

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  07/11/2025
NAME OF PROVIDER OR SUPPLIER  Bluebonnet Point Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.  (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure the resident was oriented with a planned, safe and orderly discharge for 1 of 5 residents reviewed for discharge (Resident #3). Resident # 3 was discharged to the hospital, the facility refused to take him back due to nonpayment. Resident # 3 resided at the hospital for over 30 days until the hospital was able to find placement. This Failure could place residents at risk of not permitting a safe and orderly discharge Findings included: During an interview on 6/30/25 at 11:42 a.m. the Administrator said there were no records for Resident #3 in their computer system, because he was discharged out of the system prior to their change of ownership on 7/1/24. She said she had to go to the hospital after she started working at the facility because the facility had been blacklisted and the hospital would not refer any residents to them. She said the hospital was upset because the former owners had dumped Resident #3 and refused to take him back. She said she would request Resident # 3's records from the prior facility owners. Record review of Resident # 3's face sheet indicated he was an [AGE] year-old male admitted to the facility on [DATE]. He had diagnoses of anxiety disorder, paralysis affecting the right dominant side, adjustment disorder, diabetes, right leg above the knee amputation, need for personal care assistance, age related cognitive decline, and housing instability, housed with risk of homelessness. Record review of Resident #3's discharge MDS dated [DATE] indicated it was an unplanned discharge to a short-term general hospital with a discharge date of 6/10/24. Record review of a 30-day notice dated 12/29/23 indicated Resident # 3 had failed after reasonable notice to pay under Medicare or Medicaid to stay at the facility. His effective date of discharge was 1/29/24. Record review of Resident #3's petition for Eviction indicated the grounds for eviction was unpaid rent as of December 2023 amounting to \$18,330.00. The notice to vacate was hand delivered. The notice was filed at the county court on 3/26/24. Record review of Resident #3's nursing notes dated 6/10/24 at 1:25 a.m. indicated the resident complained of shortness of breath with oxygen status fluctuating between 90 to 92. He was sent to the hospital. Record review of social services notes dated 6/11/15 at 11:00 a.m. indicated Resident #3 was discharged and would not return per eviction notice served on 4/18/24 for nonpayment. His family was notified to pick up his belonging, and Adult Protective Services was notified. Record review of Resident #3's nursing notes from 5/30/24 until discharge on [DATE] did not indicate any discharge actions in place. Record review of Resident # 3's hospital records indicated he was admitted to the hospital on [DATE] due to shortness of breath. Record Review of the hospital Social Worker note dated 7/19/24 indicated they had made approximately 35 referrals for Resident # 3's discharge with 12 referrals being denied out right and 26 pending during his admission. The records indicated the facility his admitting facility refused to take him back. Resident #3 was discharged from the hospital on 7/19/24 to another facility. During an interview on 7/9/25 at 10:24 a.m. the Social Worker said she worked at the facility for two years. She said she had been trying to get Resident #3 discharged from the facility due to nonpayment prior to 6/10/24. The Social Worker said he did not want to go anywhere and did not want to provide any financial paperwork to apply for Medicaid. The Social Worker said Resident # 3 was getting some kind of money, he had Medicaid but lost in 2023 because he was overcompensated. She said he paid \$12, 000 for a van that he could not drive, she said he could not walk. She said the facility had given him a 30-day discharge notice at one time, but they could not get him to leave. The Social Worker said the former owners of the facility had taken him to court and gotten an eviction notice. She said she had never seen an eviction notice at a nursing facility before. The Social Worker said they had given him the eviction notice back in April of 2024 and she thought Resident #3 had gone over the time of his eviction. The Social Worker said she thought they contacted the Deputy, but no one came to evict Resident # 3. She said Resident # 3 had gone to the hospital 6/10/24 and the hospital called and said he needed to come back. She said the former Administrator talked to the hospital and told them the facility was not taking Resident #3 back. She said the hospital was upset and pulled out their Medical Director, NP, and the hospital stopped sending them admissions. She said Resident #3 had to stay in the hospital for over 30 days because the hospital could not find placement for him. She said she called the family to come and get his things, but it took them over a week to come and get Resident # 3's things after he was discharged from the facility on 6/10/25. During an interview on 7/9/25 at 11:15 a.m. the Ombudsman said she was not aware of Resident 3's discharge and was not involved. During an interview on 7/11/25 at 8:50 a.m. the Administrator and Regional Compliance Nurse said they had not put any corrective measures in place regarding Resident # 3's</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review the facility failed to ensure a resident environment remained as free of accident hazards as is possible for 1 of 3 residents reviewed for accidents (Resident #1) Resident #1 asked for hot water, MA A heated the water in the microwave and did not place a lid on the cup. Resident #1 spilled the water and received a burn on her leg. The facility failed to have measures in place to prevent residents from burns. The noncompliance was identified as Immediate Jeopardy PNC (past non-compliance). The IJ (Immediate Jeopardy) began on 9/1/24 and ended on 9/10/24. The facility had corrected the noncompliance before the survey began. This failure could place resident at risk of suffering, injuries, and hospitalization. Findings included: Record review of Resident #1's face sheet dated 7/11/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses were Cervical disc disorder with myelopathy (compressed cervical spine with a potential for problems with fine motor skills, balance, and walking). Record review of Resident #1's quarterly MDS dated [DATE] indicated a BIMS score of 12 (moderate cognitive impairment). Resident #1 had functional limited range of motion on one side of the upper extremity. The assessment indicated that for eating, Resident #1 required substantial to maximal assist, with the helper providing more than half the effort. Record review of Resident #1's care plan dated 9/1/24 indicated she was at risk for burns due to hot liquids. Some of the interventions were coffee and other hot liquids should not be served if over 140-degree, the resident was to use a cup with a lid, and use dominate hand for drinking. Record review of Resident #1's nursing notes dated 9/1/24 indicated the following: *at 10:40 a.m. indicated the resident notified staff of spilling chicken broth in her lap. The skin assessment completed at that time had findings of a scald marks measuring 15 cm long and 1 cm wide at the widest point. Vaseline was applied to the area, and the resident denied pain at this time. The responsible party and the physician were notified. *At 11:41 a.m. indicated the physician gave an order for Silvadene cream to be applied two times daily to the right medial thigh until resolved. *At 1:25 p.m. indicated reassessed burn to the right medial thigh *At 1:00 p.m. indicated A blister was noted to be forming to the superior portion of the original scald mark measuring 1.5 cm x 0.9cm. Record review of Resident #1's first hot liquid assessment dated [DATE] indicated she had a loss of mobility /reduced movement to the upper extremities. Resident #1 could not consume hot liquids without interventions. She required lids on cups to reduce the potential for burns with coffee or hot liquids. Record Review of a facility Provider Investigation Report indicated on 9/1/24 around 10:50 a.m. Resident #1 asked MA A for some hot water for some chicken broth. The aide provided the hot water, and the resident spilled her chicken broth in her lap. Record review of a written statement from MA A indicated on 9/1/24 Resident #1 requested hot water. The MA said she heated the water in the microwave and took it back to Resident #1's room. She said the resident put a cube of stock in the cup and stirred it up and took a sip. The MA said she exited the room, and a short time later Resident #1 came to the nurse's station with an empty cup stating she had spilled the hot liquid on her thighs. MA A said at that time Resident #1 said she usually had a lid on her cups to prevent spills. The MA said she had not known Resident #1 used lids for her cups. Record review of a written statement from RN B indicated on 9/1/24 at about 10:50 a.m. Resident #1 wheeled herself to the nursing station. Resident #1 said she spilled chicken broth in her lap. A skin assessment was done at that time and the burn was found to the right medial thigh measuring 15 cm x 1 cm. The resident stated when she picked up the mug with the broth in it the mug slipped from her fingers and spilled on her lap and on the floor. The resident stated she did not have a lid for her mug. The physician was notified and ordered Silvadene ointment twice a day until resolved. At 1:00 p.m. the resident was reassessed and had a blister measuring 1.5 cm x 0.9 cm noted to the superior portion of the burn. Aides and CNAs were instructed this resident needed a lid on all cups of hot liquids. During an interview on 6/30/25 at 10:30 a.m. Resident #1 said a long time ago, she spilled hot water on her lap, and it burned her leg. She said the cup just slipped and the cup of hot water spilled onto her lap. She said she could not feel it at the time but told the nurse. She said she asked the MA to bring her some hot water to make her broth. She said the MA heated the water in the microwave and brought it to her. She said since then, the facility had removed the microwaves, and they cannot use them anymore. During an interview on 7/10/25 at 12:22 p.m. the Regional Compliance Nurse said their company took over the facility 7/01/24. She said when they first took over the building there were microwaves available throughout the building. She said after the incident with Resident #1 they removed all the microwaves from nutrition rooms. They placed only</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents reviewed for medications (Resident #2). The facility failed to follow their policy on medication administration resulting in a significant medication error. *Resident #2 was readmitted [DATE] and had an order on 12/22/24 for Eliquis to be held until 12/27/24- the order did not have a restart date. *Resident #2 had an order on 12/23/24 to hold Eliquis for 4 days and restart the medication on 12/27/24. *The facility did not resume Resident #2's Eliquis medication and he was sent to the hospital on 1/26/25 with DVT and pulmonary embolism. The noncompliance was identified as Immediate Jeopardy PNC (past non-compliance). The IJ (Immediate Jeopardy) began on 1/26/25 and ended on 2/28/25. The facility had corrected the noncompliance before the survey began. This failure could jeopardized resident health and could have been terminal. Findings Included: Record review of Resident#2's face sheet dated 1/28/25 indicated he was an [AGE] year-old male admitted to the facility 2/13/23. He had diagnoses of Hemorrhage of anus and rectum, history of pulmonary embolism, and chronic embolism and thrombosis of deep veins of left lower extremity. Record review of Resident #2's quarterly MDS dated [DATE] indicated a BIMS score of 13(cognitively intact). His functional limitation in range of motion indicated he had impairment on both sides of his lower extremities and used a wheelchair for mobility. Record review of Resident #2's care plan dated 7/2/24 indicted a focus area of anticoagulant(Eliquis-mediation used to prevent and treat blood clots in the blood vessels and the heart) therapy. An intervention was to monitor, document and report to the physician, signs and symptoms of anticoagulant complications. Record review of Resident #2's computerized physician an order dated 6/28/24 indicated an order for Eliquis 5mg to give one tablet by mouth two times a day related to personal history of pulmonary embolism. Record review of Resident #2's nursing notes dated 12/20/24 at 3:21 a.m. indicated he was transferred to the hospital. Record review of Resident #2's nursing notes dated 12/21/24 indicated the following: *at 4:32 a.m. indicated Resident #2 returned to the facility. *At 4:54 p.m. the report from the hospital nurse indicated Resident #2 was schedule for a polyp removal and to hold Eliquis for 6 days. *At 8:00 p.m. indicated to hold the Eliquis until 12/27/24. Record review of Resident #2's physician orders indicated an order dated 12/22/24 indicated to place the medication on hold on 12/27/24 with no duration or start date. Record review of Resident #2's physician order dated 12/23/24 indicated place the Eliquis on hold from 12/23/24 with a duration of 4 days and restart on 12/27/24. Record review of Resident #2's December 2024 MAR revealed Eliquis oral table 5mg by mouth two times a day. The MAR indicated on 12/20/24 the resident was hospitalized and from 12/21/24 the medication was on hold through 12/31/24. Record review of Resident #2's MAR for January 2025 revealed Eliquis oral table 5mg by mouth two times daily was not administered and was on hold until 1/29/25. During an interview on 7/11/25 at 9:15 a.m. the Regional Compliance Nurse said the two orders for Resident #2's Eliquis canceled each other out. She said the facility computer system would automatically rerestart medications that were on hold. However, the order written on 12/23/24 said to restart the medications on 12/27/24 and that order ended on 12/27/24 at 12:00 a. m. She said the 12/22/24 order placed the Eliquis on hold starting 12/27/24 and began on 12/27/24 at 12:00 a.m. That was why the medication were placed on hold indefinitely. The Regional Compliance Nurse said the 12/22/24 order did not indicate a duration or a restart date. Record review of Resident #2's hospital records dated 1/26/25 indicated he was admitted with diagnosis of noncompliant with Eliquis. Resident #2 presented to the hospital with syncope, he was found to have symptomatic acute pulmonary embolism with right ventricular strain and right DVT requiring mechanical thrombectomy (surgical intervention to remove blood clots) and transition to Eliquis. Record review of the facility Self-Reporting Protocol /Ad Hoc QAPI- Neglect-Medication Error Resulting in Harm. indicated the following:* conducted an audit to determine if any other residents were affected. *An abuse and neglect in-service for all staff to include failure to administer medications as ordered by the physician can be considered neglect. *Staff were in serviced on notification of a change in condition to include reporting change of condition to the nurse. *An in-service was conducted on following MD orders for all nurses to include how to place a medication on hold and add stop/start dates to the physician orders. *An in-service was conducted on Medication Administration policy to include the ensure medications were given correctly. *A medication error policy in-service was conducted with Mas and all nurses to include notification of the physician. *An in service was conducted on medication reconciliation for all nurses to include medication review upon admission and readmission to reduce the incidence of</p>		