

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

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Form Approved OMB
No. 0938-0391

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 03/04/2026
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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess each resident once every three months, using the quarterly review instrument specified by the state and approved by CMS, for 1 of 26 residents (Resident #1) reviewed for quarterly assessments. The facility failed to ensure Residents #1 had a quarterly MDS assessment completed within three months from the previous assessment. This failure could place residents at risk of not receiving necessary care or receiving inappropriate care for their conditions. Findings included: Record review of Resident #1's face sheet, dated 03/04/2026, indicated Resident #1 was [AGE] year-old male, admitted [DATE], with diagnoses of dementia (a decline in mental ability - specifically memory, thinking, and reasoning) and hypertension (elevated blood pressure). Record review on 03/04/2026 at 10:00 a.m., Resident #1's medical record indicated an admission MDS was completed on 10/29/2025 and a subsequent quarterly MDS ARD was 01/29/2026. Further record review indicated a Quarterly MDS for Resident #1 was not initiated nor completed. During a joint interview on 03/04/2026 at 10:50 a.m., MDS Nurse A said Resident #1 was on managed care for over 100 days. She said their computer system failed to trigger a quarterly MDS as being due. She said Resident #1 was still on skilled services. She said unless she went in and looked at each resident, she did not know when MDSs were overdue while receiving skilled services. She said this was an oversight on her part and she just missed it. MDS Nurse B said Resident #1 was on skilled services for over 100 days and Resident #1's quarterly MDS was missed. MDS Nurse A and MDS Nurse B both said they were educated on MDS accuracy. MDS Nurse B said not completing MDS assessments could possibly result in care plan inaccuracy, negative outcomes to the residents, and could also affect payor source. During an interview on 03/04/2026 at 12:50 p.m., the DON said the MDS nurses were responsible for the timely completion of each MDS assessment. She said her expectations were for all MDS assessments to be completed accurately and timely, as the MDS reflected the resident and necessary care and services provided. During an interview on 03/04/2026 at 12:55 p.m., the EDO said he expected all MDS assessments to be completed timely per guidelines. Record review of facility policy titled, MDS 3.0 completion, dated October 2025, indicated, . Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. 2.e. Quarterly Assessment - completed using an ARD no > (longer than) 92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD). Review of the RAI manual, dated October 2019, indicated, quarterly assessments are completed by calculating from the ARD (assessment reference date) of the previous assessment plus 92 calendar 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676444	Facility ID: 676444
		If continuation sheet Page 1 of 5

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviewed, the facility failed to ensure an encoded, accurate, and complete MDS discharge assessment was electronically transmitted to the CMS System for 1 of 26 residents records reviewed for MDS assessments. (Residents #127) The facility failed to ensure the discharge MDS assessment was completed and transmitted as required for Resident #127. This failure could place residents at risk for MDS assessments not being transmitted and not receiving care and services as needed. Findings included: Record review of admission record for Resident #127, dated 03/04/2026, indicated Resident #127 was admitted on [DATE], [AGE] years old with diagnoses of anxiety, high blood pressure, heart failure and chronic pain. The admission record included the date of discharge was 09/09/2025. Record review of Resident #127's transfer record, dated 09/09/2025, indicated she was transferred to the local hospital with physician's orders. Record review of Resident #127's discharge MDS assessment, dated 09/09/2025, indicated she was discharged on 09/09/2025 however the MDS was not completed, signed or transmitted. Record review of the electronic record for Resident #127 indicated a list of MDSs, dated 08/30/2025 to 09/9/2025, revealed the discharge MDS was not completed, signed or transmitted. The discharge MDS assessment indicated the status was in progress and was 162 days late. During an interview on 03/04/2026 at 11:00 a.m., MDS Nurse B said Resident #127's discharge assessment was not completed, signed or transmitted. She said she was unsure who started the discharge MDS assessment and said she would complete the assessment. During an interview on 03/04/2026 at 12:50 p.m., the DON said the MDS nurses were responsible for the timely completion and transmitting each MDS assessment. She said her expectations were for all MDS assessments to be completed accurately and timely as the MDS reflected the resident and necessary care and services provided. During an interview on 03/04/2026 at 12:55 p.m., the EDO said he expected all MDS assessments to be completed timely per guidelines. Record review of facility policy titled, MDS 3.0 completion, dated October 2025, indicated, . Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. f. Discharge Assessment-completed using the discharge date as the ARD. Must be completed within 14 days of the discharge date /ARD. Review of the RAI manual, dated October 2024, indicated, Discharge Assessment - return anticipated (Non-Comprehensive) completion date was discharge date plus 14 calendar days and MDS Completion Date plus 14 calendar days.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #21) reviewed for activities of daily living. The facility failed to clean, trim, and clip Resident #21's fingernails. This failure could place residents at risk of not receiving care and services to meet their needs, feelings of poor self-esteem, and lack of dignity and health. Findings included: Record review of Resident #21's face sheet, dated 03/03/2026, indicated a [AGE] year-old male, re-admitted [DATE]. Diagnoses included injury to unspecified level of lumbar spinal cord (a spinal cord injury that does not have a clearly defined location or severity, impacting motor and sensory functions in the lower body), paraplegia (injury to the spinal cord or brain that stops signals from reaching the lower body), pain, personal history of traumatic brain injury (brain injury that is caused by an outside force) and depression (mental illness that negatively affects how you feel, the way you think and how you act). Record review of Resident #21's MDS, dated [DATE], indicated a BIMS score of 13, indicating he was cognitively intact. Record review indicated he was dependent on staff to provide self-care including oral hygiene, toileting, shower/bathe, upper and lower bod dressing, putting on/taking off footwear and personal hygiene. He had impaired range of motion to both lower extremities and required an electric wheelchair for mobility. Record review of Resident #21's care plan, dated 03/09/2025, indicated he had a self-care performance deficit and was dependent on staff for most ADLs. Record review indicated an intervention for bathing/showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Record review of Resident #21's bedside electronic system utilized for documenting, organizing and easily referencing resident information, indicated on 03/03/2026, his task of bathing/showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. During a record review of Resident #21's task assignments for bathing, dated 02/03/2026 to 03/02/2026, indicated he received a bed bath three times a week by the CNAs with no indication of nail care offered or provided. During an observation and interview on 03/02/2026 at 11:05 a.m., Resident #21's fingernails were not clean, trimmed, nor cut. His nails on fingers and thumbs of both hands were uneven, jagged edged, and were approximately 1.5 cm in length, and all his fingernails had brown substance underneath. During an interview with Resident #21, he said he liked his fingernails cleaned and cut. He said he did not like his nails that long and the staff had not offered to cut his nails. He said he bathed three times a week, but the CNA did not offer to cut or trim his nails during his bath. He said he would like his nails trimmed for comfort. During an observation on 03/03/2026 at 1:21 p.m., Resident #21 was visiting with family in the front lobby. His fingernails remained long with jagged edges, and dirty. During an observation and interview on 03/04/2026 at 12:20 p.m., Resident #21 was up in his electric wheelchair in his room. He said CNA C provided him with a bath yesterday evening and cut, cleaned, and trimmed his fingernails. His fingernails were clean, trimmed, and well-manicured. During an interview on 03/04/2026 at 1:18 p.m., CNA C said she worked as a prn CNA, and she was the CNA assigned to care for Resident #21 on 03/03/2026 for the 2:00 p.m. - 10:00 p.m. shift. CNA C said she provided Resident #21 with a bed bath. CNA C said she trimmed and cleaned his fingernails because they were too long, jagged and dirty. She said that trimming and cleaning nails were part of a bath and residents' nails should be kept trimmed and cleaned to prevent scratching and poor hygiene. CNA C said she received training regarding nail care procedures. During an interview with the DON on 03/04/2026 at 1:45 p.m., she said staff should have cleaned, trimmed, and cut Resident #21's nails, and all residents' nails should be kept clean and trimmed, if desired. She said it is the CNAs responsibility to clean and trim nails during routine baths except for the brittle diabetic residents, whose r nails are trimmed by nursing or podiatry. The DON said if residents' nails are not cleaned, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trimmed, or cut it would increase risk of skin impairment, infection, and/or decrease in activities of daily living (difficulty picking up objects/food). During an interview with the EDO on 03/04/2025 at 2:0 p.m., he said he expected staff to clean, trim, and cut Resident #21's nails as desired. He said he expected staff to provide nail care to all residents' nails regularly and as needed for good hygiene. Record review of the facility's policy titled, Nail Care, dated 10/01/2025, indicated, Policy: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines. 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. 5. The resident's plan of care will identify: a. The frequency of nail care to be provided. b. The type of nail care to be provided. c. The person(s) responsible for providing nail care (e.g., licensed nurse, nurse aide, podiatrist, activity professional). 6. Principles of nail care: a. Nails should be kept smooth to avoid skin injury. b. Only licensed nurses shall trim or file fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems shall be filed only. c. If a resident has a toe infection, diabetes mellitus, neurologic disorders, renal failure, or PVD, toenail trimming should be performed by a physician or practitioner. d. Resident without complicating disease processes, may have their toenails clipped by staff who have received education and training to provide this service within professional standards of practice and as per facility policy. e. Each resident will have his/her own nail care equipment (e.g., clippers, emery boards, files, etc.). Equipment will not be shared between residents. Clean equipment after each use and before storing.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 8 medication carts (Medication cart D) reviewed for medication storage. The facility failed to ensure the narcotic box was attached and secured with double locks in Medication cart D. This failure could place residents at risk for drug diversion. Findings included: During an observation and interview on 03/04/2026 at 10:40 a.m., LVN D said this was the medication cart D. During observations of items in the medication cart, the narcotic box was not attached to the drawer and the narcotic box lifted off the drawer. The narcotic box freely slid out of the medication cart and exposed the narcotics. The medication cart drawer was the bottom of the box, which left the narcotics only secured by one lock on the medication cart. LVN D said she was unaware the narcotic drawer was loose and not secured. She said narcotics required two locks to prevent the risk of drug diversion. During an interview on 03/04/2026 at 10:45 a.m., the Maintenance Supervisor said he was not told the drawer was broken or not attached. He said he does not normally check medication carts routinely. The Maintenance Supervisor said if the nurses reported a concern, he would have fixed it. During an interview on 03/04/2026 at 10:47 a.m., the DON said she ordered a new medication cart every month for the last few months; however, she was unaware of this cart having an unsecured narcotic box. She said now she was aware the narcotic box could be lifted out; she would have nurses check that when they count each shift. Record review of Medication Storage policy dated 2025 indicated Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. 2. Narcotics and Controlled Substances: a. Schedule II drugs and back -up stock of Schedule III, IV and V medications are stored under double-lock and key.		