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Form Approved OMB
No. 0938-0391

| 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 06/12/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bluebonnet Point Wellness | 151 Heritage Springs Drive<br>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.

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204<br><br>Based on interviews and record review, the facility failed to ensure an encoded, accurate, and complete MDS discharge assessments were electronically completed and transmitted to the CMS System within 14 days after completion for 2 of 5 residents (Residents #'s 59 and 81) reviewed for discharge MDS assessments.<br><br>The facility failed to complete and transmit a discharge MDS assessment for Residents #59.<br><br>The facility failed to complete and transmit a discharge MDS assessment for Residents #81.<br><br>These failures could place residents at risk of not having records completed and submitted in a timely manner as required.<br><br>Findings included:<br><br>Record review of a face sheet dated 06/12/2024 indicated Resident #59 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included sepsis (a life-threatening infection in the blood), age-related debility, and hypertension. The face sheet indicated Resident #59 had a date of discharge to home of 01/04/2024 with a discharge status of return anticipated.<br><br>Record review of Resident #59's electronic medical record indicated he did not return to the facility.<br><br>Record review of Resident #59's electronic medical record indicated there was no discharge MDS assessment on record.<br><br>Record review of a face sheet dated 06/12/2024 indicated Resident #81 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included chronic pain, fibromyalgia (widespread musculoskeletal pain with sleep, fatigue, memory, and mood issues), and age-related debility. The face sheet indicated Resident #81 had a date of discharge to home of 03/19/2024 with a discharge status of return anticipated.<br><br>Record review of Resident #81's electronic medical record indicated she did not return to the facility.<br><br>(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 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #81's electronic medical record indicated there was no discharge MDS assessment on record.<br><br>During an interview on 06/12/2024 at 03:50 PM with the MDS Coordinator H, she said she and the MDS Coordinator, M, were responsible for completing discharge MDS assessments. MDS Coordinator H said she was not aware the discharge assessments were not completed and transmitted. She said, they were missed, and she did not know why they were not done. MDS Coordinator H said the discharge MDS assessments should have been completed when Resident #63 and Resident #81 were discharged from the facility. MDS Coordinator H said it was important to complete and transmit the MDS assessments timely because they affect quality of care measures and payments. She said failure to complete and transmit discharge MDS assessments could result in inaccurate Quality Measures.<br><br>During an interview on 06/12/2024 at 04:15 PM with MDS Coordinators, LVN H and LVN M, they said admissions and discharges were discussed in the daily morning team meetings. They said they used the RAI Manual's schedule for completing and transmitting all MDS assessments.<br><br>During an interview on 06/12/2024 at 04:22 PM, the DON said the MDS Coordinators were responsible for completing the discharge MDS assessments. The DON said she expected the MDS Coordinators to complete and transmit the MDS assessments as scheduled and required by state and federal governing agencies.<br><br>Record review of the CMS's RAI Version 3.0 Manual dated October 2023, Chapter 2:2-17, 2-37, and 2-44 indicated the following under required assessment summary: MDS Completion Date No Later Than discharge date +7 Calendar days. Transmission Date No Later Than discharge date +14 Calendar days. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37495<br><br>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs for 1 of 4 residents (Residents #41) reviewed for care plans.<br><br>The facility failed to ensure Resident #41's use of continuous oxygen was documented in her comprehensive care plan.<br><br>This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs.<br><br>Findings included:<br><br>Record review of Resident #41's face sheet, dated 06/11/24, indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), paroxysmal atrial fibrillation (an irregular heartbeat that starts and stops suddenly), and shortness of breath.<br><br>Record review of Resident #41's care plan, dated 09/03/21, indicated there was no documentation addressing the use of oxygen therapy.<br><br>Record review of Resident #41's MDS dated [DATE] indicated she had diagnoses of hypertension (high blood pressure), paroxysmal atrial fibrillation (an irregular heartbeat that starts and stops suddenly), and acute respiratory failure with hypoxia (lungs cannot provide enough oxygen to the body or remove enough carbon dioxide). Resident #41 was cognitively intact. Resident #41 had oxygen therapy.<br><br>Record review of Resident #41's physician's order dated 11/08/23 indicated she had an order for continuous O2 (Oxygen) at 3 Liters (volume of oxygen delivered) via nasal canula.<br><br>During an observation and interview on 06/10/24 at 10:20 a.m., Resident #41 was lying in bed and wearing a nasal canula that was connected to an oxygen machine. The oxygen machine was on and set at 4 Liters (volume of oxygen delivered). Resident #41 said she had difficulty breathing at times and used her oxygen when she needed.<br><br>During an observation on 06/11/24 at 3:12 p.m., Resident #41 was lying in bed and wearing a nasal canula that was connected to an oxygen machine. The oxygen machine was on and set at 4 Liters (volume of oxygen delivered).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/11/24 at 3:45 p.m., the DON said the IDT was responsible for completing and updating a resident's care plan. The DON said she was on the IDT along with the ADON and the MDS nurse. The DON said the purpose of the care plan was to identify the resident's needs and for the staff to know what kind of care and interventions were needed. The DON said Resident #41 was on oxygen and it should be documented in her care plan. The DON checked Resident #41's care plan and said there was no care plan for oxygen. The DON said she expected all resident care plans to be updated and correct to ensure each resident received individualized care to meet their needs.<br><br>Record review of the facility's Care Plans, Comprehensive Person-Centered policy revised on 12/2016 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695<br><br>Based on observations, interviews, and record review the facility failed to provide residents treatment and care in accordance with professional standards of practice for 1 of 3 residents reviewed for quality of care. (Resident #258)<br><br>The facility failed to provide dressing change to Resident #258's Peripherally Inserted Central Catheter (PICC) line per facility policy.<br><br>This failure could place residents at risk for infection.<br><br>Findings included:<br><br>A face sheet dated 06/12/2024 indicated Resident #258 was [AGE] years old, admitted on [DATE] with diagnoses of wedge compression fracture of fourth lumbar vertebra.<br><br>A care plan dated 06/06/2024 indicated Resident #258's care plan did not address his Peripherally Inserted Central Catheter (PICC) line.<br><br>Physician orders dated 06/12/2024 indicated Resident #258 had an order to receive a Peripherally Inserted Central Catheter (PICC) line dressing change weekly using sterile technique per protocol, after surveyor intervention.<br><br>A TAR dated June 2024 for Resident #258 indicated a Peripherally Inserted Central Catheter (PICC) line dressing change order written 06/12/2024, after surveyor intervention.<br><br>During an observation on 06/10/2024 at 11:30 a.m. Resident #258 was in his room lying in bed. Resident #258 had a Peripherally Inserted Central Catheter (PICC) line to the inside of his right upper arm and a tegaderm dressing (transparent film waterproof sterile dressing) dated 06/02/2024 covering it.<br><br>During an observation on 06/11/2024 at 10:25 a.m. Resident #258 was in his room lying in bed. The left corner of Resident #258's PICC line dressing, dated 06/02/2024, was dangling down approximately 1 inch from his arm.<br><br>During an observation and interview on 06/12/2024 at 8:43 am with resident #258 in his room lying in bed. The left corner of Resident #258's Peripherally Inserted Central Catheter (PICC) line dressing, dated 06/02/2024, was dangling down approximately 1 inch from his arm. Resident #258 said his Peripherally Inserted Central Catheter (PICC) line dressing had not been changed. He said this was the same dressing from the hospital and thought it should be changed.<br><br>During an interview on 6/10/24 at 2:00pm, LVN J said she had all the IVs on the hall and said the facility policy was to change the Peripherally Inserted Central Catheter (PICC) line dressing every 7 days, and it was the nurse who had the resident with any IV to assure that the dressing was clean with no signs of infections and were changed as per facility policy.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/11/24 at 9:00am, LVN K said she was agency nurse, and she had all the IVs on the hall. She said she wasn't for sure what the facility policy was to change the Peripherally Inserted Central Catheter (PICC) line dressing, but usually it's every 7 days. She said she thought that the RN in this facility would do the dressing changes.<br><br>During an interview on 6/12/24 at 9am LVN C said she was the charting nurse and LVN D said she was the Medication Nurse. They both said they were agency nurses and would notify the DON that Resident #258 needed his IV dressing changed. They stated they did not see an order, both said they were not aware of who's responsibility it was, but know how to assess for infection, and knew the site should be clean and dry which it was.<br><br>During an interview on 06/12/24 at 9:30 a.m., the DON said to prevent infection PICC line dressings were changed once a week and documented on the resident's TAR. The DON said an RN had to change a PICC line dressing because it required sterile technique when changed. The DON said there were 4 residents with PICC lines. The DON said Resident #258 did not have an order for a PICC line dressing., She said the facility has standing protocols for PICC line dressing changes, but this resident did not have an order in place. The DON said Resident #258's dressing had not been changed in a week, and he was at risk for infection.<br><br>A Peripheral IV Dressing change policy dated 2001 states the purpose of this procedure was to prevent catheter-related infections associated with contaminated, loosened, or soiled catheter-site dressings. Change the dressing if it became damp, loosened, or visibly soiled, and at least every 7 days. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37495<br><br>Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care, consistent with professional standards of practice for 1 of 4 residents (Residents #41) residents reviewed for oxygen orders.<br><br>The facility failed to administer oxygen for Residents #41 as ordered by the physician.<br><br>This failure could place residents at risk of receiving incorrect or inadequate oxygen support, resulting in a decline in health.<br><br>The findings included:<br><br>Record review of Resident #41's face sheet, dated 06/11/24, indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), paroxysmal atrial fibrillation (an irregular heartbeat that starts and stops suddenly), and shortness of breath.<br><br>Record review of Resident #41's care plan, dated 09/03/21, indicated there was no documentation addressing the use of oxygen therapy.<br><br>Record review of Resident #41's MDS dated [DATE] indicated she had diagnoses of hypertension (high blood pressure), paroxysmal atrial fibrillation (an irregular heartbeat that starts and stops suddenly), and acute respiratory failure with hypoxia (lungs cannot provide enough oxygen to the body or remove enough carbon dioxide). Resident #41 was cognitively intact. Resident #41 had oxygen therapy.<br><br>Record review of Resident #41's physician's order dated 11/08/23 indicated she had an order for continuous O2 (Oxygen) at 3 Liters (volume of oxygen delivered) via nasal canula.<br><br>During an observation and interview on 06/10/24 at 10:20 a.m., Resident #41 was lying in bed and wearing a nasal canula that was connected to an oxygen machine. The oxygen machine was on and set at 4 Liters (volume of oxygen delivered). Resident #41 said she had difficulty breathing at times and used her oxygen when she needed.<br><br>During an observation on 06/11/24 at 3:12 p.m., Resident #41 was lying in bed and wearing a nasal canula that was connected to an oxygen machine. The oxygen machine was on and set at 4 Liters (volume of oxygen delivered).<br><br>During an observation on 06/11/24 at 3:12 p.m., Resident #41 was lying in bed and wearing a nasal canula that was connected to an oxygen machine. The oxygen machine was on and set at 4 Liters (volume of oxygen delivered).<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 06/11/24 at 3:28 p.m., LVN A said she worked the 6 a.m.-6 p.m. shift and was the charge nurse responsible for Resident #41. LVN A said she checked Resident #41's oxygen when she made rounds this morning and her oxygen was set at 2 Liters. LVN A checked Resident #41's physician orders and said she had an order for continuous oxygen at 3 Liters. LVN A entered Resident #41's room and checked her oxygen setting. LVN A said Resident #41's oxygen was set at 4 Liters and should have been set at 3 Liters per the physician's order. LVN A said Resident #41 was not ad LVN A said she did not check Resident #41's oxygen orders before she made rounds this morning or when she worked on 06/10/24 like she should have done.<br><br>During an interview on 06/11/24 at 3:45 p.m., the DON said she expected the charge nurses to review the physician's order and check the oxygen settings at the beginning of their shift to ensure oxygen was being administered as ordered. The DON checked Resident #41's physician orders and said she had an order for continuous oxygen at 3 Liters. The DON said, when asked about Resident #41's oxygen settings at 4 Liters, she was administered the wrong amount of oxygen because they did not follow her physician's order.<br><br>Record review of the facility's Oxygen Administration policy revised on 10/2010 indicated, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>42190<br><br>Based on observations and interviews, the facility failed to store all drugs and biologicals in locked compartments on 1 of 8 medication carts (400 Hall medication cart) reviewed for labeling and storage of medication.<br><br>The facility did not ensure the 400 Hall medication cart was secured and unable to be accessed by unauthorized personnel.<br><br>This failure could place residents at risk for not receiving drugs and biologicals as needed or a drug diversion.<br><br>Findings included:<br><br>During an observation on 06/12/24 at 10:21 a.m., the medication cart midway the 400 Hall, was observed to be unlocked and unsecure. The key lock button was not pushed in and when pulled on, the drawers came open, exposing all medications, in each drawer. The CNA working the 400 Hall was observed standing near the nurses' station and no residents were in the corridor of the 400 Hall, at the time of this observation.<br><br>During interview on 06/12/24 at 10:25 a.m., CNA E was asked to observe the medication cart on 400 Hall. She said, It's not locked. I know it's open because I saw you when you open the drawers. She said the nurse was across the hall.<br><br>During an interview on 06/12/24 at 10:28 a.m., LVN B said she was sorry, she forgot to lock the cart. She said she went to check on another resident, and just forgot. LVN B said a resident could take the wrong medications and cause injury to themselves, or medications could come up missing. She said this was her first day and she was just thrown out here. She said the RN had reminded her earlier to lock the cart.<br><br>During interview on 06/12 /24 at 10:44 a.m., RN F said he reminded LVN B, approximately an hour ago, to lock her cart. He said he was just going around doing observations and he reminded her to lock her cart.<br><br>During interview on 06/12/24 at 10:38 a.m., the DON said her expectations were, that all medication and treatment carts would be locked at all times, when not in use. She said all the LVN's know that. The Administrator was present during this interview.<br><br>Record review of the facility policy titled Storage of Medication, with a revised dated of 2019, indicated. 8. Compartment (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. 9. Unlocked medication carts are not left unattended. |