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	01/15/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for 1 of 3 residents reviewed for dignity. (Resident #2) The facility failed to ensure Resident #2 was treated with dignity and respect when LVN A told him he was acting like a 2-year-old. This failure placed residents at risk for diminished quality of life, loss of dignity and decrease in comfort. Findings include: Record review of the undated face sheet indicated Resident #2 was a [AGE] year-old male that admitted [DATE].Record review of the physician's orders dated 1/14/26 indicated Resident #2 had diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (impairments on one side of the body due to brain cell death from interrupted blood flow, a stroke), Bell's Palsy (a sudden temporary facial paralysis or weakness on one side of the face caused by inflammation or damage to the facial nerve), and Type 2 Diabetes (high blood sugar and lack of insulin). Record review of the quarterly MDS dated [DATE] indicated Resident #2 had minimal difficulty hearing, usually understood others and was usually understood by others. The MDS indicated he had a BIMS of 15 indicating he was cognitively intact. Record review of an undated care plan indicated Resident #2 had hemiplegia/hemiparesis related to a stroke. The care plan indicated his stroke was related to heart disease. Resident #2 had impaired cognitive function/dementia or impaired thought processes and problems communicating. The PIR provided to the state authority indicated family had reported to the ADM on 1/4/26 LVN A had spoken to Resident #2 in a demeaning manner stating, You are acting like a 2-year-old. This was a video recording. During an interview on 1/14/26 at 8:15 AM, the ADM said LVN A was suspended, was termed on Monday (1/12/26) after the investigation. She said LVN A admitted to saying Stop acting like a child or a 2-year-old or something similar. She said it was a condescending thing to say. She said Resident #2 did not have any lingering effects from her saying that to him. She said she believed it was a dignity issue. The ADM said she did not feel like LVN A was abusive but was discourteous and disrespectful. Record review of LVN A's personnel file indicated an Employee Disciplinary Report dated 1/5/26 revealed LVN A hired on 8/6/25 as a charge nurse and was suspended 1/5/26 due to suspicion of verbal abuse (LVN A to Resident #2) on 1/4/26. She was termed on 1/12/26. During an observation and interview on 1/14/26 at 9:36 AM, revealed Resident #2 was in his room in bed. He was slow to speak. He said a staff had been rude to him. He could not say what she said. The resident was asked if she said he was acting like a child, or a 2-year-old. He said yes that was close to what she said but he did not remember word for word. He said he felt about that tall. and indicated by moving his index finger to his thumb with approximately 3 inches in between. The surveyor asked, Small? He said Yes. He said, other than that, everyone was very kind to him. He said once the incident was over, he did not care about it anymore. He said he felt small at the time it happened but felt good about (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	himself now. During an interview on 1/14/26 at 10:37 AM, the RCN said the ADM told her, on the video LVN A was trying to get Resident #2's blood pressure or something. She said he was probably giving her a hard time. Resident #2 would pick and play, and staff had to talk him through what they needed to do. She said she had not seen the video. The ADM told her LVN A's comment was demeaning and condescending. The RNC said LVN A said she probably said that. The RCN said LVN A had a gruff personality. She said it was a dignity issue, and she should not have said that because it could affect his dignity and make him feel bad about himself. That was why she was termed. During a telephone interview on 1/14/26 at 12:00 PM, LVN A said she did tell Resident #2 to stop acting like a child, or a 2-year-old or something like that; but when you have to constantly ask to care for a resident and they are moving around and not allowing you to do what you need to, they are acting like a child. She said it might have been wrong to say but it was not abuse, it was what he was doing. She would not talk to the surveyor anymore. During an observation on 1/14/26 at 1:26 PM, the ADM showed this surveyor a video on her computer dated 1/4/26. LVN A was attempting to get Resident #2's blood pressure as he was moving and grabbing at an item appearing to be the TV remote. LVN A was asking him to be still. Resident #2 continued wiggling and LVN A said You are acting like a 2-year-old. Nothing else was said. LVN A removed the blood pressure cuff and left the room. During an interview on 1/15/26 at 10:07 AM, RN F said if she heard a staff tell a resident they were acting like a 2-year-old she would immediately remove the staff from the room. She would then report it the Abuse Coordinator/ADM. She said that was definitely a dignity issue. During an interview on 1/15/26 at10:44 AM, CNA H said it would be completely wrong for a staff to tell a resident they were acting like a child or a 2-year-old. She said that was verbal abuse and had to be reported to the ADM/Abuse Coordinator. She said anything like that had to be reported. During an interview on 1/15/26 at10:47 AM, the ADON said if a staff told a resident they were acting like a 2-year-old, or a child that should be reported to the ADM immediately because it could be a dignity issue. During an interview on 1/15/26 at 11: 09, the SW said she was not on shift when LVN A told Resident #2 he was acting like a child/2-year-old. She said she viewed the video tape. She said it could have been a dignity issue and did not believe it was abuse. Some people just did not know how to talk to people. LVN A did not have a hateful tone when she said that, she was just very direct. She said she spoke with Resident #2 and he said he had no concerns about the incident with LVN A and he did not need to talk about it. He told her he was ok and had no problems. She said she did not believe he had any lasting effects. Record review of a trauma assessment for Resident #2 dated 1/5/25 indicated he had no issues or effects. Record review of an undated resident rights policy indicated: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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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** Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative where there was a significant change in the resident's physical, mental, or psychosocial status and when there was a need to alter treatment significantly for 1 of 2 residents (Resident #1) reviewed for enteral nutrition. The facility failed to notify Resident #1's attending physician when her tube feeding was stopped early due to her diarrhea. The facility failed to notify Resident #1's attending physician when her tube feeding was held due to diarrhea. These failures could place residents at risk for delayed treatment, not receiving necessary treatments and medications, and a decreased quality of life. Findings included: Record review of the undated face sheet indicated Resident #1 was a [AGE] year-old female that admitted [DATE] and readmitted [DATE]. Record review of the physician's orders dated 1/14/26 indicated Resident #1 had diagnoses that included: Hemiplegia (paralysis of one side of the body), Cerebral Infarction (brain tissue death caused by a blockage in a blood vessel cutting off oxygen and nutrients), Dementia (severe memory, thinking, and reasoning decline that interferes with daily life, caused by diseases damaging brain cells), and gastrostomy status (a surgically created opening into the stomach for a feeding tube to provide nutrition, fluids, or medication). The physician's orders indicated: 12/16/25 Glucerna 1.2 at 65 ml/hr with water flush of 50 ml/hr. Record review of the quarterly MDS dated [DATE] indicated Resident #1 had unclear speech, usually understood others, and was usually understood by others. Resident #1 had a BIMS of 2 indicating severe cognitive impairment. She had a feeding tube. Record review of the undated care plan indicated Resident #1 had hemiplegia and weakness on her right side related to a stroke, impaired cognitive function/dementia or impaired thought processes, and required tube feeding. Record review of the facility PIR dated 12/23/25 indicated on 12/23/25 Resident #1's family called the ADM and was questioning whether the tube feeding was provided on the night shift. RN C reported she did not administer Resident #1's feeding on 12/22/25 due to her diarrhea and stopped the feeding early the prior night 12/21/25 for the same reason. CNA E's statement was consistent with RN C's account that Resident #1 was experiencing multiple bouts of diarrhea since beginning her new tube feeding. CNA E did not see a tube feeding bag hung or running on the night shift 12/22/25 - 12/23/25.RN C used clinical judgement based on Resident #1's status believing the tube feeding should be held due to diarrhea. However, she failed to follow facility policy/procedures related to medication/treatment administration and reporting on residents experiencing a change of condition. On 12/23/25 RN C was suspended pending investigation. Record review of a statement given by CNA E indicated she did not see a feeding tube running at all during her shift 12/22/25 at 10:00 PM -12/23/25 at 6:00 AM (her shift) and Resident #1 told her she was not in pain. Record review of Resident #1's progress notes 12/21/25 - 12/23/25 indicated RN C did not document anything regarding her diarrhea or tube feeding. There was no documentation of notification to the MD/NP. The progress notes dated 12/19/25 - 12/23/25 did not indicate any staff had documented Resident #1 had diarrhea or that any tube feedings had been stopped or held. There was no documentation of notification to the MD/NP. During an interview on 1/14/26 at 8:15 AM, the ADM said Resident #1's family had a camera in her room that was motion controlled. They reported they did not see her feeding hanging on the pole the evening/night of 12/22/25 or the early morning of 12/23/25. Resident #1 was new to tube feeding and had diarrhea. The ADM said RN C ended Resident #1's tube feeding early on 12/21/25 because the resident had diarrhea, then withheld the tube feeding the following night (12/22/25) and did not follow the procedure (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for notifying the MD, or documenting anything about her diarrhea, stopping the feeding early on 12/21/26 or holding the feeding on 12/22/26. During an observation and interview on 1/14/26 at 9:46 AM, revealed Resident #1 was bed, positioned with pillows. The head of the bed was up approximately 40 degrees. There was a sign in her room indicating NPO. Resident #1 was asked if staff was nice to her and she said Yeah. She said staff was kind. She then closed her eyes and turned her head. She had feeding tube supplies in her room. During an interview on 1/14/26 at 10:37 AM, the RCN said Resident #1's family reported on 12/23/25 that her feeding had not been hooked up. They suspended RN C pending the investigation. When they called the RN C in to talk with her, RN C said Resident #1 was a new g-tube (returned from the hospital with it in 12/15/25 or 12/16/25). RN C said Resident #1 was having diarrhea. The RCN said Resident #1 had bolus (a large single meal of liquid formula over a short period of time), feedings during the day and a continuous feeding at night. RN C did not document Resident #1 was having diarrhea or notify the MD and that was a problem. The RCN said the CNA at the time corroborated Resident #1 was having diarrhea. Resident #1 had labs drawn every Monday. They let the NP know Resident #1 had missed a feeding on 12/22/25 and had a feeding stopped early on 12/21/25. The NP reviewed Resident #1's labs from 12/22/25 and she felt like she might be getting too much water and decreased her water flushes. There were no changes with her skin. RN C said the night before (12/21/25) she had stopped the feeding early. She said the resident missed one feeding on 12/22/25 that should have started at 10:00 PM and run until 6:00 AM. RN C did not call the MD, she held the feeding on her own. She did not document anything regarding Resident #1's diarrhea or holding her feeding. She said it was a problem because the feeding was ordered for nutrition and hydration. Holding the feeding could lead to dehydration and poor nutrition. She said the RN C did not let anyone know. RN C documented she gave the nighttime feeding, but they know she did not because she told them she did not. RN C said the documentation was a mistake, she clicked it off but said it was marked in error, and she meant to document it as not administered. The RCN said RN C should have contacted the MD and notified her of the change with Resident #1 and followed whatever orders she was given. But, she did not do that. She was suspended pending investigation. During an interview on 1/14/26 at 2:25 PM, RN C said on the night of 12/21/25 she stopped Resident #1's feeding at approximately 4:00 AM, 2 hours before she was supposed to because Resident #1 had bad diarrhea. She said on 12/22/25 she decided not to give Resident #1 her night feeding because she had massive diarrhea. They had to change her bed several times due to diarrhea. She said she should have called the MD but she did not. She said she should have documented it but she did not. She did not know it could not wait until morning, but she did not call the MD or NP in the morning. RN C said now she realizes she should have called the MD/NP right then. She gave report the morning of 12/22/25 to the oncoming shift, LVN D. She said she thought she told LVN D she stopped Resident #1's feeding early but she did not remember. She said since that incident she had in-services with charge nurses on when to call the MD, documentation, change of condition, and several others. (This surveyor reviewed the in-services provided to the charge nurses. She did not document that she stopped Resident #1's feeding early on 12/21/25, did not document Resident #1 had diarrhea on 12/21/25 and 12/22/25, and did not document she held Resident #1's feeding on 12/22/25. She believed she had documented the feeding on 12/22/25 as not given. She said the harm that could come from not feeding a resident could be so many things, dehydration, malnutrition, electrolyte imbalance. She said it was clear to her now that she messed up. During an interview and observation on 1/15/26 at 8:35 AM, the ADM said the Resident #1's family said the video in her room was motion activated. She said a person had to get to a certain point in the room before the video would pick up. She said the family agreed it did not pick up everything that went on (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the room when she had discussed the video camera with them. She said from what she had seen it was not a continuous running video, it was only clips. Family emailed the videos to her and said that was all the camera picked up between 10:00 PM on 12/22/25 to 6:00 AM on 12/23/25. There were only clips, not full video that she was sent. The ADM had her computer and pulled up the emailed videos for Resident #1 to show the surveyor. This surveyor reviewed: Clip 1. Video clip dated 12/22/25 at 9:55 PM. The surveyor saw Resident #1 in bed. CNA E came in the room then the video stopped. CNA E was talking to the resident and had some wipes in her hand. There was no feeding bag on the pole, and no indication Resident #1 had a feeding running. Clip 2. Video clip dated 12/22/25 at 9:56 PM. The surveyor saw CNA E performing incontinent care. There was no feeding bag on the pole, and no indication Resident #1 had a feeding running. Clip 3. Video clip dated 12/23/25 at 1:08 AM. The surveyor saw the resident moving around in her bed. There was no feeding bag on the pole, and no indication Resident #1 had a feeding running. Clip 4. Video clip dated 12/23/24 at 5:01 AM. The surveyor saw the same CNA (CNA E) going into the room. Resident #1 was in bed. There was no feeding bag on the pole, and no indication Resident #1 had a feeding running. The ADM said the nighttime tube feeding was not given to Resident #1 on 12/22/25. She said it was not appropriate for RN C to document a feeding she did not give because that was against the nursing standard of practice. She said there was a potential for harm to Resident #1, but according to nursing and the NP there was no harm. She said she understood why RN C stopped the feeding early, but she did not notify the MD/NP for a change of condition or follow the proper procedure for notifying the MD/NP. She did not document the diarrhea, stopping the feeding early on 12/21/25, or holding the feeding on 12/22/25. RN C not notifying the MD/NP caused a potential for harm because Resident #1 had a change of condition, and she did not know how the MD/NP would have addressed Resident #1's diarrhea. The ADM said when they notified the NP Resident #1 had a feeding stopped early on 12/21/25 and did not receive her nighttime feeding on 12/22/25 the NP assessed Resident #1 on 12/23/25 and reviewed her labs. She had labs on 12/22/25 because she was a newer tube feeding. Based on the labs, the NP thought Resident #1 was getting too much on the water, so she decreased the water Resident #1 received with her feedings. Record review of Resident #1's CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) labs dated 12/22/25 indicated she had low sodium. Her sodium was 129 mmol/l and normal was indicated to be 136.0-145.0 mmol/l. During an attempted phone interview on 1/15/26 at 9:10 AM, called Resident #1's Family Member K. Her voice mail was full, and the surveyor could not leave a message. During an interview and record review on 1/15/26 at 9:15 AM, the RCN said they had an in-service on documentation. She showed the surveyor a Weight Watchers note dated 12/23/25 indicating: Resident #1 was NPO. The note indicated [Resident #1] recently admitted to the hospital from [DATE] to 12/15/25. CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) drawn on 12/22/25.Nutritional needs reviewed by nurse practitioner and dietician. Enteral orders adjusted to Glucerna 1.2 at 65 ml/hr with h20 flush 40 ml/hr from 10:00 PM to 6:00 AM. Also, Glucerna 1.2 bolus 1 1/2 cartons, 375 ml 4 times during the day from 8:00 AM to 8:00 PM with 45 ml h20 flush before and after. Reason for physician notification and any new orders: Resident missed enteral feeding 12/22/25 from 10:00 PM to 6:00 AM. Resident experienced no negative effects, labs reviewed by NP and enteral orders adjusted from 10:00 PM to 6:00 AM for h20 flush to be 40 ml/hr. The note was signed by the NP on 12/23/25 at 2:30 PM.The RCN showed the surveyor an in-service on Documentation dated 12/23/25 signed by the charge nurses. She provided the Medication Error Report dated 12/23/25 which indicated Resident #1's enteral feeding was not administered on 12/22/25 from 10:00 PM to 6:00 AM. Action taken indicated: Education provided to staff on medication administration, medication error, notification of change in condition, documentation, and enteral (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutrition/hydration. During an interview on 1/15/26 at 9:42 AM, The NP said she had done labs on Resident #1 on 12/22/25. She said the labs indicated she was getting too much water because her sodium was a little low, so she decreased the water that went with the feeding. She said the nurse should have notified her about Resident #1's diarrhea so she could have monitored her. She said if the nurse had called her, she probably would have agreed to stop the feeding due to the diarrhea, but she could have monitored her more closely. She assessed the resident the next day (12/23/25) once she was told of the situation and there were no issues or problems with the resident. During an interview on 1/15/26 at 10:07 AM, RN F said if a resident had a tube feeding and got diarrhea or any change of condition, she would immediately notify the MD/NP for new orders. She said she would document the changes with the resident and document she called the MD/NP and any new orders that were given. She would never just not give an ordered tube feeding, she would notify the MD. During an interview on 1/15/26 at 10:40 AM, LVN G said a nurse should always call the MD/NP if a resident had a change of condition. She said a nurse should never hold a feeding on their own, the MD/NP had to give an order. She said a nurse had to document everything, every change with a resident, and when the nurse notified the MD. She said if a tube feeding was held without an MD order it could cause an adverse reaction to a resident such as dehydration or malnutrition depending on the resident. During an interview on 1/15/26 at 10:47 AM, the ADON said she had heard that RN C had stopped a feeding early and held a feeding for Resident #1. She said nurses should absolutely call the MD with any change of condition with a resident. She said a nurse should document any changes the resident had and when they notified the MD/PA. During a telephone interview on 1/15/26 at 1:37 PM, LVN D said on the morning of 12/22/25, RN C reported off to her. RN C told her she had stopped Resident #1's feeding a couple of hours early. She did not call the MD because she assumed RN C had. She said the morning of 12/23/25 RN C reported off to her. RN C did not tell her she held Resident #1's feeding. She said when she got to the facility at 6:00 AM the feeding would have been finished, and the bag (that held the feeding) would have been discarded so she would not have thought anything of the feeding not being in the room. She said on 12/21/25 or 12/22/25 she did not see Resident #1 having diarrhea. She said she gave Resident #1 her daily bolus feedings at 8:00 AM, 12:00 noon, and 4:00 PM with no issues. Record review of an undated Enteral Nutrition Policy indicated: Enteral Nutrition We will provide nutritionally complete enteral or parenternal feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth. Procedure: 1.The Nursing Services Department is responsible for all feeding equipment and the administration of tube feedings. Record review of an undated Notifying the Physician of Change in Status Policy indicated: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. This 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.1.The nurse will notify the physician or their delegated nurse practitioner or physician assistant with change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.7.The nurse will document all attempts to contact the physician, all attempts to notify the family and/or legal representative, the physician's response, the physician's orders and the resident's status and response to interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including the accurate acquiring, administering, and receipt of all drugs and biologicals, to meet the needs of 1 of 2 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure that Resident #1's Atorvastin (for reducing cholesterol), Cetrizine (for allergies), Melatonin (for sleep), Ropinirole (for discomfort of restless legs), Venlafaxine (for depression-mood disorder causing persistent sadness and loss of interest affecting thoughts feelings and daily activities), Depakene (to prevent migraine headaches), Gabapentin (for neuropathy-numbness, tingling, and burning of feet and hands), and Biotin (for moisture in the mouth) were administered per physician's orders. This failure could place residents at risk for not receiving the therapeutic benefit of medications, or at risk of not having accurate records of medication administration.Findings included: Record review of the undated face sheet indicated Resident #1 was a [AGE] year-old female that admitted [DATE] and readmitted [DATE]. Record review of the physician's orders dated 1/14/26 indicated she had diagnoses that included: Hemiplegia (paralysis of one side of the body), Dementia (severe memory, thinking, and reasoning decline that interferes with daily life, caused by diseases damaging brain cells), gastrostomy status (a surgically created opening into the stomach for a feeding tube to provide nutrition, fluids, or medication) and depression (mood disorder causing persistent sadness and loss of interest affecting feelings, thoughts, and daily activities). Record review of the quarterly MDS dated [DATE] indicated Resident #1 had unclear speech, usually understood others, and was usually understood by others. Resident #1 had a BIMS of 2 indicating severe cognitive impairment. She had a feeding tube. Record review of the undated care plan indicated Resident #1 had hemiplegia and weakness on her right side related to a stroke, impaired cognitive function/dementia or impaired thought processes, and required tube feeding. Record review of Resident #1's physician's orders dated 12/22/25 indicated: 12/16/25 Biotin 10 ml orally three times per day for buccal moisture (moisture in the mouth).12/15/25 Cetirizine HCL tablet 5 mg via g-tube, one time per day related to allergic rhinitis (seasonal allergies)12/15/25 Atorvastin Calcium Oral 40 mg via g-tube one time a day related to hyperlipidemia (high cholesterol)12/18/25 Depakene oral solution 250 mg/5ml, 10 ml via peg tube two times daily related to cerebral infarction (death of brain tissue due to lack of oxygen).12/20/25 Gabapentin oral tablet 100 mg via g-tube two times a day for neuropathy (nerve damage causing numbness tingling or weakness).12/20/25 Melatonin 5 mg 2 tabs by mouth one time per day for sleep-aid.12/15/25 Ropinirole HCL oral table 0.25 mg via g-tube one time a day for restless legs syndrome12/15/25 Venlafaxine HCL tablet 75 mg via g-tube one time per day related to depression. Record review of the PIR, called into the state authority, dated 12/23/25 indicated on 12/23/25 Resident #1's family called the ADM and was questioning whether Resident #1's medications were provided on the night shift. RN C said she did not administer the g-tube medications because she had received written communication that the g-tube medications had been administered. LVN D said she had left written communication for the oncoming nurse, however she stated that she specified which rooms/beds where she had administered medications, and she did not indicate [Resident #1's room number] was administered. RN C failed to follow facility policy/procedures related to medication administration. There was also a miscommunication/misunderstanding between the exiting and the oncoming nurse as it related to medications. On 12/23/25 RN C was suspended pending investigation. Record review of a statement given by CNA E indicated during her shift 12/22/25 at 10:00 PM -12/23/25 at 6:00 AM (her shift) she did not specifically see RN C go into Resident #1's room, and Resident #1 told her she was not in pain. During (continued on next page)

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	676494	A. Building B. Wing	01/15/2026

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an observation and interview on 1/14/26 at 9:46 AM, revealed Resident #1 was in bed, positioned with pillows. This surveyor asked if staff was nice to her and she said Yeah. She said staff was kind. She then closed her eyes and turned her head. She had feeding tube supplies in her room. During an interview on 1/14/26 at 10:37 AM, the RCN said Resident #1's family reported on 12/23/25 they did not believe she got her g-tube medication on 12/22/25. They suspended RN C pending the investigation. When they called RN C in to talk with her, RN C said she had not given the g-tube medication because LVN D had given Resident #1 her g-tube medication. LVN D had not given Resident #1 her g-tube medications. Resident #1 had labs drawn every Monday. They let the NP know Resident #1 had missed her PM medications on 12/22/25. The NP reviewed Resident #1's labs from 12/22/25 and assessed her to have no harm or negative effect. During an interview and record review on 1/14/26 at 1:01 PM, the RCN showed the surveyor a note from LVN D indicating she had given medications to rooms [rooms were listed] and the rooms did not indicate Resident #1's room as a room she had given medication to. She said RN C signed off on Resident #1's PM medications on the MAR and showed the MAR to the surveyor. The RCN and the surveyor reviewed the MAR for December 2025. The MAR reflected RN C had signed off on the following PM medications for Resident #1 on 12/22/25. The RCN said she assumed the following medications were not given to Resident #1 on 12/22/25: Atorvastin Calcium Oral 40 mg via g-tube one time a day related to hyperlipidemia. (high cholesterol) Cetirizine HCL Oral tablet 5 mg one time per day related to allergic rhinitis. (allergies) Melatonin 5 mg 2 tabs by mouth one time per day for a sleep aid. Ropinirole HCL oral table 0.25 mg via g-tube one time a day related to restless legs syndrome. (irresistible urge to move the legs often with unpleasant crawling, tingling, or aching sensations) Venlafaxine HCL oral tablet 75 mg, one time per day related to depression. (mood disorder causing persistent sadness and loss of interest affecting thoughts, feelings and daily activities) Depakene oral solution 250 mg/5ml, 10 ml viz peg tube two times daily related to cerebral infarction. Gabapentin oral tablet 100 mg via g-tube two times a day for neuropathy. (tingling, burning, and numbness in hands and feet) Biotin 10 ml orally three times per day for buccal moisture. (moisture in the mouth) During an interview on 1/14/26 at 1:39 PM, the RNC said the Melatonin by mouth was an error and she fixed it for g-tube administration. Resident #1 came back from the hospital 12/16/25 with a feeding tube, and they had to change all the orders to be administered by g-tube. She said RN C believed Resident #1's g-tube medications were already given. However, she did not understand why she would check off medications she had not given. During an interview on 1/14/26 at 2:17 PM, LVN D said RN C relieved her on the night of 12/22/25. She said she told RN C she would give the PO medications, but Resident #1 did not have any PO medications. She said it was possible RN C thought she had given the g-tube medications to Resident #1. LVN D said she left a note that said she had given the 8:00 PM medications for rooms: [rooms listed] but Resident #1's room was [room listed]. So, RN C should have known she did not give Resident #1's medications, but RN C could have read the note quickly, and she was working a lot of hours. She showed this surveyor the note LVN D had written. She said RN C was not the type of person that would say she gave medications she did not. She said RN C checked the medications off (as given) because she believed she (LVN D) had given them. She said sometimes she would give medications, only the PO's, to some of the residents to help out the night shift. She said if the medications did not pop up in the computer, she could sign off on them and that was why RN C would have signed off on them. During an interview on 1/14/26 at 2:25 PM, RN C said she did not give the PM g-tube medications to Resident #1 on 12/22/25. She said she did not get to work until 10 PM.She said when she got to work, there was a note from LVN D indicating LVN D had given the medications, but she must have misread the note, she realized later. She said she had signed off on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications she believed LVN D had given, but would not ever do that again. She said she signed off on Resident #1's PM medications and agreed she did not give Resident #1 her atorvastin, cetirizine, melatonin, ropinirole, venlafaxine, depakene, gabapentin, or biotin. She said since then she had in-services on the 5 rights of medications, not signing off on medications she did not give and several others. She said the harm that could come from not giving Resident #1 her medications could be so many things. She said it was clear to her now that she messed up. She said the medications that Resident #1 did not receive were for high cholesterol, pain, depression, trouble sleeping, allergies, and that was all she could think of. During an interview on 1/14/26 at 2:57 PM, the RCN said since the incident with Resident #1 and RN C on 12/22/25 they had 3 nurses all the time at night, and 3-4 during the day beginning 12/23/25. There were no more split shifts, so there were more nurses now. She said she knew, after the fact, that RN C had signed off on medications that LVN D had supposedly given. She said they did an in-service on the 5 rights of medication administration. The RCN said she did not know why LVN D would not check off the medications she had given because they can start those check-offs at 6:30 PM. She said the computer program did not allow staff to check off the evening medications before 6:30 PM. During an interview and observation on 1/15/26 at 8:35 AM, the ADM said Resident #1's family said the video in her room was motion activated. She said a person had to get to a certain point in the room before the video would pick up. She said the family agreed it did not pick up everything. From what she had seen it was not a continuous running video, it was only clips. Family emailed the videos to her and said that was all the camera picked up between 10:00 PM on 12/22/25 to 6:00 AM on 12/23/25. There were only clips, not full video that she was sent. The ADM had her computer and pulled up the emailed videos for Resident #1. This surveyor reviewed the following: Clip 1. Video clip dated 12/22/25 at 9:55 PM. The surveyor saw Resident #1 in bed. CNA E came in the room then the video stops. The CNA was talking to the resident and had some wipes in her hand. Clip 2. Video clip dated 12/22/25 at 9:56 PM. The surveyor saw the CNA performing incontinent care. Clip 3. Video clip dated 12/23/25 at 1:08 AM. The surveyor saw the resident moving around in her bed. Clip 4. Video clip dated 12/23/24 at 5:01 AM. THe surveyor saw CNA E going into the room. The surveyor did not see RN C or LVN D go into the room to administer g-tube medications. The ADM said she did not believe Resident #1 received her PM medications. The ADM said it was not appropriate for RN C to document medications she did not give because that was against the nursing standard of practice. She said there was a potential for harm to Resident #1, but according to nursing and the NP there was no harm. The ADM said when they notified the NP Resident #1 probably did not receive her PM medications on 12/22/25 the NP assessed Resident #1 on 12/23/25 and reviewed her labs. She had labs on 12/22/25 because she was a newer tube feeding. Other than changing the amount of water in the tube feedings, the NP had no new orders. Record review of Resident #1's CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) labs dated 12/22/25 indicated she had low sodium. Her sodium was 129 mmol/l and normal was indicated to be 136.0-145.0 mmol/l. During an attempted phone interview on 1/15/26 at 9:10 AM, called Resident #1's Family Member K, her voice mail was full, and the surveyor could not leave a message. During an interview and record review on 1/15/26 at 9:15 AM, the RCN said they had an in-service on documentation. She showed this surveyor a Weight Watchers note dated 12/23/25 indicating: Resident #1 was NPO. The note indicated [Resident #1] recently admitted to the hospital from [DATE] to 12/15/25.She was placed on an NPO diet with enteral tube feedings. Diet change and g-tube are new for resident returning from hospital. CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) drawn on 12/22/25. PM to 6:00 AM. Resident experienced no negative effects, labs reviewed by NP and enteral orders adjusted. The note was signed by the NP on 12/23/25 at 2:30 PM.The RCN showed the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor an in-service on Documentation dated 12/23/25 signed by the charge nurses. She provided the Medication Error Report dated 12/23/25 due to the possibly missed medications for Resident #1. The Med Error report indicated it was suspected Resident #1 did not receive her PM medications. RN C started her shift at 10:00 PM and was unsure if the medications were administered because there was a note left saying some PM medications had been administered. The NP was notified and indicated she would be at the facility to assess Resident #1. The RCN showed this surveyor the time sheet indicating LVN D had clocked out at 6:23 PM on 12/22/25. During an interview on 1/15/26 at 9:42 AM, the NP and this surveyor went over the medications Resident #1 had likely missed on 12/22/25 (Atorvastin, Cetrizine, Melatonin, Ropinirole, Venlafaxine, Depakene, Gabapentin, and Biotin). She said the missed medications were not a problem. She said Resident #1's depakene was for migraines, not seizures, she did not have seizures. She said she had done labs on Resident #1 on 12/22/25. She said the labs indicated she was getting too much water because her sodium was a little low, so she decreased the water that went with the feeding. She assessed the resident the next day (12/23/25) once she was told of the situation and there were no issues or problems with the resident. During an interview on 1/15/26 at 10:07 AM, RN F said checking off medications given by someone else was a medication error and had to be reported to the DON and the ADM. She said checking off a medication that you did not give yourself was a big no-no. She said if you did not do it, you do not document that you did. During an interview on 1/15/26 at 10:40 AM, LVN G said nurses did not chart they gave medications that someone else gave, that had to be reported to the ADM and DON. She said if medications were not given as ordered it could cause an adverse reaction to a resident depending on the resident and the medications. During an interview on 1/15/26 at 10:47 AM, the ADON said she had heard that RN C signed off on Resident #1's PM medications even though she did not administer them. She said something like that had to be reported to the DON and ADM. She said all nurses knew not to document giving medications if they did not give them. During an telephone interview on 1/15/26 at 1:37 PM, LVN D said the morning of 12/23/25 RN C reported off to her. RN C did not ask about Resident #1's PM medications nor did they discuss Resident #1's PM medications for 12/22/25. Record review of an undated Medication Administration and General Guidelines Policy indicated: Policy Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Procedure 1.Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. 2.Medications are administered in accordance with written orders of the attending physician.11.The resident's MAR is initialed by the person administering a medication, in the space provided under the date and on the line for that specific medication dose administration. Adheres to the 6 Rights of Medication Administration1.Right Dose2.Right Route3.Right Resident4. Right Medication5.Right Time6.Right Documentation.