

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  12/03/2025
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)
F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 3 residents (Resident #1) reviewed for quality of care. The facility failed to conduct a comprehensive bowel elimination assessment and document 's bowel pattern in the electronic health record for 2 of 3 shifts on 11/28/2025 and 2 of 3 shifts on 11/29/2025. This failure could place residents at risk for not receiving bowel assessments leading to fecal impactions. Findings included: Record review of Resident #1's face sheet, dated 12/03/2025, indicated she was a 72- year- old female, re-admitted [DATE], with diagnoses of constipation (hard stool), anemia (reduced oxygen to body), dementia (decline in cognitive function, (affecting memory, and thinking), pain, cognitive communication deficit (difficulty communicating). Record review of Resident #1's care plan, dated 11/17/2025, indicated she was incontinent of bowel and at risk for constipation. The listed goal was for Resident #1 not to experience constipation and have a normal bowel pattern elimination. The listed intervention was to assess and document Resident #1 for usual bowel movement history, describing her usual pattern, time of day, amount/ frequency, color, and consistency of stool. RNs and LVNs to assess and RNs, LVNs, and CNAs to document findings. Record review of Resident #1's Minimum Data Set, dated [DATE], indicated she had a BIMS score of 4 indicating severe cognitive impairment. Section GG- Functional Abilities, indicated Resident #1 was dependent on staff to meet her urinary and bowel incontinent needs. Section H- Bladder and Bowel, indicated Resident #1 was always incontinent of bowel. Record review of Resident #1's medication administration record, dated November 2025 indicated she received scheduled Acetaminophen- codeine (Opioid- pain medication) tablet 300-60 milligram by mouth four times a day and tizanidine (sedative/ hypnotic- muscle relaxant) tablet 2 milligram by mouth two times a day. Record review of Resident #1's order summary, dated 12/02/2025, indicated she had orders for the facility to monitor opioid side effects: In part- closely monitor for constipation every shift. Record review of Resident #1's order summary, dated 12/02/2025, indicated she had orders for the facility to monitor sedative/ hypnotic side effects: In part- observe closely for significant side effects of sedative/ hypnotic medication including constipation every shift. Record review of Resident #1's hospital notes dated 11/21/2025-11/24/2025 indicated she was admitted to the hospital with bradycardia (slow heart rate) and received two units of blood due to low blood count. The hospital report indicated patient is having stool impaction she received enema last night, but it did not help. Will consult surgery. Resident #1 had the fecal impaction removed during a colonoscopy. Discharge diagnosis of fecal impaction, bradycardia. Record review of Resident #1's assessments dated 11/28/2025-11/29/2025 indicated there was no nursing bowel assessment initiated nor completed by an RN or LVN when she went without a bowel movement four days after hospital discharge for fecal impaction, and bradycardia (slow heart rate). Record review of nursing staff schedule and bowel elimination dated 11/28/2025-11/29/2025 indicated: 11/28/2025-Shift: 6 a.m.- 2:00 p.m.- LVN A did not assess Resident #1 bowels nor document if resident had a bowel movement. 6 a.m.- 2:00 p.m.- CNA D did not document if Resident #1 had a bowel movement. 10:00 p.m.- 6:00 a.m.- LVN B did not assess Resident #1 bowels nor document if resident had a bowel movement. 10:00 p.m.- 6:00 a.m.- CNA E did document if Resident #1 had a bowel movement. 11/29/2025-Shift: 2:00 p.m.- 10:00 p.m.- RN C did not assess Resident #1 bowels nor document if resident had a bowel movement. 2:00 p.m.- 10:00 p.m.- CNA F did not document if Resident #1 had a bowel movement. During an attempted interview with Resident #1 on 12/02/2025 at 10:50 a.m., she was being transported out of the facility to the hospital by medical transport unrelated to constipation. Resident #1 did not return to the facility during investigation. During an interview with the facility nurse practitioner on 12/02/2025 at 1:30 p.m., he said nursing should have done a bowel assessment on Resident #1 when she had not had a bowel movement for two days due to her recent fecal impaction that was surgically removed four days ago. He said he had not given the facility an order for a two-day assessment. During an interview with the facilities physician on 12/02/2025 at 2:00 p.m., he said Resident #1 was sent to the hospital due to a syncope episode and bradycardia. The hospital discovered she was impacted with stool in her colon that the hospital removed. He said the nurses were responsible for assessing, monitoring, documenting and reporting changes in Resident #1's bowel patterns. During an interview with unit manager G on 12/02/2025 at 2:15 p.m., she said nurses were responsible for assessing, monitoring, documenting and reporting changes in Resident #1's bowel patterns. She said the CNAs was</p>		