STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195327	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gonzales Healthcare Center	905 West Cornerview Road Gonzales, LA 70737

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46361 Based on record review and interview the facility failed to report the results of an investigation to the required state agency within 5 working days of a reportable incident for 1 (Resident #6) of 7 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) residents reviewed for abuse and/or neglect. Findings: Review of Resident #6's Facility Reported Incident entered on 05/30/2024 revealed an allegation of neglect. Review of the Facility Reported Incident log documentation revealed Resident #6 had an incident reported on 05/30/2024 and the investigation report was due to the state survey agency on 06/06/2024. In an interview on 06/13/2024 at 1:45 p.m., S4Corporate Clinical Specialist stated the results of Resident #6's investigation were submitted to the state survey agency on 06/07/2024 and should have been submitted by 06/06/2024. .

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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NAME OF PROVIDER OR SUPPLIER Gonzales Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 905 West Cornerview Road Gonzales, LA 70737	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46361 Based on record review and interviews, the facility failed to ensure an alleged incident of neglect was thoroughly investigated by the facility for 1 (Resident #4) of 7 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) residents reviewed for abuse and/or neglect. Findings: Review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2024 revealed, in part, Resident #4 had a Brief Interview for Mental Status (BIMS) of 15 which indicated Resident #4's cognition was intact. Further review revealed Resident #4 required substantial/maximal assistance from staff for toileting and partial/moderate assistance from staff for toilet transfers. Review of the Resident #4's facility incident report dated on 05/29/2024 revealed, in part, an investigation was initiated for Resident #4 with an allegation of neglect. Further review revealed Resident #4 reported problems receiving timely care from the night staff. S1Administrator documented Resident #4 was not forthcoming with information and provided no specific date or time pertaining to the allegation. S1Administrator also documented the facility reviewed the call system log and noted Resident #4 had to wait an extended amount of time for assistance on one occasion but did not document a date or time the incident occurred. Further review revealed there was no documented evidence the facility investigated why Resident #4 had to wait an extended amount of time for assistance or identified the staff member who was caring for the resident at that time. Review of Resident #4's nurse note dated 05/27/2024 at 5:23 p.m. revealed, in part, Resident #4 reported to S5Registered Nurse on the night shifts on 05/25/2024 and 05/26/2024 Resident #4 had to yell out for help to request assistance to the bathroom. Further review revealed Resident #4 reported she pressed her call light and staff would enter and stated they would help her but would leave and never return to provide care. Review of Resident #4's call light alarm log from 05/23/2024 through 05/31/2024 revealed, in part, on 05/27/2024 Resident #4's call light alarm was initiated at 5:16 a.m. and was cleared at 6:52 a.m. for a total of 96 minutes. In an interview on 06/12/2024 at 10:39 a.m., S1Director of Nursing (DON) stated S6Certified Nursing Assistant (CNA) was responsible for Resident #4 on 05/26/2024 at 7 p.m. through 05/27/2024 at 7 a.m. Review of the facility's investigation documentation for Resident #4's allegation of neglect revealed no evidence and the facility did not present any documented evidence a verbal or written statement was obtained from S6Certified Nursing Assistant (CNA) related to the investigation or the extended call light alarm time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/13/2024 at 11:15 a.m., S1Administrator stated he was aware of the nurse's noted dated 05/27/2024 which indicated Resident #4 alleged she did not receive care in a timely manner from staff on the night shift 05/25/2024 and 05/26/2024. S1Administrator confirmed this information was not included in Resident #4's investigation report. S1Administrator also confirmed a verbal and/or written statement from S6CNA was not included in the facility's investigation documentation for Resident #4 as required.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 46361 Based on record reviews and interviews, the facility failed to ensure a dependent resident received timely incontinence care for 1 (Resident #5) of 4 (Resident #1, Resident #4, Resident #5, and Resident #6) sampled residents investigated for incontinence care . Findings: Review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/22/2024 revealed, in part, Resident #5 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated Resident #5 had moderately impaired cognition. Further review revealed Resident #5 was incontinent of bowel and bladder, and dependent on staff for toileting. Review of the facility's incident report dated 05/29/2024 revealed, in part, the report was initiated for an allegation of neglect. Further review revealed Resident #5 reported on 05/30/2024 she was not changed by the day shift Certified Nursing Assistant (CNA) on 05/29/2024. Further review revealed the facility identified S7CNA as the accused associate with the allegation and obtained a verbal statement from S7CNA on 05/31/2024. Further review revealed S7CNA confirmed she was assigned to provide care to Resident #5 on the day shift on 05/29/2024 and after lunch she did not go back to Resident #5's room to provide any care or services. Further review of the facility incident report revealed S8CNA was assigned to provide care to Resident #5 on the evening shift on 5/29/2024 and reported Resident #5 was found saturated with urine. In an interview on 06/13/2024 at 12:22 p.m., S8CNA indicated at the start of her shift on 05/29/2024 Resident #5 was found to be saturated with urine through her adult brief onto her incontinence pad and onto the sheets. In an interview on 06/13/2024 at 12:31 p.m., S1Administrator confirmed he obtained a verbal statement from S7CNA which indicated Resident #5 did not receive any care from S7CNA from approximately 11:30 a.m. through the end of her shift at 7:00 p.m. S1Administrator confirmed Resident #5 should not have been left unchanged and/or unattended to on 05/29/2024 from approximately 11:30 a.m. until the next shift provided care.