| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676494 | A. Building<br>B. Wing | 08/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| 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** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS assessment was electronically transmitted to the CMS System within 14 days after completion for 1 of 6 residents (Resident #74) reviewed for encoding/transmitting assessments.The facility failed on 08/04/2025 to transmit a quarterly assessment to CMS for Resident #74 within 14 days of completion when the assessment was completed on 07/21/2025 by the Corporate RN Assessment Coordinator and the facility submitted the quarterly assessment for Resident #74 to CMS 9 days pass due on 08/13/2025. This failure could place residents at risk of not having records completed and submitted in a timely manner as required.Findings included:Record review of a face sheet dated 08/13/2025 indicated Resident #74 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included aortocoronary bypass graft (a surgical procedure to treat coronary artery disease), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), atherosclerotic coronary heart disease (damage or disease of the heart's major blood vessels), and diabetes.Record Review of Resident #74's quarterly MDS dated [DATE] indicated the MDS target date was 07/07/2025 and was signed as completed on 07/21/2025 by the corporate RN Assessment Coordinator. The MDS was marked as accepted by CMS on 08/08/2025. The MDS was to be submitted to CMS by 08/04/2025 (within 14 days of completion): 07/21/2025 plus 14 days equals 08/04/2025.Record review of a MDS 3.0 NH CMS Submission Final Validation report printed 08/13/2025 indicated the facility tracking form assessment was submitted late indicated by: Warning: Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment.During an interview on 08/13/2025 at 9:30 AM with the MDS Coordinator B, said she or the other MDS Coordinator were not responsible for submitting the MDS assessments. She said she did not know why it had not been transmitted timely to the CMS system because the RN that signs the MDS as being completed was the person responsible for uploading the MDS Assessments. The MDS Coordinator said it was important to complete and transmit the MDS assessments timely because they affect quality of care measures. She said failure to complete and transmit MDS assessments could result in inaccurate Quality Measures. The MDS Coordinator said the facility used the RAI 3.0 Manual's schedule for completing and transmitting all MDS assessments. During an interview with the Administrator on 08/13/2025 at 10:20 AM, she said she expected the MDS assessments to be completed and transmitted as scheduled and required by state and federal governing agencies. She said the person responsible for completing the submissions was the Corporate RN responsible for signing the MDS assessments as being completed. Record review of the CMS's RAI Version 3.0 Manual dated October 2023, Chapter 5: Submission and Correction of Resident Assessments indicated the following: Comprehensive assessments, including the CAA Summary (Section V), must be transmitted within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). Other assessments, like Quarterly and Discharge assessments, must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days). |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 2 of 12 residents (Resident's #4 and #8) reviewed for MDS assessment accuracy.The facility failed to ensure a comprehensive MDS assessment dated [DATE] for Resident #4 captured oxygen use, suctioning, and tracheostomy care.The facility failed to ensure a quarterly MDS assessment dated [DATE] for Resident #8 was not inaccurately coded for tracheostomy, dialysis, and hospice care. These failures could place residents at risk of not receiving adequate care and services to meet their needs. Findings included:1.Record review of a facility face sheet dated 8/13/25 for Resident #4 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of acute respiratory failure with hypoxia. Record review of a Comprehensive MDS assessment dated [DATE] for Resident #4 indicated a BIMS assessment should not be completed due to resident being rarely/never understood. He had moderate cognitive impairment. Assessment reference dated was 7/27/25 with Section O (Special Treatments, Procedures, and Programs) not reflecting use of oxygen therapy, suctioning or tracheostomy care during the previous 14 days, while a resident, or not a resident of the facility. Record review of a Physician's Order Summary Report dated 8/13/25 for Resident #4 indicated he had the following physician orders: .Trach care 2 times a day prn. dated 7/22/25.change inner cannula Q7day one time a day every Thursday. dated 7/22/25 .change trach ties one time a day every Thursday. dated 7/22/25 .tracheal suctioning Q HR prn (as needed) every shift. dated 7/22/25 .oxygen at 8LPM via trach collar with humidification at 28 FiO2 every shift. dated 8/9/25Record review of a comprehensive care plan dated 8/8/25 for Resident #4 indicated he had a tracheostomy with an intervention to suction as necessary, and that he received oxygen therapy. Record review of a physician progress note dated 7/23/25 for Resident #4 and signed by MD G read: .today.the nurses removed his cannula and cleaned it. Suction[ed] easily. Record review of a nursing progress note dated 7/27/25 for Resident #4 and signed by LVN F read: .O2 LPM: 8L/M (Liters per minute) trach. 2. Record review of a face sheet dated 8/11/2025 for Resident #8 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included dementia, heart failure, diabetes, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and anemia. Observation on 8/11/25 at 9:45 AM revealed Resident #8 was lying in bed with her head slightly elevated. Resident was asleep. Respirations were even, unlabored, and quiet. No observation of a tracheostomy or ventilator were noted, and she was not receiving any oxygen therapy. No evidence of a dialysis shunt on the arms or neck was noted. Record review of a quarterly MDS assessment dated [DATE] for Resident #8 reflected she had a BIMS score of 4 indicating her cognition was severely impaired. The Assessment Reference Date was 6/9/2025 with Section O (Special Treatments, Procedures, and Programs) reflecting Resident #8 was receiving hospice, dialysis, and tracheostomy care and services. Record review of physician orders dated 06/11/15 for Resident #8 indicated no orders for dialysis, hospice, or tracheostomy care and services. Record review of a care plan dated 8/11/2025 for Resident #8 indicated no concerns for or interventions to address dialysis, hospice, tracheostomy, or ventilator care and services. During an interview on 08/11/25 at 3:15 PM, RN H said Resident #8 did not have a tracheostomy and was not receiving dialysis nor hospice care. RN H said Resident #8 had never had a tracheostomy. During an interview with MDS Coordinator A on 8/12/25 at 3:24 PM, who said Resident #8 had not been on hospice, received dialysis, nor had a tracheostomy. She said Resident #8's quarterly assessment dated [DATE] was incorrectly coded for dialysis, hospice, tracheostomy, and ventilator care and services. MDS Coordinator A said she was the nurse who coded the assessment. She said she must have been thinking of another resident when she coded the assessment. MDS Coordinator A said the facility used the RAI 3.0 Manual as their guide for coding MDS assessments. MDS Coordinator A said the MDS assessments needed to be accurate because they serve as a guide for determining residents' care needs. During an interview with the Administrator on 06/12/2025 at 3:45 PM, who said she expected the MDS Nurses to correctly code the MDS assessments. Review of CMS's RAI Version 3.0 Manual: Section 1.3 Completion of the RAI indicated the following: While its primary purpose as an assessment instrument is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments are also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents The RAI |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and 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 6 residents (Resident #36) and 1 of 6 staff (CNA E) reviewed for infection control. The facility failed to ensure CNA E changed gloves when going from dirty to clean and washed or sanitized her hands between glove changes when providing care to Resident #36 on 8/12/2025.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:Record review of a facility face sheet dated 8/13/25 for Resident #36 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of dementia.Record review of a Quarterly MDS assessment dated [DATE] for Resident #36 indicated a BIMS score of 06 which indicated she had severely impaired cognition. She required substantial/maximal assistance with all ADLs. She was always incontinent to bowel and bladder. Record review of a comprehensive care plan dated 6/5/25 for Resident #36 indicated she had an ADL self-care performance deficit and was dependent on 2 staff members for toileting.During an observation on 8/12/25 at 9:20 am CNA E was observed to provide incontinent care to Resident #36 with assistance of 2 staff members. After performing care on pubic/groin area, resident was rolled over and CNA E cleaned rectal area and buttocks. Soiled brief was then removed from underneath resident, and without changing her gloves, CNA E then placed clean brief underneath resident and applied barrier cream. CNA E then proceeded to remove her gloves and without using hand sanitizer, or washing her hands with soap and water, she applied new gloves and applied clean brief to Resident #36.During an interview on 8/12/25 at 9:30 am CNA E said she did not use sanitizer or wash her hands between her glove change and said she did not change her gloves before placing clean brief on resident. She said she should have put on clean gloves before applying the clean brief, and she said she should have used hand sanitizer or washed her hands between her glove change. She said it could cause cross contamination and put residents at risk of infection if hand were not cleaned appropriately. During an interview on 8/12/25 at 9:40 am ADON C said she expected CNAs to appropriately change gloves when going from dirty to clean and the use sanitizer or wash hands between glove changes. She said it was an infection control risk if appropriate hand hygiene was not performed. During an interview on 8/12/25 at 2:45 pm ADON D said she expected her staff to perform appropriate hand hygiene during perineal care. She said residents could be at risk for cross contamination and spreading of infections if hand hygiene was not performed as required. During an interview on 8/13/25 at 1:42 pm DON said he expected his staff to follow policy and procedures. He said residents could be at risk of infections if gloves were soiled and not changed appropriately or if proper hand hygiene were not performed. He said residents and staff could be at risk for outbreaks of diseases. He said he and ADON D were both responsible for staff training/checkoffs. He said they would be doing check offs more often to improve compliance.During an interview on 8/13/25 at 2:55 pm Administrator said she expected her staff to follow infection control policy and procedures. She said residents could be at risk for infections if proper hand hygiene was not followed. She said going forward, she would be re-educating and training staff to ensure compliance.Record review of a facility policy titled Perineal Care dated 5/11/22 indicated after providing care to back (rectal/buttock) area: .doff (remove) gloves.perform hand hygiene. and .conclude: .provide resident comfort and safety by reclothing (if applicable - incontinent pad(s) and brief. and .always perform hand hygiene before and after glove use. |