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	05/13/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, the facility failed to ensure a thorough investigation was completed for an allegation of physical abuse for 2 (Resident #21 and Resident #60) of 3 sampled residents reviewed for abuse and/or neglect. Findings:Review of the facility's Training on Resident-to-Resident Abuse Prevention and Response policy and procedure revised on 10/22/2025 revealed, in part, the facility would conduct a thorough investigation and document all findings and actions taken. Review of the facility's documentation of the investigation sent to the state agency on 04/29/2026 revealed, in part, Resident #60 was the reported victim and Resident #21 was the reported accused for an allegation of physical abuse. S1Administrator further wrote the incident was witnessed by staff and residents. Resident #21 Review of Resident #21's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/10/2026 revealed, in part, Resident #21 had a Brief Interview Mental Status (BIMS) Score of 15, which indicated Resident #21 was cognitively intact. In an interview on 05/12/2026 at 10:50AM, Resident #21 indicated she had an altercation with Resident #60 in the dining room on 04/29/2026. Resident #60 Review of Resident #60's MDS with an ARD of 04/07/2026 revealed, in part, Resident #60 had a BIMS score of 13, which indicated Resident #60's was cognitively intact. In an interview on 05/12/2026 at 1:04PM, Resident #60 indicated she had an altercation with Resident #21 on 04/29/2026. Review of the facility's investigation documents for Resident #21 and Resident #60's alleged physical altercation on 04/29/2026 revealed, in part, no documented evidence the facility interviewed and/or obtained a witness statement from S9Assistant Dietary Manager. In an interview on 05/13/2026 at 9:05AM, S9Assistant Dietary Manager indicated she was the only staff member present in the dining room on 04/29/2026 and witnessed the resident-to-resident altercation between Resident #21 and Resident #60. S9Assistant Dietary Manager further indicated the facility's administrative staff never questioned her and/or obtained a witnessed statement for 04/29/2026 during Resident #21 and Resident #60's resident-to-resident altercation. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/13/2026 at 2:44PM, S1Administrator indicated he was responsible for overseeing the investigation for Resident #21 and Resident #60's alleged resident-to-resident physical altercation on 04/29/2026. S1Administrator further indicated he was not aware S9Assistant Dietary Manager was present in the dining room when the incident occurred and did not interview and/or obtain a statement from S9Assistant Dietary Manager who observed Resident #21 and Resident #60 during the resident-to-resident altercation on 04/29/2026. S1Administrator further indicated the facility's investigation of the alleged resident-to-resident physical abuse for Resident #21 and Resident #60 was lacking and the facility could have done a better job gathering information and documenting the investigation.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, interviews, and record reviews, the facility failed to ensure an ordered nutritional supplement was provided for 1 (Resident #5) of 1 sampled resident reviewed for nutritional supplements.Findings:Review of Resident #5's clinical record revealed Resident #5 had diagnoses which included Unspecified Protein-Calorie Malnutrition.Review of Resident #5's May 2026 physician orders revealed an order for a Mighty Shake nutritional supplements to be given to Resident #5 with lunch and supper.Review of Resident #5's Care plan with implementation date of 10/16/2025 revealed to provide Resident #5 with nutritional supplements as ordered.Observation on 05/11/2026 at 12:01PM revealed Resident #5's lunch meal tray did not contain the ordered Mighty Shake supplement.Observation on 05/12/2026 at 12:10PM revealed Resident #5's lunch meal tray did not contain the ordered Mighty Shake supplement.In an interview on 05/13/2026 at 9:29AM, S3Assistant Director of Nursing indicated Resident #5 was to receive Mighty Shake supplements from dietary with his lunch and supper meal tray. In an interview on 05/13/2026 at 10:16AM, Resident #5 indicated the Mighty Shake nutritional supplements had not been placed on his meal trays. In an interview on 05/13/2026 at 4:18PM, S8Dietary Manager indicated dietary staff had not been putting Mighty Shake nutritional supplements on Resident #5's lunch and supper meal trays.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to:1. Ensure a Personal Protective Equipment gown was used during intravenous central line (tube placed in a large vein for medication administration) medication administration (Resident #5); and,2. Ensure proper hand hygiene during nephrostomy tube (catheter inserted into the kidney to drain urine) site care (Resident #55).This deficient practice was identified for 1 (Resident #55) of 29 sampled residents observed and/or investigated during the medication administration and/or the infection control tasks. Findings:1. Review of the facility's Enhanced Barrier Precautions policy and procedure, last reviewed on 03/03/2026 revealed, in part, applying personal protective equipment for residents on Enhanced Barrier Precautions was based on the activity provided and/or assistance needed while in the resident's room. Further review revealed Enhanced Barrier Precautions are used when there is an indwelling medical device such as central lines. Further review revealed during device care or use, including central line, urinary catheter, feeding tube, tracheostomy/ventilator, apply gloves and a gown when care was provided. Review of Resident #55's electronic medical record revealed, in part, a diagnosis of urinary tract infection (an infection in the urinary system) dated 05/04/2026. Review of Resident #55's May 2026 Physician Orders revealed, in part, Meropenem 1 gram (an intravenous antibiotic solution used to treat severe bacterial infections) and to administer two times a day related to a urinary tract infection and unspecified Escherichia Coli (a type of bacteria), for 7 days beginning on 05/04/2026 and with an end date of 05/12/2026. Review of Resident #55's May 2026 electronic medication administration record revealed, in part, Meropenem 1 gram, an intravenous antibiotic solution, was administered through Resident #55's central line device as ordered on 05/11/2026 at 8:00AM. Observation on 05/11/2026 at 9:22AM revealed an Enhanced Barrier Precautions sign on the outside of Resident #55's door. Observation on 05/11/2026 at 9:23AM, during medication administration revealed S5Licensed Practical Nurse administered Resident #55's scheduled Meropenem 1 gram, intravenous antibiotic solution, without a personal protective equipment gown as required for Enhanced Barrier Precautions. In an interview on 05/13/2026 at 1:28PM, S5Licensed Practical Nurse indicated on 05/11/2026 she failed to apply a personal protective equipment gown as required for Enhanced Barrier Precautions during Resident #55's central line intravenous antibiotic solution administration. In an interview on 05/13/2026 at 1:30PM, S3Assistant Director of Nursing/Infection Preventionist indicated S5Licensed Practical Nurse did not apply a gown as required for Enhanced Barrier Precautions during Resident #55's central line intravenous antibiotic solution administration, and should have. 2. Review of facility's Handwashing/Hand Hygiene policy and procedure, last revised/reviewed on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/16/2026, revealed, in part, when applying gloves, remove one glove from the dispensing box at a time, touching only the top of the cuff. Resident #55 was admitted to the facility on [DATE] with diagnosis, in part, acute kidney failure, urinary tract infection, and obstructive uropathy (a blockage in the urinary tract that prevents urine from flowing properly). Review of Resident #55's Physician's Orders revealed an order that Resident #55's nephrostomy tube site was to be cleansed with wound cleanser, pat dry, and cover with split gauze and cover with mediplex tape daily and as needed on 04/30/2026. Observation on 05/12/2026 at 2:10PM revealed S4Wound Care Nurse performed hand hygiene and then placed on a placed a PPE gown and placed one pair of gloves on top of another pair of gloves and proceeded to revoke the dressing from Resident #55's nephrostomy tube site and cleaned with normal saline. S4Wound Care Nurse then removed her top layer of gloves and took a pair of gloves from her pocket and put on top of the remaining pair of gloves S4Wound Care Nurse was already wearing. S4Wound Care Nurse then put on the new split gauzed dressing and taped it down. In an interview on 05/12/2026 at 2:18PM, S4Wound Care Nurse indicated she should not have used the gloves that were in her pocket. In an interview on 05/12/2026 at 4:25PM, S3Assistant Director of Nursing/Infection Preventionist confirmed S4Wound Care Nurse should not have used gloves that were in her pocket. In an interview on 05/13/2026 at 10:50AM, S2Director of Nursing indicated S4Wound Care Nurse should not have used gloves that were in her pocket. S2Director of Nursing further indicated S4Wound Care Nurse should not have double gloved.