Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676444	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonne Vie	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 41057 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental, and psychosocial needs for 3 of 24 residents reviewed for care plans. (Residents #28, #42, & #87) The facility did not include interventions and goals for Resident #28's hospice care plan. The facility did not have a care plan to address Resident #42's use of Trazadone. The facility did not have a care plan to address that Resident #87 was PASRR positive and refusing services. These failures could place residents at risk of not having their individual needs met and not receiving needed services. Findings included: 1. Record review of a face sheet dated 12/18/24 indicated Resident #28 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral infarct (stroke). Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #28 had a BIMS score of 14 indicating cognitively intact and indicated she received hospice care. Record review of physician''s orders dated 12/18/24 indicated Resident #28 was admitted to hospice services as of 08/23/24 for diagnoses of cerebral infarct. Record review of Resident #28''s care plans printed 12/18/24 indicated Resident #28 required hospice services but did not include any goals or interventions related to the hospice services. During an observation on 12/16/24 at 09:30 a.m., Resident #28 was lying in bed, she said she was treated well but was unsure if she received hospice services. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/24 at 10:50 a.m., Unit Manager A said she was responsible for care planning Resident #28's hospice goals and interventions. She said the goals and interventions should have been care planned but were not. Unit Manager A said she was responsible for care planning Resident #42's trazadone. She said it should have been care planned but was not. She said they were overlooked. Unit Manager A said she was educated on care plans and was aware to care plan the hospice goals and interventions and the antidepressant medication. She said the resident risk of Resident #28 not care planned for her goals and interventions for hospice and Resident #42's antidepressant medication was the nurses could be unaware of the care and services the resident's received. During an interview on 12/18/24 at 11:08 a.m., MDS Nurse D said she was responsible for writing PASRR care plans. She said Resident #87 qualified for PASRR services but was refusing the services. She said the resident should have a care plan to address that she was PASRR positive, refused PASRR services, and quarterly meetings were being held to offer services and document Resident #87's refusal. She said she just overlooked writing a PASRR care plan because the resident was not receiving PASRR services. She said she had received PASRR training through HHSC, her corporate office, and webinars. She said a possible negative outcome of not having a PASRR care plan was staff would not be aware Resident #87 was PASRR positive, refused services, and the quarterly meetings held. During an interview on 12/18/24 at 11:18 a.m., the DON said she and other nursing administration were responsible for overseeing care plans and nursing administration met quarterly to review care plans for accuracy. She said the nursing staff were educated on accuracy and completeness of care plans. She said the missed care plans were overlooked. The DON said the resident risk of missed care plans was the potential risk of the nurses being unaware of the resident plan of care. She said she expected all care plans to be updated and completed timely. During an interview on 12/18/24 at 11:22 a.m., the Administrator said nursing was responsible for completed care plans. He said the staff were educated on care planning. The Administrator said the resident risk of services or medication not care- planned was potentially the nurses may not know the plan of care. He said he expected all care plans to be completed timely and accurately. Record review of a facility policy titled Care Plans, Comprehensive Person-Centered revised March 2022 indicated . The comprehensive person-centered care plan: a. includes measurable objectives and time frames; B. describes the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASRR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice and problem areas and conditions.