

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 09/05/2024
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47081</p> <p>Based on observation, interview, and record review, the facility failed to properly secure residents in the facility's transportation vehicles for 2 (Resident #5 and Random Resident #6) of 2 (Resident #5 and Random Resident #6) sampled residents reviewed for accident hazards.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 08/22/2024 at 11:47 a.m. for Resident #5 when S6Driver failed to properly secure the resident in a forward facing direction in the facility's transportation bus, Resident #5's wheelchair tipped over backwards during transport, and caused Resident #5 to strike the back of her head. Resident #5 was transported to the hospital where she was assessed as having an abrasion to the back of the head and had to receive pain medication. The IJ continued on 09/03/2024 at 12:30 p.m. for Random Resident #6, when S4ActivitiesDirector (AD) was observed failing to secure Random Resident #6 into the facility's transport van using both the lap belt and the shoulder strap and left the facility with Random Resident #6 improperly restrained.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 09/03/2024 at 5:59 p.m.</p> <p>The Immediate Jeopardy was removed on 09/04/2024 at 2:39 p.m., after it was verified through observations, interviews, and record reviews, that the facility implemented an acceptable Plan of Removal, prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimal harm to the 75 residents who resided in the facility and may use the use of the facility's transportation vehicles.</p> <p>Findings:</p> <p>Resident #5</p> <p>Review of the facility's Policy and Procedure titled Securing Residents in Van dated 04/2015 revealed, in part, the driver shall ensure residents in wheelchairs are forward facing in vehicles.</p> <p>Review of Resident #5's Electronic Medical Record (EMR) revealed, in part, Resident #5 was admitted to the facility on [DATE] with diagnoses of muscle weakness, cognitive communication deficit, and lower back pain.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195327
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of Resident #5's care plan with a planned review date of 09/29/2024 revealed, in part, Resident #5 was at high risk for falls due to confusion and gait/balance problems.</p> <p>Review of S6Driver's written and signed statement revealed, in part, Resident #5 was being transported in the facility bus, when the van hit a bump in the road. S6Driver then saw Resident #5's wheelchair had tipped backwards. Further review revealed S6Driver did not have Resident #5 forward facing in the facility vehicle.</p> <p>Review of Resident #5's medical records revealed, in part, Resident #5 was evaluated at a local emergency department on 08/22/2024 for a head injury sustained during transport in the facility's bus.</p> <p>Review of Resident #5's nurse's notes dated 08/22/2024 revealed, in part, Resident #5 had an abrasion to the back of her head. Further review revealed Resident #5 received pain medication while in the emergency department.</p> <p>In an interview on 09/03/2024 at 11:30 a.m., S1Administrator indicated Resident #5 was not secured in accordance with facility transportation guidelines.</p> <p>In an interview on 09/05/2024 at 11:30 a.m., S5Maintenance Director (MD) indicated resident wheelchairs should be secured to the transport vehicle using 4 straps and forward per the training videos related to vehicle safety. S5MD further indicated if a wheelchair is strapped down properly it should not move or tip over.</p> <p>Random Resident #6</p> <p>Review of Facility's Policy and Procedure entitled Securing Residents in Van dated 04/2015 revealed, in part, the driver shall ensure the shoulder straps cross diagonally across the upper chest of the passenger.</p> <p>Review of Random Resident #6's record revealed, in part, Random Resident #6 was admitted to the facility on [DATE] with diagnoses of muscle weakness, hemiplegia, and intervertebral disc degeneration.</p> <p>Review of Random Resident #6's care plan with a planned review date of 09/01/2024 revealed, in part, Random Resident #6 was a high risk for falls and at risk for bleeding if a fall would occur.</p> <p>Observation on 09/03/2024 at 12:08 p.m., revealed S4AD loaded Random Resident #6 in the facility's transportation van without using the vehicle's installed shoulder straps.</p> <p>In an interview on 09/03/2024 at 12:15 p.m., S4AD indicated Random Resident #6 did not need to use the shoulder strap to secure residents in the facility transport vehicles. S4AD further indicated she did not routinely use the shoulder strap when she transported residents.</p> <p>Observation on 09/03/2024 at 12:30 p.m. revealed S4AD left the facility, and transported Random Resident #6 in the facility's transportation van without securing Random Resident #6 with the shoulder straps.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>In an interview on 09/03/2024 at 12:55 p.m., S5MD indicated the shoulder harness should always be used to secure residents in the facility's transport van. S5MD further indicated S4AD should have used the shoulder strap prior to transporting Random Resident #6.</p> <p>In an interview on 09/03/2024 at 1:10 p.m., S1Administrator indicated Resident #6 should have been secured with the shoulder belt.</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>47081</p> <p>Based on observations, record reviews, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by failing to have an adequate system in place to ensure residents were properly restrained in the facility's transportation vehicles, vehicle transportation logs were completed as required for the facility's transportation vehicles, and the facility's transportation drivers were competent on the use of the facility's van and bus restraint systems prior to transporting residents.</p> <p>This lack of administrative oversight resulted in an Immediate Jeopardy situation on 08/22/2024 at 11:47 a.m. for Resident #5 when S6Driver failed to properly secure the resident in a forward facing direction in the facility's transportation bus, Resident #5's wheelchair tipped over backwards during transport, and caused Resident #5 to strike the back of her head. Resident #5 was transported to the hospital where she was assessed as having an abrasion to the back of the head and had to receive pain medication. The IJ continued on 09/03/2024 at 12:30 p.m. for Random Resident #6, when S4ActivitiesDirector (AD) was observed failing to secure Random Resident #6 into the facility's transport van using both the lap belt and the shoulder strap and left the facility with Random Resident #6 improperly restrained.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 09/03/2024 at 5:58 p.m.</p> <p>The Immediate Jeopardy was removed on 09/04/2024 at 2:39 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimal harm to the 75 residents who resided in the facility and may use the facility's transportation vehicles.</p> <p>Findings:</p> <p>Cross reference F689.</p> <p>Review of the facility's job description for the Administrator dated 2003 revealed, in part, the Administrator shall ensure all facility personnel follow established safety regulations.</p> <p>Review of the facility's policy titled Facility Vehicle Log dated 04/2015 revealed, in part, the van use log will be completed by the driver for each trip. Further review revealed the driver's weekly vehicle safety inspection will be completed by the driver each week.</p> <p>Review of the facility's Van Use Log for the transport bus revealed, in part, incomplete entries for mileage and times. Further review revealed no entry dated 08/22/2024 for Resident #5's initial transport by S6Driver in which the fall with injury occurred.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of the facility's Driver Weekly Safety Inspection log for bus #09796 dated 08/02/2024, 08/09/2024, and 08/23/2024 revealed, in part, blank forms with no entries or inspections performed.</p> <p>Review of the facility's Quality Assurance (QA) Plan for transporting residents safely in facility vehicles dated 08/27/2024 revealed, no documented evidence, and the facility could not provide any documented evidence, that weekly driver audits were performed from 08/27/2024 through 09/03/2024 or that an immediate in-service safety training for all drivers was performed from 08/27/2024 to 09/03/2024.</p> <p>In an interview on 09/03/2024 at 1:10 p.m., S1Administrator indicated the facility's transportation drivers should secure the facility's residents in the transportation vehicles according to the manufacturer's instructions and facility policy. S1Administrator further indicated he was aware the transported residents should have both a lap belt and shoulder strap during transport in a facility vehicle. S1Administrator offered no explanation or comment related to the deficient practice.</p> <p>In an interview on 09/03/2024 at 1:50 p.m., S1Administrator confirmed there had been no weekly driver audits performed since the QA plan for transporting residents safely in facility vehicles began on 08/27/2024.</p> <p>In an interview on 09/04/2024 at 10:00 a.m., S1Administrator indicated he was overall responsible for the safety of residents being transported in facility vehicles. S1Administrator further indicated the van's transportation logs should have been reviewed for completeness and accuracy.</p> <p>In an interview on 09/04/2024 at 10:45 a.m., S1Administrator indicated he was overall responsible for the training and competency of the facility's vehicle drivers.</p> <p>In an interview on 09/04/2024 at 11:15 a.m., S5Maintenance Director confirmed there was no documented evidence and he was unable to provide any documented evidence that safety inspections were performed for the weeks of 08/02/2024, 08/09/2024, and 08/23/2024 and should have been.</p> <p>In an interview on 09/04/2024 at 1:15 p.m., S1Administrator indicated the facility was unable to produce any documented evidence that the required weekly safety inspections were performed on transport bus.</p>