facility. The facility did not ensure Resident #3 was repositioned to effectively alleviate pressure to right buttock on 4/4/25 and 4/5/25. The facility did not ensure Resident #3 was repositioned to effectively alleviate pressure to the right heel on 4/4/25 and 4/5/25. These failures could place residents at risk for new development or worsening of existing pressure injuries, pain, and decreased quality of life. Findings included: Record review of the face sheet dated 4/4/25 indicated Resident #3 was [AGE] years old and admitted to the facility on [DATE] with diagnoses including aftercare following joint replacement surgery, pressure ulcer of the sacral region, pressure injury of the left heel, type II diabetes, and presence of right artificial hip joint. Record review of the admission MDS dated [DATE] indicated Resident #3 usually made herself understood and understood others. The MDS indicated Resident #3 had no cognitive impairment, (BIMS score of 13). The MDS indicated Resident #3 had no behavior of refusing care. The MDS indicated Resident #3 had functional limitation of range of motion to both the extremities of the upper and lower body. The MDS indicated Resident #3 was dependent on staff for repositioning (rolling left and right from her back while in bed; the ability to move from sitting on the side of the bed to lying flat on the bed; and the ability to sit on the side of the side of the bed from laying flat on the bed). The MDS indicated Resident #3 was always incontinent of bowel and bladder. The MDS indicated Resident #3 was at risk for pressure injury and indicated she had 1 unstageable pressure injury presenting as a deep tissue injury (DTI, pressure injury where the underlying tissue, including muscles and subcutaneous tissue, is damaged, but the skin surface may remain intact) that was present on admission and 1 unstageable pressure injury, unstageable due to slough (type of non-viable [dead] tissue that accumulates in a wound. Usually yellowish, grayish, or brownish in color and, often with a stringy or wet consistency) or eschar (type of non-viable tissue covering the wound bed, usually tan, brown, or black in color with a dry, thick, leathery consistency) also present on admission. The MDS indicated Resident #3 received the following skin and ulcer/Injury treatments; pressure reducing device for her bed, pressure ulcer/injury care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #3's the care plan revised on 4/4/25 indicated she had the following identified pressure injuries; Stage II pressure injury (a stage II pressure injury has partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. A stage II pressure injury may also present as an intact or open blister) to the right buttock; a stage II pressure injury to the left buttock; and a stage II pressure injury to the right heel. The care plan interventions included to follow facility policies and protocols for the prevention/treatment of skin breakdown. The care plan also indicated Resident #3 needed assistance to turn/reposition every two hours. The care plan stated Resident #3 was resistant to repositioning. Record review of the physician wound care note dated 3/14/25 indicated Resident #3 had a resolved (healed) sacral DTI and an unstageable DTI to the right heel measuring 0.4 cm in length x 0.5 cm in width. The physician wound care note recommended interventions included; float heels in bed, off load wound, and reposition per facility protocol. Record review of the physician wound care note dated 3/21/25 indicated Resident #3 had an unstageable DTI to the right heel measuring 0.6 cm in length x 0.7 cm in width. The physician wound care note recommended interventions included; float heels in bed, off load wound, and reposition per facility protocol. Record review of the physician wound care note dated 3/25/25 indicated Resident #3 had an unstageable DTI to the right heel measuring 1.2 cm in length x 2.2 cm in width. The physician wound care note recommended interventions included; float heels in bed, off load wound, and reposition per facility protocol. Record review of the physician wound care note dated 4/1/25 indicated Resident #3 had an unstageable DTI to the right heel measuring 1.0 cm in length x 0.5 in width. The physician wound care note recommended interventions included; float heels in bed, off load wound, and reposition per facility protocol. Record review of Resident #3's nursing skin assessment on 4/3/25 indicated she had a pressure injury measuring 1.3 x1.2 x0.2 to the right buttock and was described as an open area. During an interview and observation on 4/4/25 at 10:10 am Resident #3 was laid in a semi- [NAME] (reclined position at approximately a 30- to- 45- degree angle) in her bed. Resident #3 had a wedge positioned to the lower back of the left side. Her buttock was on the surface of the mattress. Both her right and left heels laid on the surface of the mattress. Resident #3 said she could only barely lift her heels from the bed without assistance. Resident #3 tried to demonstrate to the state surveyor lifting the left then right heel off the surface of the bed. Resident #3 slightly elevated the left heel approximately 1 cm off the surface of the mattress. Resident #3 did not effectively raise the right heel from the surface of the mattress. Resident #3 said she could not turn side to side by herself in the bed. Resident #3 indicated no one had attempted to move her in the bed yet today. During an interview and observation on 4/4/25 at 12:40 p.m., Resident #3 remained in the semi- [NAME] (reclined position at approximately a 30- to- 45- degree angle) in her bed. Resident #3 had a wedge positioned to the lower back of the left side. Her buttock was on the surface of the mattress. Both her right and left heels laid on the surface of the mattress . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/4/25 at 2:13 pm CNA E indicated she regularly worked the hall Resident #3 resided on. CNA E said she rounded on residents every 2 hours. CNA E was asked what care she provided during those rounds. CNA E did not mention repositioning or alleviating pressure areas of dependent residents. During an interview and observation on 4/4/25 at 2:30 p.m., Resident #3's family member was sitting in Resident #3's room. Resident #3 remained in the semi- [NAME] (reclined position at approximately a 30-to-45-degree angle) in her bed. Resident #3 had a wedge positioned to the lower back of the left side. Her buttock was on the surface of the mattress. Resident #3 had a very small wedge under the right ankle. Resident #3's heel laid on the surface of the mattress. Resident #3's family member said she had placed that wedge under Resident #3's ankle to try to get her heel off of the bed. Resident #3's family member said she had a wound to the right heel. Resident #3's family member said she brought the wedge to the facility because the facility staff were not raising her heels off of the bed and she thought bringing the wedge would help. Resident #3's family member stated she came regularly to the facility to see Resident #3 and stayed for several hours at a time and never would see the facility staff reposition Resident #3 . Resident #3's family member said she voiced her concerns regarding Resident #3 needing to be repositioned to alleviate pressure to her buttock and heels but could not provide names of staff or specific dates and times. During an observation on 4/5/25 at 7:40 a.m., Resident #3 laid in her bed. Resident #3 had a wedge positioned to the lower back of the left side. Her buttock was on the surface of the mattress. A pillow was under her calves but both her right and left heels laid on the surface of the mattress . During an interview and observation on 4/5/25 at 10:00 a.m., Resident #3 laid in in her bed. Resident #3 had a wedge positioned to the lower back of the left side. Her buttock was on the surface of the mattress. A pillow was under her calves but both her right and left heels laid on the surface of the mattress. Resident #3 indicated no staff had attempted to reposition her. During an observation on 4/8/25 at 12:15 p.m., Resident #3 was assessed by the LVN F and the wound care physician. The wound to Resident # 3's right heel was bright red with a dry blister. The wound care physician said the right heel wound was a stage II pressure injury. Resident #3 was rolled to the left lateral side while in her bed. Resident #3 had red open area to the right buttock. The wound care physician said the wound was a stage III pressure injury. Resident #3 also had an additional area to the buttock measuring 0.7 cm in length x 0.1 cm in width below the stage III pressure area. The wound care physician stated the intact discolored skin below the stage III pressure injury was a DTI. During an interview on 4/8/25 at 12:25 p.m., LVN F said it was very important to ensure Resident #3's buttock and heels were positioned to alleviate pressure from those areas in order to promote wound healing and prevent deterioration of, and/ or the development of new pressure wounds. LVN F said residents should be repositioned every 2 hours by nursing staff (CNAs and nurses). During an interview on 4/8/25 at 1:00 p.m., the DON said nursing staff (CNAs and nurses) should ensure repositioning was attempted every 2 hours in order to prevent pressure injuries from getting worse as well as prevent the development of new pressure injuries. During an interview on 4/8/25 at 1:10 p.m., the Administrator said it was important for residents to be repositioned to prevent the development of pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility policy and procedure titled Pressure Injury: Prevention, Assessment and Treatment revised 8/12/16, stated, Procedure: Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection . (6.) Nursing Action/Rationale: Prevention: The nurse can assist in the prevention of pressure injuries by performing the following nursing interventions .Add any interventions to care plan. (1.) Determine resident' s skill tolerance to pressure and develop a turning schedule; residents should be turned every two (2) hours or more often if necessary and notify the Treatment Nurse/designee of any potential problems. (2.) Do the blanching test by pressing the finger into a reddened area, a normal blood supply to the reddened area is seen when the area blanches white and then turns pink again. If the area remains red, a pressure sore is impending due to impaired circulation, keep resident off the area for 24 hours and then repeat the test .(5.) Maintain body alignment with support for body parts; pillows, cradles, pads, heel/elbow protectors, and mattresses can be used to help relieve pressure .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44637 Based on observations, interviews, and record review, in accordance with State and Federal laws, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys on 3 of 7 medication carts reviewed for labeling and storage of medication. The facility did not ensure the medication cart on hall 200 and 2 medication carts on hall 300 were secured and unable to be accessed by unauthorized personnel. This failure could place residents at risk for not receiving drugs and biologicals as needed or a drug diversion. Findings included: 1. During an observation on 4/5/25 at 5:08 a.m. the medication cart on the 200 Hall was in the middle of the hallway unlocked with the keys lying on top of the cart and no staff nearby. During an interview on 4/5/25 at 5:10 a.m. LVN A said she was the nurse for the 200 Hall. LVN A said she did not always leave her medication cart unlocked with the keys on top of the cart. LVN A said a CNA had called her into a resident room to assist with a mechanical lift transfer (uses specialized equipment to safely lift and move individuals who cannot safely bear weight) and she walked away from the medication cart leaving it unlocked and the keys lying on top of the cart. LVN A said the importance of ensuring the medication carts were locked and the keys were secure was to keep the medications and the residents safe. 2. During an observation on 4/5/25 at 5:12 a.m. the medication cart on the 300 Hall was unlocked. RN B walked by the unlocked cart and did not lock the cart. 3. During an observation on 4/5/25 at 5:13 a.m. The second medication cart on the 300 Hall was unlocked. A staff member walked past the cart and did not lock the cart. During an interview on 4/5/25 at 5:14 a.m. RN B said she was the nurse for the 300 Hall. RN B said she did not always leave her medication carts unlocked. RN B said she had gone to get trash bags and had just finished passing her morning medications. RN B said the importance of ensuring medication carts were locked was so the residents could not get into the medications and take something not prescribed to them. During an interview on 4/7/25 at 11:29 am the DON said she expected the nurses and the MAs to keep their medication carts locked at all times unless they were pulling medications from the cart. The DON said the importance of keeping the medication cart locked was to prevent drug diversion and to prevent residents from getting in the cart and possibly taking the incorrect medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Storage of Medication policy dated 2003 indicated, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .Medication rooms, carts, and medication supplies are locked and attended by persons with authorized access.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44637 Based on observations, interviews, 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 1 of 4 staff (CNA C) observed for infection control. The facility failed to ensure CNA C changed gloves and performed hand hygiene while performing incontinent care on Resident #1. This failure could place residents and staff at risk for cross-contamination, spread of infection, and could potentially affect all others in the building. Findings included: 1. During an observation on 4/5/25 at 8:33 a.m. CNA C entered Resident #1's room without performing hand hygiene. CNA C stopped at Resident #1's roommate's bed, laid gloves on the bed, and adjusted something on the bed rail. CNA C picked up the gloves, did not perform hand hygiene, and put the clean gloves on. CNA C went to the Resident #1's chest and removed a clean gown and socks. CNA C assisted Resident #1 out of bed. Resident #1's gown was observed to be wet up to the middle of her back. CNA C did not remove her gloves or perform hand hygiene. CNA C pushed Resident #1 in her wheelchair to the bathroom. CNA C did not change gloves or perform hand hygiene and left the bathroom to get wipes. CNA C removed Resident #1's wet brief and took off her gown. CNA C did not change gloves or perform hand hygiene. CNA C moved Resident #1's clean clothes off the wheelchair and retrieved a clean brief out of storage drawer in bathroom. CNA C dried the urine off Resident #1 and did not change gloves or perform hand hygiene. CNA C put a clean gown on Resident #1, used clean wipes to wipe Resident #1's bottom, took her own glasses off her face, and continued to wipe Resident #1's bottom using clean wipes. CNA C put a clean brief on Resident #1, removed her gloves, and did not perform hand hygiene. CNA C left the room to get barrier cream, returned to the bathroom, put on clean gloves, and applied barrier cream to Resident #1's bottom. CNA C did not change gloves or perform hand hygiene. CNA C pulled up Resident #1's brief and assisted her to the wheelchair. CNA C removed her gloves and did not perform hand hygiene. CNA C pushed Resident #1 in the wheelchair back to her side of the room. CNA C put on gloves, bagged up the wet linens and clothing, removed her gloves, and did not perform hand hygiene. During an interview on 4/5/25 at 10:14 a.m. CNA C said hand hygiene should be performed after removing gloves and before putting on clean gloves. CNA C said gloves should be changed when going from dirty to clean, after applying cream, if gloves were visibly soiled, and when changing tasks. CNA C said she should have changed her gloves and performed hand hygiene after several steps when providing care for Resident #1. CNA C said she should not have used the gloves she set on Resident #1' roommate's bed when providing Resident #1's care. CNA C said the importance of proper glove changes and hand hygiene was to prevent the spread of bacteria and contamination. (continued on next page)

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	676494	A. Building B. Wing	04/08/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/25 at 11:29 am the DON said hand hygiene should be performed when entering and exiting a resident room, between glove changes, and when going from clean to dirty. The DON said the importance of proper glove changes and hand hygiene was to prevent infections and the spread of bacteria. Record review of the facility's Fundamentals of Infection Control Precautions last revised 3/2024 indicated, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. The measures make up the fundamentals of the infection control precautions. Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: .Before and after assisting a resident with personal care .Before and after assisting a resident with toileting .After contact with a resident's mucous membranes or bodily fluids or excretions .After removing gloves or aprons .Consistent use by staff of proper hand hygiene practices and techniques is critical to preventing the spread of infections .Gloves are worn for three important reasons: To provide a protective barrier and prevent cross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and nonintact skin. The wearing of gloves in specific circumstances will reduce the risk of exposures to blood borne pathogens and is mandatory for all employees .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. Failure to change gloves between resident contacts is an infection control hazard.