

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 11/12/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879</p> <p>Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 5 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to ensure LVN A did not verbally abuse Resident #1 when she yelled, screamed, and made intimidating remarks at the resident on 12/05/2023.</p> <p>This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 11/11/2024, indicated an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (loss of cognitive functioning), transverse myelitis (is a rare, acquired focal inflammatory disorder often presenting with rapid onset weakness, sensory deficits, and bowel/bladder dysfunction), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), calculus of kidney (kidney stones - hard deposits made of minerals and salts that form inside your kidneys), hypertension (a condition in which the force of the blood against the artery walls is too high), atherosclerotic heart disease of native coronary artery (a condition where the blood vessels become narrowed and hardened due to buildup of fats in the blood vessel wall), and history of falls.</p> <p>Record review of Resident #1's quarterly MDS Assessment, dated 12/06/2023, indicated he was usually able to make himself understood and usually understood others. He had moderate difficulty hearing. He had moderate cognitive impairment, identified with a BIMS score of 8.</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
---	-------	-----------

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 11/12/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan, effective on 08/10/2022, indicated the resident was at risk for falls and had a fall 12/05/2023. The interventions included placed call bed/light within easy reach and keep areas free of obstruction to reduce the risk of falls or injuries. The resident had potential risk for injury due to unsafe independent transfer as identified by the nursing/rehab assessment. The interventions include educate patient/responsible party on proper lift/transfer; patient to transfer with assistance of two or more and use of gait belt or stand aid; if staff feels the transfer technique is in appropriate, notify supervisor immediately to determine a safe and appropriate manner of transfer; notify the DON/physician and responsible party of any incident involving transfers; and encourage patient to requested needed assistance in all transfers and keep call light in reach.</p> <p>Record review of Resident #1 progress note dated 12/05/2023 at 5:21 p.m. authored by LVN A indicated Resident #1 sitting on floor at foot of bed, no apparent injury noted or voiced. IV team here to put in IV to left upper arm.</p> <p>Record review of the Incident Self Report, dated 12/05/2023, indicated Resident #1 was verbally abused by LVN A speaking to him in a verbally abusive tone. During the investigation, a witness interview with LVN B corroborated the statement. Assessment of Resident #1 showed no signs of physical injury or emotional distress.</p> <p>Record review of a Facility Investigation Report, dated 12/05/2023, indicated the incident was reported on 12/05/2023 and occurred between 5:00 p.m. and 5:30 p.m. on 12/05/2023. LVN C provided head to toe assessment to Resident #1 on 12/05/2023 indicating no signs of physical injury or emotional distress. The Administrator and DON interviewed Resident #1 individually as part of the facility investigation and he reported feeling safe at the facility. The investigation summary confirmed (and witnessed) verbal abuse. LVN A's employment was terminated effective immediately. Provider action taken post investigation was continued education and in service on prevention of abuse and neglect. The alleged perpetrator (LVN A) was placed on suspension during the investigation and terminated during the investigation process. Facility staff were in-serviced on Abuse Neglect and Resident Rights.</p> <p>During an interview on 11/11/2024 at 1:45 p.m., LVN B said he was working on 12/05/2023 and was requested to assist LVN A to get Resident #1 off the floor after a fall. LVN B said when he entered the room, LVN A was already in the room standing near Resident #1 and he heard LVN A say, he should be restrained to the bed, and he had fallen multiple times today. LVN B said that during the transfer Resident #1 appeared upset with LVN A and he tried to speak calmly to the resident. LVN B said while transferring Resident #1 back to bed that Resident #1 and LVN A made negative statements like don't touch me, you are always grabbing your dick with those hand (s) and pervert, nasty person. LVN B said that during the transfer Resident #1 scratched LVN A and she said, hope I don't get an infection from the scratch from that nasty person. LVN B said that LVN A left the room, and he tried to calm Resident #1. LVN B said that another person (Outside Vendor X) was in the room and witnessed some of the incident. LVN B said Outside Vendor X started talking with Resident #1 and he seemed calmer, and she began providing care, so he (Vendor X) exited the room. LVN B said that he considered the incident as verbal abuse towards Resident #1 because LVN A was using verbal aggressive behaviors while caring for resident. LVN B said he reported the incident to the UM, DON, and the Administrator/AC and that the other person (Outside Vendor X) in the room had already reported the incident as well.</p> <p>(continued on next page)</p>		

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 11/12/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/12/2024 at 11:27 a.m., UM C said she recalled the incident between Resident #1 and LVN A, she said she was notified concurrently by DON and facility staff of the incident. UM C said she immediately returned to the facility and contacted LVN A prior to her arrival to facility and directed her to not provide any care to any residents and complete any unfinished documentation for her shift. UM C said she arrived at the facility in less than 30 minutes, briefly discussed allegation and suspended LVN A, took report, did medication cart count, and directed LVN A to leave the facility and told her she would be contacted during the investigation process. UM C said she took over the responsibilities of CN for LVN A. UM C said she immediately assessed Resident #1 and identified no injuries or distress. UM C said that during the follow-up assessment that Resident #1 was confused which was a preexisting issue, and he was unable to give details of the incident.</p> <p>During an interview on 11/12/2024 at 1:00 p.m., LVN A said she recalled the incident with Resident #1 on 12/05/2023 and said Outside Vendor X had reported to her that Resident #1 was on the floor. LVN A said she requested LVN B to assist her to get him up off the floor. LVN A said, the facility accused me of verbally abusing the resident, but I do not remember saying anything abusive. LVN A said [Resident #1] scratched her during the transfer, but she did not recall her response. LVN A questioned if she assessed resident after fall she said, I am sure I asked him if he was OK, but I don't recall. LVN A said [Resident #1] was known to pleasure himself or play with himself. LVN A said she was contacted by UM C immediately after the incident and was instructed to not perform any additional care on any residents, complete any charting and she would be at the facility shortly. LVN A said UM C arrived at the facility and briefly discussed with her the allegation of abuse and that she would need to leave the facility (suspended) until the investigation was completed. LVN A said the incident with Resident #1 occurred between 5:00 and 5:30 p.m. on 12/05/2024 and the UM C contacted her around 5:45 p.m. regarding the incident/allegation and told her not to provide any patient care and complete her current shift documentation. She said UM C arrived at the facility around 6:00 p.m. they completed report, and cart counts, and she completed her shift documentation and left the facility. LVN A said that she did not provide any care to any resident once she was directed by UM C not too. LVN A said she was contacted by the Administrator later that same day and terminated her for a confirmed allegation of abuse. LVN A said she was provided training by the facility regarding abuse and neglect during orientation and routinely.</p> <p>During an interview on 11/12/2024 at 1:30 p.m., the Administrator stated he was the abuse coordinator and abuse allegation between Resident #1 and LVN A was confirmed and witnessed. The Administrator said Resident #1 was hard of hearing and was unsure if he heard the verbal aggression by LVN A. The Administrator said he interviewed Resident #1 following the incident and he did not exhibit any signs of fear or distress. The Administrator said safe surveys were conducted with other residents on that hall and no other incidents were reported. The Administrator said the facility investigation confirmed verbal abuse and LVN A was suspended during the investigation process and terminated immediately with the confirmation of the allegation. The Administrator said resident abuse was not tolerated at the facility and confirmation of resident abuse was an immediate termination. The Administrator said the facility trained staff on abuse and neglect and management staff made rounds with residents to monitor for abuse.</p> <p>Attempts to interview Outside Vendor X were unsuccessful. Two attempts were made to reach her by telephone on 11/11/2024 at 10:00 a.m., 11/12/2024 at 7:23 a.m., and via email on 11/11/2024 at 7:31 p.m. No return call or email was received prior to exit.</p> <p>(continued on next page)</p>		

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 11/12/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a statement from Outside Vendor X indicated Outside Vendor X said the purpose of this email is to report an incident concerning a patient and a nurse in your facility. I was called in for vascular access placement for [Resident #1]. Upon arrival 12/5/23 around 5:00 p.m. the patient was found on the ground asking for help. I immediately found the nurse [LVN A] and notified her of the patient being on the floor. [LVN A] proceeded to tell me It's the fifth time. We approached the patient's room to assist the patient to the bed. He was sitting on the ground with a wheelchair in front of him. [LVN A] moved the wheelchair as I turned the light on, and the patient screamed. [LVN A] screamed at the patient I did not hit you. (I did not witness if he was hit or not) she also told the patient You're getting on my last nerve. You need to be tied up, if this was the good old days, you'd be tied up already. As she is walking my way towards the door she states, I'm not touching him with no gloves his hand is always on his dick. She proceeded to grab gloves from her cart and asked another nurse for assistance. As they were assisting the patient up to the bed the patient tried to hold on to the nurse for stability, but she started screaming Don't touch me! Do not touch me! while swinging arm to get loose from him. The patient expressed his anger as well. The patient was assisted on to the mattress. When [LVN A] and [LVN B] stepped out of the room the patient was upset and very apologetic to me about what had happened. He attempted to communicate about the nurse and said the word screaming but I am unaware if he was referring to this instance or a prior instance. His speech was delayed and not very clear but was understandable. I reassured him he had nothing to apologize for. He did not have any apparent injury. I am unaware of the patient's baseline. He complained of pain but was unable to communicate the location of pain. Bed was lowered and call light was given to patient as well as instructed to press call light and not to attempt getting out of bed himself. He was no longer upset when I was leaving at around 5:30 p.m. I notified [LVN A] I was leaving the facility. This incident has been reported to my chain of command as well as Texas Health and Human Services.</p> <p>Record review of employee time records indicated that UM C returned/ clocked in at 6:00 p.m. on 12/05/2023. LVN A clocked in at 12:50 p.m. and clocked out at 7:13 p.m.</p> <p>Record review of LVN A's employee file indicated she received training regarding abuse, neglect, and misappropriation of property during initial orientation on 7/12/2023. LVN A was suspended and terminated on 12/05/2023 for abuse allegation.</p> <p>Record review of the facility's Abuse Prohibition Protocol, dated August 2024, indicated The patient has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the patient's symptoms.</p>		