

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Bonne Vie		STREET ADDRESS, CITY, STATE, ZIP CODE 8595 Medical Center Boulevard Port Arthur, TX 77640	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115</p> <p>Based on observation, interview and record review 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 2 of 15 residents (Resident #1 and #2) reviewed for infection control.</p> <ol style="list-style-type: none"> 1. CNA A failed to wash or sanitize her hands or change gloves while performing incontinent care for Resident #1. 2. CNA D failed to wash or sanitize her hands or change gloves while performing incontinent care for Resident #2. <p>These failures could place residents at risk of exposure to communicable diseases and infections.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Record review of Resident #1's face sheet, dated 04/10/24, reflected a male who was admitted to the facility on [DATE], he was [AGE] years old, and his diagnoses included paraplegia (impairment in motor or sensory function of the lower extremities), flaccid neuropathic bladder (doesn't contract enough-leads to urinary retention or the inability to fully empty the bladder) and overactive bladder (muscles of the bladder start to tighten on their own even when the amount of urine in the bladder is low). <p>Record review of Resident #1's quarterly MDS assessment, dated 01/23/24, reflected he was able to make himself understood and understood others, was cognitively intact (BIMS score of 13), utilized a wheelchair for mobility, had an indwelling catheter and was always incontinent of bowel.</p> <p>Record review of Resident #1's care plan, dated 08/07/23 reflected Resident #1 was at risk for infection related to indwelling catheter. Interventions included clean around catheter with soap and water or may use wipes as appropriate and report any sign of infection, wash hands before and after procedure.</p> <p>(continued on next page)</p>

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/02/24 at 5:30 p.m., CNA A assisted by CNA B, performed incontinent care for Resident #1. CNA A and CNA B entered Resident #1's room, washed hands and put on gloves and gown (enhanced barrier precautions). CNA A explained care provided to Resident #1 and performed peri-care/indwelling catheter care by wiping Resident #1's penis and scrotum area with wipes and held the catheter tubing and wiped the catheter tubing. Resident #1 was incontinent of stool and the brief was soiled. CNA A then removed her gloves and put on a pair of new gloves without washing or sanitizing her hands. CNA A and CNA B rolled Resident #1 on his left side. CNA A took a wet wipe and wiped Resident #1's rectal area and removed stool. CNA A removed the used brief from underneath Resident #1 and placed it in the trash. CNA A then took a clean brief placed it under the resident, while wearing the same soiled gloves that were used to wipe the resident's rectal area and removed the old brief. CNA B commented to CNA A she should have changed her gloves. CNA A removed the soiled gloves, sanitized her hands, and placed on a pair of new gloves, then applied Vaseline to Resident #1's coccyx/buttocks area, CNAs A and B positioned Resident #1 on his back and fastened the brief. CNA A and CNA B positioned Resident #1 to a comfortable position. CNA A and CNA B removed their PPE, placed it in the trash and removed the trash from Resident #1's room upon exit.</p> <p>During interview on 04/02/24 at 5:45 p.m., CNA A said she was aware she should have changed her gloves after she wiped the resident's rectum and removed stool. She said the gloves were considered soiled. She said she should have washed or sanitized her hands and applied new clean gloves.</p> <p>During an interview on 04/10/24 at 9:40 a.m., CNA A said she was aware she should have changed her gloves and washed or sanitized her hands when she performed incontinent care for Resident #1. She said she was trained in orientation, on 03/12/24, and after the incident on 04/02/24 on infection control and incontinent care.</p> <p>2. Record review of Resident #2's face sheet, dated 04/11/24, reflected a female who was admitted to the facility on [DATE], she was [AGE] year old, and her diagnoses included obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow)and dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities).</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 02/22/24, reflected she was able to make herself understood and understood others, had moderate cognitive impairment (BIMS score of 11), utilized a walker and a wheelchair for mobility, had an indwelling catheter and was always incontinent of bowel.</p> <p>Record review of Resident #2's care plan 09/18/23 reflected Resident #2 was at risk for infection related to an indwelling catheter. Interventions included clean around catheter with soap and water or may use wipes as appropriate and report any sign of infection, wash hands before and after procedure.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/02/24 at 6:00 p.m., CNA D was assisted by CNA C and performed incontinent care for Resident #2. CNA D and CNA C entered Resident #2's room, washed hands and put on gloves and gowns (enhanced barrier precautions). CNA D explained care provided to Resident #2 and performed peri-care by wiping the Resident #2's peri area from top to bottom with wipes. CNA D then removed her gloves and washed/sanitized her hands and applied a new pair of gloves. CNA D used a wet wipe and wiped Resident #2's rectal area, then removed the old brief from underneath Resident #2 and placed it in the trash. CNA D then took a clean brief placed it under Resident #2, applied barrier cream, while wearing the same gloves that were used to remove the old brief. CNA D and CNA C positioned Resident #2 to a comfortable position. CNA D and CNA C removed their PPE, placed it in the trash and removed trash from room upon exit.</p> <p>During interview on 04/02/24 at 6:10 p.m., CNA D said she was aware she should have changed her gloves after she removed Resident #2's old brief. She said the gloves were considered soiled. She should have washed or sanitized her hands and applied new clean gloves.</p> <p>During interview on 04/02/24 at 6:12 p.m., CNA C said CNA D should have changed her gloves after she had removed Resident #2's old brief.</p> <p>During an interview on 04/10/24 at 9:15 a.m., the DON said staff should have changed gloves and performed hand hygiene per the facility's protocol for incontinent care. She said residents could be at risk of an infection if they did not wash or sanitize their hands when changing their gloves. She said staff were trained upon hire in orientation regarding the facility's protocol for incontinent care and as needed.</p> <p>Record review of the facility's, undated, Incontinent Care Skills Checklist reflected .9. Wash from front towards rectum, front to back, using clean stroke, repeat if necessary with a new wipe as all feces must be cleaned off. With a new wipe, cleanse the entire buttock area and surrounding hip area. Turn over surface of wipe to cleanse other side of buttock. 10. Wash and sanitize hands. Apply clean gloves.</p>		