

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Gonzales Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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** 49259</p> <p>Based on interviews and record reviews, the facility failed to protect a resident's right to be free from verbal abuse by staff. This deficient practice was identified for 1 (Resident #1) of 4 (Resident #1, Resident #2, Resident #3, and Resident #4) sampled residents reviewed for abuse.</p> <p>Findings:</p> <p>Review of the facility's Abuse Prohibition Policy review dated 05/17/2024 revealed, in part, verbal abuse was defined as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to the residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.</p> <p>Review of the facility's documentation related to an incident dated 07/26/2024 revealed an anonymous bystander from Resident #1's physician's office and staff from Resident #1's physician office reported to the facility that they witnessed S4Transportation Driver (S4TD) refuse to assist Resident #1 with filling out his paperwork and yelled nothing was wrong with his hands he was there for his legs.</p> <p>Review of Resident #1's record revealed he was admitted on [DATE] with diagnoses, in part, of right ankle effusion, sepsis, generalized weakness and injury to left eye.</p> <p>Review of Resident #1's Minimum Data Set with an Assessment Reference Date of 07/25/2024 revealed Resident #1 had a Brief Interview for Mental Status of 14 which indicated Resident #1 was cognitively intact.</p> <p>In an interview on 08/12/2024 at 10:34 a.m. Resident #1 indicated S4TD was rude to him while he was at his physician's appointment. Resident #1 further indicated he needed help filling out his paperwork, and when he requested help S4TD told him there is something wrong with your legs, not your hands, you can do it yourself.</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: 195327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Gonzales Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/14/2024 at 1:51 p.m. S1Administrator (ADM) indicated a bystander in the waiting room at Resident #1's physician's office, reported they witnessed S4TD refused to assist Resident #1 with his paperwork and yelled at Resident #1. S1ADM further indicated Resident #1's physician's office corroborated the bystander's report. S4TD was suspended on 07/26/2024 and subsequently was terminated on 08/05/2024 after the facility investigation substantiated the above mentioned verbal abuse occurred.</p>