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	03/10/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49753 Based on interviews and record reviews, the facility failed to ensure a resident remained free from neglect when nursing staff failed to provide peri-care for 1(Resident #3) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated for neglect. Findings: Review of the facility's Abuse Prohibition Policy, dated 05/17/2024, revealed, in part, neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, good or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Review of Resident #3's medical records revealed, in part, Resident #3 was admitted to the facility on [DATE], with diagnoses of dysphagia following cerebral infarction, generalized muscle weakness, other lack of coordination, unsteadiness on feet, and neuromuscular dysfunction of bladder. Review of Resident #3's quarterly Minimum, Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/2025 revealed, in part, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #3 was cognitively intact. Further review revealed Resident #3 was always incontinent of bowel and bladder and was dependent upon staff for toileting hygiene needs. Review of Resident #3's Care Plan dated 01/01/2025 revealed, in part, Resident #3 had a neurogenic bladder. Further review revealed interventions included for the facility's staff to perform incontinent care on Resident #3 during daily care and as needed (PRN), to change Resident #3's clothing PRN after incontinence episodes, and to provide Resident #3 with briefs/incontinent pads as needed. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Statewide Incident Management System SIMS investigation completed by S1Administrator, dated 02/02/2025, revealed, in part, Resident #3 alleged she was neglected by S4Certified Nursing Assistant (CNA) and S5CNA when she was left wet and dirty for an extended period of time. Review also revealed, Resident #3's oncoming CNAs confirmed Resident #3's allegations and reported they found Resident #3 wet, over saturated and dirty brief. Review further revealed that S4CNA indicated he viewed the schedule for that shift and he was not assigned to Resident #3's room, but S5CNA indicated she had a verbal conversation with S4CNA about him adding Resident #3 to his assignment. Review also revealed S6Licensed Practical Nurse (LPN) indicated she was not aware of any changes in the CNAs assignment on 02/02/2025, and S5CNA recorded ADL documentation on 02/02/2025 for Resident #3 and his roommate. Further review revealed Resident #3's allegation of neglect was substantiated by the facility. In an interview on 03/10/2025 at 3:44PM, S2Director of Nursing (DON) confirmed that the miscommunication about the assignment for 02/02/2025 between S4CNA and S5CNA did result in Resident #3 being neglected by the staff, and it should not have.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46361 Based on interviews and record reviews, the facility failed to implement the facility's abuse policy by failing to ensure staff reported an allegation of abuse for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated for abuse. Findings: Review of the facility's Abuse Prohibition policy and procedure, revised on 05/17/2024, revealed in part, each resident had the right to be free from abuse and mistreatment. Further review revealed verbal abuse was defined as use of oral language that willfully included derogatory terms to residents. Further review revealed any employee who became aware of an allegation of abuse should report the incident to the abuse coordinator immediately. Review of Resident #1's Minimum Data Set with an Assessment Reference Date of 01/17/2025 revealed, in part, Resident #1 had a Brief Interview of Mental Status score of 15, which indicated Resident #1's cognition was intact. In an interview on 03/03/2025 at 11:21AM, Resident #1 indicated S7Certified Nursing Assistant (CNA) was disrespectful to her last night and told her to shut up. Resident #1 further indicated the allegation of verbal abuse was reported to the social worker this morning on 03/03/2025. In an interview on 03/06/2025 at 12:03PM, S9Social Service Assistant (SSA) indicated on 03/03/2025 Resident #1 alleged that an unknown CNA told her to shut up. S9SSA further indicated she did not report the allegation of verbal abuse to anyone. In an interview on 03/06/2025 at 12:40PM, S1Administrator indicated he was not aware of Resident #1's allegation that an unknown CNA told her to shut up. S1Administrator confirmed the allegation of verbal abuse should have been reported to him immediately by S9SSA, and was not.

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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 interviews and record reviews, the facility failed to report an allegation of abuse and/or neglect to the State Agency for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated for abuse. Findings: Review of the facility's Abuse Prohibition policy and procedure, revised on 05/17/2024, revealed in part, mental abuse was defined as humiliation and threats of depravation, examples of verbal/mental abuse included denying food or care. Further review revealed the facility would report all allegations of abuse to the State Agency immediately or within two hours of the allegation. Review of Resident #1's Minimum Data Set with an Assessment Reference Date of 01/17/2025 revealed, in part, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated Resident #1's cognition was intact. Further review revealed Resident #1 had a diagnosis of cerebral palsy (a condition that affects muscle control and causes deficits in functional mobility), impaired range of motion in her bilateral upper extremities, and was dependent on staff for eating. Review of the facility's Life Satisfaction Rounds dated 03/03/2025 documented by S9Social Service Assistant (SSA) revealed, in part, Resident #1 alleged S8CNA told her to learn how to feed herself. In an interview on 03/06/2025 at 12:03PM, S9SSA confirmed she completed the above mentioned Life Satisfaction Rounds on 03/03/2025. S9SSA indicated on 03/03/2025 Resident #1 alleged S8CNA told her she needed to learn how to feed herself. S9SSA further indicated she turned in the above mentioned Life Satisfaction Rounds to S1Administrator on 03/03/2025. Review of the facility's incident reports submitted to the state agency revealed, in part, there was no documented evidence, and the facility did not present any documented evidence Resident #1's allegation of abuse and/or neglect was reported to the State Agency until 03/06/2025. In an interview on 03/06/2025 at 12:40PM, S1Administrator indicated he was aware of the above mentioned Life Satisfaction Round dated 03/03/2025 which indicated S8CNA told Resident #1 to learn how to feed herself. S1Administrator further indicated he did not report the allegation of abuse and/or neglect to the State Agency until 03/06/2025.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 46361 Based on interview and record review, the Quality Assurance and Performance Improvement (QAPI) committee failed to provide sufficient evidence that ongoing monitoring and evaluations were implemented to ensure corrective actions were put in place after many allegations of abuse and neglect were identified in 2024. Findings: Review of the facility's Quality Assessment and Assurance (QAA) policy and procedure last reviewed on 01/2024 revealed, in part, the QAA committee would develop and implement appropriate plans of action to correct identified deficiencies. Review of the facility's Immediate Plan of Improvement: Abuse and Neglect record dated 01/05/2025 revealed, in part, the facility identified a concern of having many abuse and neglect allegations in 2024. Further review revealed the corrective actions implemented by the facility were to initiate staff in-services on types of abuse and the importance of reporting suspected abuse or neglect immediately to the abuse coordinator (S1Administrator). Further review revealed the facility would implement a monthly in-service on abuse with staff, monitor the number of facility incident reports submitted to the state agency, and review the reports for any additional interventions that could be put in place. Review of the facility's QAA documentation revealed an in-service on abuse policies and procedures was completed on 01/05/2025 and an in-service on workplace aggression/violence was completed on 01/09/2025. Further review revealed no documented evidence and the facility did not present any evidence an in-service on abuse was completed with staff in the month of February 2025. Further review revealed no documented evidence and the facility did not present any evidence the facility evaluated the effectiveness of the abuse in-service training completed in January 2025. Further review revealed no documented evidence and the facility did not present any documented evidence of the monitoring, evaluation, or findings of the facility reported incidents. In an interview on 03/06/2025 at 3:05 PM, S1Administrator indicated he could not provide documentation showing how the facility monitored the effectiveness of the abuse in-services. S1Administrator further indicated he could not provide evidence the facility monitored and/or evaluated the facility reported incidents because he kept all the information in his head. S1Administrator further indicated the facility did not need to monitor the effectiveness of the abuse in-services because effectiveness could be determined by the number of facility incidents reported to the state agency concerning abuse. When S1Administrator was asked to clarify if the facility's plan was to wait for an incident of abuse or neglect to happen to a resident as opposed to monitoring the effectiveness of the staff's abuse training, S1Administrator responded, What's wrong with that?