STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195348	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacombe Nursing Centre	28119 Hwy 190 Lacombe, LA 70445

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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and interview, the facility failed to post the name, address, and telephone numbers of the Office of the State Long-Term Care Ombudsman program, in a form and manner accessible and understandable to residents and resident representatives. This deficient practice had the potential to affect any of the 71 residents residing in the facility.On 07/28/2025 at 9:45 a.m., an observation of the facility revealed no posting/signage of the required Office of the State Long-Term Care Ombudsman Program names, addresses, and telephone numbers. On 07/28/2025 at 9:50 a.m. an observation was made throughout the facility with S3ADON. S3ADON confirmed there was no information regarding the Office of the State Long-Term Care Ombudsman Program posted in the facility.

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: 195348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure all medical records regarding the resident's code status consistently reflected the resident's wishes for 2 (#4 and #66) of 25 residents reviewed in the initial screening for advanced directives. Review of the facility’s undated policy titled, “LaPOST”, revealed the following, in part:Procedure6. Place the original LaPOST form in a prominent and appropriate place in the medical record. Do not document code status in the electronic record. Resident #4Review of Resident #4’s clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #4's current Physician Orders revealed the following, in part:Order date: [DATE]-Full Code Status. Review of Resident #4's hard, physical chart revealed a Louisiana Physician Orders for Scope of Treatment (LaPOST) dated [DATE]. The LaPOST revealed Resident #4’s Health Care Representative checked DNR/Do Not Attempt Resuscitation. Resident #66 Review of Resident #66’s clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #66’s electronic medical record revealed a LaPOST dated [DATE]. The LaPOST revealed Resident #66’s Health Care Representative checked CPR/Attempt Resuscitation. Further review of Resident #66’s electronic medical record revealed no other LaPOST documents. Review of Resident #66’s hard, physical chart revealed a LaPOST dated [DATE]. The LaPOST revealed Resident #66 checked DNR/Do Not Attempt Resuscitation. On [DATE] at 12:58 p.m., an interview was conducted with S6LPN. She stated she was assigned to Resident’s #66 and #4. She stated Resident #66 was a full code but recently changed to a DNR. She stated the facility’s process was to look directly in the resident's hard, physical chart for code status and not in the resident’s electronic medical record. On [DATE] at 1:05 p.m., an interview was conducted with S2DON. She stated the facility’s process for checking a resident’s code status was to look directly in the resident’s hard, physical chart. She stated she went through all residents’ charts and deleted the code status orders to eliminate confusion. She was made aware of the findings above. She stated she did not realize LaPOST forms were scanned into some of the resident’s residents’ charts. She confirmed if a resident’s code status was found in two different places, the code statuses should match.

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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 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** Based on interviews, video observation, and record review, the facility failed to protect the resident's right to be free from physical abuse for 1 (#4) of 24 sampled residents reviewed for abuse. The facility failed to ensure Resident #4 was free from physical abuse by Resident #50.Review of the facility's policy dated 2025 and titled, Policy for Prohibition of Abuse revealed in part, the following:Each resident has the right to be free from abuse.Resident #4Review of Resident #4's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Parkinson's Disease, Depression, and Mild Intellectual Disabilities.Review of Resident #4's Quarterly MDS with an ARD of 06/05/2025 revealed a BIMS of 11, which indicated he was moderately cognitively impaired.Review of Resident #4's July 2025 Progress Notes revealed in part, the following:On 07/13/2025 S9RN wrote, Resident #4 wheeled himself into nurse's station and stated to S9RN, Resident #50 just punched me in my face. S9RN asked Resident #4 why the other Resident #50 would have punched him in the face, and he stated, I don't know. I was just down there sitting next to her and she told me to go away and I didn't, and she punched me. Once S9RN completed assessment of Resident #4, S9RN, entered day room, where incident occurred, to ask Resident #50 if she had in fact hit resident. Resident #50 responded Yeah, I sure did. But I didn't hit him hard. Notified S10WS of incident. S1ADM was then notified.Review of Resident #4's current Care Plan revealed in part, the following:On 07/13/2025, Resident #4 reported Resident #50 hit him in the face because he sat next to her and did not move when she asked him to.Resident #50 Review of Resident #50's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Depression and Anxiety.Review of Resident #50's Annual MDS with an ARD of 06/20/2025 revealed a BIMS of 10, which indicated she was moderately cognitively impaired.Review of Resident #50's July 2025 Progress Notes revealed in part, the following:On 07/13/2025 S13LPN wrote, Resident #4 stated Resident #50 punched him in the face. S13LPN completed assessment of Resident #4, entered day room, where incident occurred, and asked Resident #50 if she hit Resident #4. Resident #50 responded Yeah, I sure did. But I didn't hit him hard. Notified S10WS of incident. S1ADM was then notified. On 07/29/2025 at 8:05 a.m., review of the facility's incident log dated July 2025 revealed in part, the following:Physical Aggression Received Incidents:07/13/2025 at 2:00 p.m.-Resident #4Physical Aggression Initiated Incidents:07/13/2025 at 2:00 p.m. - Resident #50On 07/29/2025 at 8:05 a.m., review of the facility's incident report dated 07/13/2025 revealed in part, the following:Incident Location: Activity RoomPerson Preparing Report: S9RNIncident Description:Resident #4 wheeled himself into the nurse's station and stated to S9RN, Resident #50 just punched me in my face. S9RN asked Resident #4 why Resident #50 punched him in the face, and he stated he didn't know. Resident #4 stated he was sitting down next to Resident #50, she told him to go away and he didn't, and then she punched him.Immediate Action Taken:S9RN immediately assessed Resident #4. After assessing Resident #4 S9RN entered the day room, where the incident occurred. S9RN asked Resident #50 if she hit Resident #4 and she responded, Yeah, I sure did. But I didn't hit him hard. S9RN notified S10WS of the incident. S1ADM was then notified by S10WS. Review of Resident #50's current Care Plan revealed on 07/13/2025, Resident #50 became angry and hit another resident when he did not do what she asked him to do and said something inappropriate to her. Resident #50 has the potential to be physically aggressive, related to poor impulse control.An interview was conducted on 07/29/2025 at 9:20 a.m. with Resident #50. She was alert and oriented to person, place, time, and situation. Resident #50 stated around 2 weeks ago, she punched Resident #4 in the face with a closed fist in the activity room. She stated Resident #4 came to her table and began speaking to her in a sexually (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lacombe Nursing Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 28119 Hwy 190 Lacombe, LA 70445	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inappropriate manner. Resident #50 stated she told Resident #4 multiple times to leave her alone and he did not. She stated she then punched Resident #4 in the face with a closed fist. Resident #50 stated she meant to punch him and would do it again if he bothers me. She stated after the incident, S1ADM asked her what happened. Resident #50 stated she told S1ADM that she punched Resident #4 in the face when he spoke to her in a sexually inappropriate manner in the activity room.An interview was conducted on 07/29/2025 at 9:30 a.m. with Resident #4. He was alert and oriented to person, place, time, and situation. He stated around 2 weeks ago, Resident #50 punched him in the face with a closed fist in the activity room. He stated it hurt a little. He stated after the incident, S1ADM asked him what happened. He stated he told S1ADM Resident #50 punched him in the face when he was trying to talk to her in the activity room.An interview and video camera footage observation was conducted on 07/29/2025 at 11:00 a.m. with S1ADM. Review of the video camera footage with S1ADM dated 07/13/2025 at 1:49 p.m. revealed Resident #4 and Resident #50 can be seen at a table together in the activity room. Resident #50 hit Resident #4 in the head with her hand. Resident #50 then placed her head in her hands while looking down at the table.An interview was conducted on 07/29/2025 at 2:15 p.m. with S2DON. She stated she was aware of the incident on 07/13/2025 between Resident #4 and Resident #50 and stated it was not willful abuse.An interview was conducted on 07/29/2025 at 3:03 p.m. with S9RN. She stated Resident #4 and Resident #50 are alert, oriented, and able to make their needs known. She stated on 07/13/2025, Resident #4 told her Resident #50 punched me in the face. She stated Resident #50 told her Yes I sure did hit him, but I didn't hit him hard. I'll do it again if I have to. She stated Resident #50 told her she was not sorry for hitting Resident #4. She stated she immediately notified S10WS, who then notified S1ADM. She stated Resident #50 punching Resident #4 was physical abuse.An interview was conducted on 07/30/2025 at 11:57 a.m. with S10WS. She stated Resident #4 and Resident #50 are alert, oriented, and able to make their needs known. She stated on 07/13/2025, S9RN notified her Resident #50 punched Resident #4 in the face. She stated this was not abuse because Resident #50 is a b***h. She stated she immediately notified S1ADM of the incident.An interview was conducted on 07/29/2025 at 11:00 a.m. with S1ADM. He stated he was notified on 07/13/2025 by S10WS that Resident #4 was punched in the face by Resident #50 in the activity room. He stated he did not believe this incident was abuse because it was not willful.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure allegations of physical abuse were reported to the State Agency in the required timeframe for 1 (#4) of 24 sampled residents reviewed for abuse.Review of the facility's policy dated 02/2025 and titled, Policy for Prohibition of Abuse revealed in part, the following:Reporting:1. Report incidents to the state agency as required.Internal Reporting Timelines:Abuse: Immediately.Resident #4Review of Resident #4's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Parkinson's Disease, Depression, and Mild Intellectual Disabilities.Review of Resident #4's Quarterly MDS with an ARD of 06/05/2025 revealed a BIMS of 11, which indicated he was moderately cognitively impaired.Review of Resident #4's July 2025 Progress Notes revealed in part, the following:On 07/13/2025 S9RN wrote, Resident #4 wheeled himself into nurse's station and stated to S9RN, Resident #50 just punched me in my face. Once S9RN completed assessment of Resident #4, S9RN, entered day room, where incident occurred, to ask Resident #50 if she had in fact hit resident. Resident #50 responded Yeah, I sure did. But I didn't hit him hard. Notified S10WS of incident. S1ADM was then notified.Resident #50 Review of Resident #50's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Depression and Anxiety.Review of Resident #50's Annual MDS with an ARD of 06/20/2025 revealed a BIMS of 10, which indicated she was moderately cognitively impaired.Review of Resident #50's July 2025 Progress Notes revealed in part, the following:On 07/13/2025 S13LPN wrote, Resident #4 stated Resident #50 punched him in the face. Notified S10WS of incident. S1ADM was then notified. On 07/29/2025 at 8:05 a.m., review of the facility's incident log dated July 2025 revealed in part, the following:Physical Aggression Received Incidents:07/13/2025 at 2:00 p.m.-Resident #4Physical Aggression Initiated Incidents:07/13/2025 at 2:00 p.m. - Resident #50On 07/29/2025 at 8:05 a.m., review of the facility's incident report dated 07/13/2025 revealed in part, the following:Incident Location: Activity RoomPerson Preparing Report: S9RNIncident Description:Resident #4 stated he was sitting down next to Resident #50, she told him to go away and he didn't, and then she punched him.Immediate Action Taken:S9RN notified S10WS of the incident. S1ADM was then notified by S10WS. An interview was conducted on 07/29/2025 at 9:20 a.m. with Resident #50. She was alert and oriented to person, place, time, and situation. Resident #50 stated around 2 weeks ago, she punched Resident #4 in the face with a closed fist in the activity room. She stated after the incident, S1ADM asked her what happened. Resident #50 stated she told S1ADM that she punched Resident #4 in the face when he spoke to her in a sexually inappropriate manner in the activity room.An interview was conducted on 07/29/2025 at 9:30 a.m. with Resident #4. He was alert and oriented to person, place, time, and situation. He stated around 2 weeks ago, Resident #50 punched him in the face with a closed fist in the activity room. He stated after the incident, S1ADM asked him what happened. He stated he told S1ADM Resident #50 punched him in the face when he was trying to talk to her in the activity room.An interview was conducted on 07/29/2025 at 3:03 p.m. with S9RN. She stated Resident #4 and Resident #50 are alert, oriented, and able to make their needs known. She stated on 07/13/2025, Resident #4 told her Resident #50 punched me in the face. She stated she immediately notified S10WS, who then notified S1ADM. She stated Resident #50 punching Resident #4 was physical abuse.An interview was conducted on 07/30/2025 at 11:57 a.m. with S10WS. She stated Resident #4 and Resident #50 are alert, oriented, and able to make their needs known. She stated on 07/13/2025, S9RN notified her Resident #50 punched Resident #4 in the face. She stated she immediately notified S1ADM of the incident.An interview was conducted on 07/29/2025 at 11:00 a.m. with S1ADM. He stated he was notified on 07/13/2025 by S10WS that Resident #4 was (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	punched in the face by Resident #50 in the activity room. He stated he did not believe this incident was abuse because it was not willful therefore it was not reported to the state agency.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident with an identified mental health diagnosis was referred for a Preadmission Screening and Resident Review (PASRR) Level II evaluation as required for 1 (#2) of 3 (#2, #9, and #47) residents reviewed for PASRR.Review of Resident #2's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Major Depressive Disorder. Further review revealed he was diagnosed with Adjustment Disorder on 10/26/2019 and Schizophrenia on 12/23/2019. Review of Resident #2's Level 1 PASRR dated 09/24/2019 revealed Section III: Mental Illness, did not have Adjustment Disorder or Schizophrenia selected as a diagnosis. On 07/30/2025 at 9:30 a.m., an interview was conducted with S7SSD. She stated she was responsible for resubmitting resident review forms to the Office of Behavioral Health (OBH) if a new mental health diagnosis was acquired. She reviewed Resident #2's Level 1 PASSR dated 09/24/2019 and confirmed a mental diagnosis of Major Depressive Disorder was checked. She reviewed Resident #2's current diagnoses list and confirmed he received a diagnosis of Adjustment Disorder on 10/26/2019 and Schizophrenia on 12/23/2019. She confirmed a resident review form should have been resubmitted to OBH for Level II evaluation after the new mental health diagnoses and was not.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards of practice. The facility failed to ensure a resident's oxygen was administered at the physician ordered rate for 1 of 1 (#10) residents reviewed for respiratory care.Review of Resident #10's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Senile Degeneration of the Brain.Review of Resident #10's current Physician Orders revealed the following, in part:Start date 05/12/2025 - Oxygen at 3L per nasal cannula continuous every shift.An observation was made on 07/28/2025 at 12:02 p.m. of Resident #10 in her room wearing oxygen per nasal cannula at 2.5L.An observation was made on 07/29/2025 at 9:00 a.m. of Resident #10 in her wearing oxygen per nasal cannula at 2.5L.An interview was conducted on 07/29/2025 at 9:02 a.m. with S8LPN. S8LPN confirmed Resident #10 had an order for oxygen per nasal cannula continuous at 3L. S8LPN confirmed Resident #10's oxygen was set at 2.5L and should have been at 3L.An interview was conducted on 07/29/2025 at 9:13 a.m. with S3ADON. She confirmed all residents' oxygen should be administered at the ordered rate.An interview was conducted on 07/30/2025 at 10:10 a.m. with S2DON. She confirmed all residents' oxygen should be administered at the ordered rate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store and prepare food under sanitary conditions by failing to ensure the food was properly stored and labeled in the facility's kitchen. This deficient practice had the potential to affect all of the 69 facility residents who were served from the facility's kitchen. Review of facility's undated policy titled, How to Store Under Sanitary Conditions revealed in part:1. For dry storage-All items must be in a container with a lid or in a labeled zip lock bag. All items must be labeled with what it is, the date it was opened and the initial of the person who placed it in there. On 07/28/2025 at 8:27 a.m., an observation was made of the kitchen food preparation area with S5CK. The observation revealed and S5CK confirmed the following items were found to be open and undated.1 - 20 ounce package of whole wheat sliced bread; and1 - 24 ounce package of dinner rolls.On 07/28/2025 at 8:32 a.m., an observation was made of the dry storage area with S5CK. The observation revealed and S5CK confirmed the following items were found to be open and undated.1 - 26 ounce package of instant mashed potatoes;1 - 5 pound package of macaroni noodles; and1 - 5 pound package of instant sliced potatoes. On 07/28/2025 at 8:45 a.m., an observation was made of the walk in cooler with S5CK. The observation revealed and S5CK confirmed the following items were open and undated. 1 - 2 quart pitcher of red punch and 1 - 5 pound container of chicken salad. On 07/28/2025 at 10:10 a.m., an interview was conducted with S4FSD. S4SFD stated she was responsible for the staff and the meals prepared in the facility's kitchen/dietary department. S4SFD observed the above observations. S4SFD confirmed all items should be labelled with the open date once opened.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain complete and accurate records in accordance with accepted professional standards and practices for 4 (#3, #6, #19, and #32) of 19 sampled residents reviewed for accurate documentation. The facility failed to ensure the following: 1. Resident #3's medication administration and wound care treatment administration were accurately documented; 2. Resident #6's Percutaneous Endoscopic Gastrostomy (PEG) site care was accurately documented; 3. Resident #19's medication administration and wound care treatment administration was accurately documented; and4. Resident #32's suprapubic catheter care was accurately documented. 1.Resident #3Review of Resident #3’s clinical record revealed he was admitted to the facility on [DATE] with diagnoses, which included Diabetes Mellitus II (DM), Acquired Absence of Left Great Toe, Non-Pressure Chronic Ulcer of Right Ankle, Acquired Absence of Other Left Toe, Cerebral Infarction Due to Embolism of Cerebral Artery, Acquired Absence of Limb, and Chronic Osteomyelitis with Draining Sinus. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/2025 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) of 15, which indicated she was cognitively intact. Review of Resident 3’s current Physician Orders revealed the following wound care orders, in part: DM wound right lateral ankle, clean with wound cleanser, pat dry with 4x4, apply betadine, pad, gauze wrap, elastic bandage dressing and secured with tape until resolved;DM wound to right 4th toe lateral, clean with wound cleanser, pat dry with 4x4, apply betadine, alginate between 4th and 5th toe, cover with pad, gauze wrap, elastic dressing and secure with tape until resolved;DM wound to right foot lateral, clean with wound cleanser, pat dry with 4x4, apply betadine, pad, gauze wrap, elastic dressing and secured with tape until resolved; andDM wound to right heel, clean with wound cleanser, pat dry with 4x4, apply betadine, pad, gauze wrap, elastic dressing and secured with tape. Review of Resident #3’s Treatment Administration Records (TAR) dated July 2025 revealed the aforementioned wound care treatment orders were not initialed as completed from 07/04/2025 through 07/11/2025 at 16:00, 07/15/2025 through 07/25/2025 at 16:00, and 07/28/2025 at 16:00. Review of Resident #3’s Medication Administration Records (MAR) dated July 2025 revealed the following medications were not initialed as completed on the following dates/times, in part:Novolog flex pen subcutaneous solution pen injector 100 unit/milliliters (ML) inject as per sliding scale on 07/26/2025 at 16:00 and 20:00, 07/27/2025 at 16:00 and 20:00;Observe for signs and symptoms of abnormal bleeding/bruising on the 07/26/2025 and 07/27/2025 evening shift;Pain monitoring on 07/27/2025 evening shift;Protein oral liquid 30 ML by mouth (PO) Twice a Day (BID) on 07/27/2025 at 16:30;Sotalol hydrochloride oral tablet 80 milligram (MG) give 1 tablet PO BID on 07/26/2025 and 07/27/2025 at 20:00;Vitamin C oral tablet 500 mg PO BID on 07/27/2025 at 20:00;Novolog flex pen subcutaneous (SC) solution pen injector 100 unit/ml inject 4 unit SC BID on 07/27/2025 at 16:00.Pregabalin oral capsule 150 mg give 1 capsule PO every 12 hours on 07/27/2025 at 20:00;Apixaban oral tab 5 mg PO BID on 07/27/2025 at 20:00;Atorvastatin calcium oral tablet give 1 tablet PO at bedtime on 07/27/2025 at 20:00;Fenofibrate Oral Tablet 145 mg give 1 tablet PO at bedtime on 07/27/2025 at 20:00; andMiralax oral powder 17 gram/scoop give 1 scoop PO one time a day on 07/27/2025 at 20:00. On 07/28/2025 at 1:43 p.m., an interview was conducted with Resident #3. She stated the nurses had not missed any wound care treatments since her admission to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195348	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacombe Nursing Centre	28119 Hwy 190 Lacombe, LA 70445

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/30/2025 at 1:09 p.m., an interview was conducted via telephone with S12LPN. She confirmed she worked the evening shift from 3:00 p.m. to 11:00 p.m. on 07/26/2025 and 07/27/2025 and completed medication administration for all of Resident #3’s medications. She further confirmed if the box was blank on the MAR next a medication, then medication administration was not accurately documented and should have been. On 07/30/2025 at 2:20 p.m., an interview was conducted with S2DON. She stated she expected the wound care nurse to accurately document each resident’s wound care treatment administration on the TAR and medication administration on the MAR. After review of Resident #3’s TAR and MAR dated July 2025, and S2DON confirmed the aforementioned wound care treatments and medication administration dates/ times were not accurately documented and should have been. 2.Resident #6Review of Resident #6’s clinical record revealed he was admitted to the facility on [DATE] with diagnoses, which included Gastrostomy Status and Mild Protein-calorie Malnutrition. Review of Resident #6’s current Physician Orders revealed the following, in part: PEG site: Clean with wound cleanser, pat dry, and cover with a drain sponge every day shift. Review of Resident #6’s TAR dated July 2025 revealed PEG site care was not documented as complete on 07/05/2025, 07/06/2025, 07/19/2025, and 07/20/2025. On 07/30/2025 at 12:40 p.m., an interview was conducted with S11LPN. She stated she worked and performed Resident #6’s PEG site care on 07/05/2025, 07/06/2025, 07/19/2025, and 07/20/2025. She confirmed if there was a blank box on the TAR for those dates, then treatment administration was not accurately documented. On 07/30/2025 at 2:17 p.m., an interview was conducted with S2DON. She stated S11LPN was responsible for Resident #6’s PEG site care and documentation on the aforementioned dates/times. S2DON reviewed Resident #6’s TAR dated July 2025 and confirmed incomplete documentation of PEG site care. S2DON further confirmed all PEG site care should be accurately documented upon completion. 3.Resident #19Review of Resident #19’s clinical record revealed he was admitted to the facility on [DATE] with diagnoses, which included Pain in Right Knee, Hypertensive Emergency, End Stage Renal Disease and DM. Review of Resident #19’s TAR dated July 2025 revealed the following wound care treatment orders were not initialed as completed, in part:Monitor surgical areas/sutures on right knee, cleanse and keep open to air every day shift for skin healing on 07/19/2025 and 07/20/2025. Review of Resident #19’s MAR dated July 2025 revealed the following medications were not initialed as completed on the following dates/ times, in part:Novolog flexpen subcutaneous solution pen injector 100 unit/ml inject as per sliding scale on 07/27/2025 at 1600 and 2000;Right upper arm midline to be checked every shift for increased redness, heat, signs of infiltration, or drainage on 07/27/2025 evening shift;Vitamin C oral tablet 500 mg give 1 tablet PO BID on 07/27/2025 at 20:00;Haloperidol oral tablet 1 mg give 1 tablet PO BID on 07/27/2025 at 20:00;Protein oral liquid give 30 ml PO BID on 07/27/2025 at 20:00;Carvedilol oral tablet 6.25mg give 1 tablet PO BID on 07/27/2025 at 20:00;Zinc sulfate oral capsule 220 mg give 1 capsule PO at bedtime on 07/27/2025 at 20:00;Normal Saline flush intravenous solution use 1 syringe intravenously in the evening to maintain midline patency (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Lacombe Nursing Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 28119 Hwy 190 Lacombe, LA 70445	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 07/27/2025 at 20:00;Ceftriaxone sodium injection solution reconstituted 1 gram use 1 gram intravenously at bedtime for anti-infective on 07/27/2025 at 20:00;Atorvastatin Calcium Oral Tablet 20 mg give 1 tablet PO at bedtime on 07/27/2025 at 20:00; andTizanidine hcl oral tablet 2 mg give 1 tablet PO at bedtime on 07/27/2025 at 20:00. On 07/30/2025 at 12:40 p.m., an interview was conducted with S11LPN. She confirmed she worked and performed Resident #19’s wound care on 07/19/2025 and 07/20/2025. S11LPN confirmed if the box was a blank on the TAR for those dates, then treatment administration was not accurately documented. On 07/30/2025 at 1:09 p.m., an interview was conducted with S12LPN. She confirmed she worked the evening shift from 3:00 p.m. to 11:00 p.m. on 07/26/2025 and 07/27/2025 and completed medication administration for all of Resident #19’s medications. She further confirmed if the box is blank on the MAR next to the medications, then medication administration was not accurately documented and should have been. On 07/30/2025 at 2:20 p.m., an interview was conducted with S2DON. She stated she expected the wound care nurse to accurately document each residents’ wound care treatment administration on the TAR and medication administration on the MAR. After review of Resident #19’s TAR and MAR dated July 2025, S2DON confirmed the aforementioned wound care treatments and medication administration dates/ times were not accurately documented and should have been. 4. Resident #32 Review of Resident #32's clinical record revealed she was admitted to the facility on [DATE] with diagnoses, which included Acute Kidney Failure and Neuromuscular Dysfunction of Bladder. Review of Resident #32’s current Physician Orders revealed the following, in part: Suprapubic Catheter: Clean with wound cleanser, pat dry, paint with betadine and cover with a drain sponge every day shift. Review of Resident #32’s TAR dated July 2025 revealed Suprapubic Catheter care treatment was not documented as complete on 07/05/2025, 07/06/2025, 07/19/2025, and 07/20/2025. On 07/30/2025 at 12:40 p.m., an interview was conducted with S11LPN. She stated she worked and performed Resident #32’s suprapubic catheter care on 07/05/2025, 07/06/2025, 07/19/2025, and 07/20/2025. She confirmed if there was a blank box on the TAR for those dates, then treatment administration was not accurately documented. On 07/30/2025 at 2:17 p.m., an interview was conducted with S2DON. She stated S11LPN was responsible for Resident #32’s suprapubic catheter care and documentation on the aforementioned dates/times. S2DON reviewed Resident #6’s TAR dated July 2025 and confirmed incomplete documentation of suprapubic catheter care. S2DON further confirmed all suprapubic catheter care should be accurately documented upon completion.