

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/24/2026
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents' call lights were within reach for 2 (#8 and #76) of 2 residents reviewed for accommodation of needs. Findings: Review of the facility's undated policy titled Call Light, revealed the following, in part: Objective: Call-Light is to be placed within reach of resident when in the room at all times. Resident #8 Review of Resident #8's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis of Acute on Chronic Diastolic (Congestive) Heart Failure. Review of Resident #8's Quarterly MDS with an ARD of 03/19/2026 revealed she had a BIMS of 7, which indicated she was severely cognitively impaired. Further review revealed she could make her needs known. Review of Resident #8's current Care Plan revealed she required assistance with ADL care and had potential for falls. Further review revealed interventions to keep the call light within reach. On 06/22/2026 at 11:15 a.m., an observation was made of Resident #8 in her room lying in her bed. Resident #8's call light was, clipped to the curtain which was pushed toward the back wall, and out of her reach. On 06/22/2026 at 11:16 a.m., an interview was conducted with Resident #8. She stated she used the call light to call staff when she needed assistance. She stated her room was too cold, she spilled tea and needed a towel, her stomach was cramping, and she needed to be changed. She stated she could not find her call light. She stated S11CNA changed her recently. She stated most of the time, the call light was not within reach for her to use and call for assistance. On 06/22/2026 at 4:13 p.m., an observation was made of Resident #8 lying in bed sleeping. Her call light was clipped to the outer edge of the bed and out of her reach. There was signage on the wall stating Please call don't fall call for assistance, with a picture of a call light. On 06/23/2026 at 8:15 a.m., an observation was made of Resident #8 in her room lying in her bed. Her (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light was clipped to the outer edge of the bed and out of her reach. On 06/23/2026 at 8:16 a.m., an interview was conducted with Resident #8. She stated she did not know where her call light was located. After she looked around in her bed, she stated she could not find it. On 06/23/2026 at 12:14 p.m., an interview was conducted with S11CNA. S11CNA stated Resident #8 was not able to get out of bed on her own and received assistance from staff for all ADL care. S11CNA stated Resident #8 used the call light, without difficulty, if she needed assistance in between staff rounds. On 06/23/2026 at 12:27 p.m., an observation and interview was conducted with S11CNA in Resident #8's room. S11CNA confirmed the call light was clipped to the right outer edge of the bed and was not within reach for the resident. S11CNA confirmed every time she entered a residents' room she should have placed the call light within reach and she did not. Resident #76Review of Resident #76's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Unspecified Dementia, Contracture of Muscle, Left Lower Leg, Contracture, Left Knee, Dysphagia, Hemiplegia and Hemiparesis following Non traumatic Intracerebral Hemorrhage affecting left non-dominant side. Review of Resident #76's Quarterly MDS with an ARD of 03/19/2026, revealed a BIMS score of 08, which indicated she was moderately cognitively impaired. Review of Resident #76's current Care Plan revealed she was bed and geriatric chair bound, required support and comfort related to left sided hemiplegia, incontinent of bowel and bladder, and required mechanical lift for transfers. Further review revealed interventions included to ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed. On 06/22/2026 at 9:47 a.m., an observation was made of Resident #76 revealed her call light was clipped to the right side of her mattress and not within her reach. On 06/22/2026 at 9:49 a.m., an interview and observation was conducted with Resident #76. She attempted to reach the call light to call for assistance and stated she was unable to reach the call light. On 06/23/2026 at 8:05 a.m., an observation of Resident #76's call light was made. Her call light was attached to the outer edge of the mattress at the level of her head and not within her reach. On 06/23/2026 at 8:06 a.m., an observation was made of Resident #76. Resident #76 attempted to reach for the call light and admitted she could not reach or find her call light. On 06/23/2026 at 8:07 a.m., an interview was conducted with S8CNASUP. S8CNASUP stated all call lights were to be within residents' reach at all times. After viewing where Resident #76's call light was located, S8CNASUP confirmed Resident #76's call light was not within reach. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/24/2026 at 8:10 a.m., an observation was made of Resident #76. Resident #76's call light was located hanging under her bed, not within her reach. On 06/24/2026 8:49 a.m., an interview was conducted with S3ADON in Resident #76's room. S3ADON confirmed Resident #76's call light was hanging under her bed and not within Resident #76's reach. S3ADON further confirmed all call lights should have been within residents' reach at all times and were not.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and record reviews, the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior by failing to ensure: Halls A, B, and C ceiling tiles were maintained in good repair; and Room BB was maintained safely, sanitarily, and in good repair. Findings: 1. On 06/22/2026 at 9:00 a.m., a tour of the facility was conducted with the following observations made: Hall A - There were multiple ceiling tiles with a brown and yellow discolored substance. The entrance of Hall A air conditioning vent located in close proximity to the nurses' station was observed to have active condensation with multiple black spots with yellow, brown, grey and black discoloration to the ceiling tile. The air conditioning vent cover was covered in a black substance. Hall B - There were numerous ceiling tiles with a brown and yellow discolored substance ranging in various sizes. The common/day room area of Hall B had multiple ceiling tiles with a brown, yellow and grey-black discoloration. Hall C - There were multiple ceiling tiles with a brown and yellow discolored substance. Additional observations were conducted of Hall A, Hall B, and Hall C on 06/23/2026 at 9:00 a.m. and 06/24/2026 at 9:00 a.m. which revealed the same observations listed above. On 06/24/2026 at 9:10 a.m., an observation was made of Hall A, Hall B, and Hall C with S10MS. He stated the brown and yellow discolored ceiling tiles were caused from either leaking condensation from air conditioning duct work or pin holes in the roof of the building. He stated these tiles didn't need to be changed and only needed a coating of paint primer. He stated the ceiling tiles that appeared to be grey and black in discoloration appeared to be mildew and needed to be changed immediately. 2. Resident #11 Review of Resident #11's clinical record revealed an admission date of 06/04/2026, and Resident #11 resided in Room BB. Review of Resident #11's admission MDS with an ARD of 06/11/2026 revealed, in part, the resident was assessed by the facility to have a BIMS of 15, which indicated he was cognitively intact. Resident #57 Review of Resident #57's clinical record revealed an admission date of 05/18/2026, and Resident #57 resided in Room BB. Review of Resident #57's admission MDS with an ARD of 05/25/2026 revealed, in part, the resident was assessed by the facility to have a BIMS of 15, which indicated he was cognitively intact. Review of the facility's Maintenance Log dated May 2026 to current revealed the following: 05/28/2026: Location: Room BB - AC leaking; 06/06/2026: Location: Room BB - AC leaking; and 06/13/2026: Location: Room BB - AC unit is leaking water on the floor. On 06/23/2026 at 8:50 a.m., observations were conducted of Room BB, which revealed the following: There was a grey wash basin underneath the air conditioning unit with water leaking into the basin. There was a small amount of water on the floor next to the basin at the foot of Resident #57's bed; electrical outlet in which the air conditioning unit was plugged into was off centered exposing interior wall, with staining of brown substance on the wall; Resident #11 and Resident #57's bathroom wall to the left of the sink had areas of bulged out paint. On 06/24/2026 at 8:50 a.m., additional observations were conducted of Hall B/Room BB environment. The grey wash basin underneath the air conditioning unit was 1/4 full of water due to continued leaking of air conditioning unit. All other aforementioned findings remained unchanged. On 06/24/2026 at 8:55 a.m., an interview was conducted with Resident #11 and Resident #57. Resident #11 and Resident #57 stated the air conditioning unit had been leaking since their admission. Resident #11 and Resident #57 stated maintenance attempted to fix the air conditioning unit, but everything they had attempted at this point had not resolved the issue. Resident #57 stated water was leaking all over the floor so his daughter had to put the grey wash basin underneath the air conditioning unit to collect dripping water. Resident #57 stated he would like to have the air conditioning unit fixed so his (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daughter would not have to keep emptying out the wash basin. On 06/24/2026 at 9:00 a.m., an interview was conducted with S10MS. He stated the air conditioning unit in Room BB had been serviced numerous times due to the drain hole becoming clogged with algae. He stated this was a common issue with all units within the facility. He stated the only fix for this was to drill the drain plug area to help facilitate better drainage. He confirmed this had not been done at this time and should have been to alleviate recurrent, ongoing issues with the leaking window unit into the interior of the building. On 06/24/2026 at 9:45 a.m., observations with an interview was conducted with S1ADM of the above findings. S1ADM confirmed the ceiling tiles on Hall A, Hall B, and Hall C needed to be replaced to prevent the growth of mildew or mold from visible water damage. S1ADM stated he was unaware of any ongoing issues of Resident #11 and Resident #57's leaking air conditioner. S1ADM stated he would expect his maintenance staff to repair any issues in full repair to resolve the issue and to not patch or apply band aids to any repairs within facility. S1ADM confirmed the facility should always be maintained in a sanitary, homelike environment and of good repair.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents or resident representatives understood the arbitration agreement signed on admission for 3 (#11, #15, and #17) of 3 residents reviewed for arbitration. Findings: Resident #11 Review of Resident #11's clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #11's admission packet dated 06/03/2026 revealed an arbitration agreement signed by Resident #11's RP. An interview was conducted on 06/23/2026 at 10:12 a.m. with Resident #11's RP. She stated she recalled signing Resident #11's admission documents. She stated S7AC told her where to sign, but she was not educated on what an arbitration agreement was. She stated she would not have signed this arbitration agreement if she would have been educated on what it meant. Resident #15 Review of Resident #15's clinical record revealed she was admitted to the facility on [DATE]. Review of Resident #15's admission MDS with ARD of 06/09/2026 revealed a BIMS of 15 which indicated she was cognitively intact. Review of Resident #15's admission packet dated 05/27/2026 revealed an arbitration agreement signed by Resident #15. An interview was conducted on 06/23/2026 at 9:40 a.m. with Resident #15. She stated she was not educated by the facility on what an arbitration agreement was prior to signing the admission documents. Resident #17 Review of Resident #17's clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #17's admission packet dated 06/10/2026 revealed an arbitration agreement signed by Resident #17's RP. An interview was conducted on 06/23/2026 at 12:30 p.m. with Resident #17's RP. She stated she recalled signing Resident #17's admission documents. She stated S7AC told her where to sign but she was not educated on what an arbitration agreement was. An interview was conducted on 06/23/2026 at 9:20 a.m. with S7AC. She reviewed Resident #11, #15, and #17's signed admission packets. She confirmed all 3 residents' admission packets included a signed arbitration agreement. She confirmed the residents or their RPs had not been educated on what an arbitration agreement was. She stated she was responsible for educating the residents and RPs on arbitration agreements upon admission. She stated she should have educated them on what an arbitration agreement was and did not. An interview was conducted on 06/23/2026 at 9:28 a.m. with S1ADM. He stated the staff member getting an admission packet signed had the responsibility to educate residents and RPs on arbitration agreements.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure a resident fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding by failing to ensure enteral water flushes were administered per Physician's Orders for 1 (#49) of 1 resident reviewed for enteral feedings. Findings: Review of the facility's undated policy titled Gastric Tube Feeding, Continuous revealed in part, the following: 7. Key Points - Rate prescribed by physician. Review of Resident #49's clinical record revealed he was admitted to the facility on [DATE] with diagnoses, which included Gastrostomy Status. Review of Resident #49's current Physician Orders revealed, in part, the following: Enteral Feed Order - Continuous enteral feeding with 275 mL water flush every 4 hours. Start date: 06/18/2025. On 06/22/2026 at 9:03 a.m., an observation was made of Resident #49's enteral feeding pump with water flushes infusing at 200 mLs every 4 hours. On 06/22/2026 at 9:03 a.m., an observation was made of Resident #49's enteral feeding pump with S8LPN. S8LPN confirmed Resident #49's water flushes were infusing at 200 mLs every 4 hours. On 06/22/2026 at 12:45 p.m., an observation was made of Resident #49's enteral feeding pump with water flushes infusing at 200 mLs every 4 hours. On 06/22/2026 at 3:40 p.m., an observation and interview was conducted with S8LPN. She observed Resident #49's enteral feeding pump with water flushes infusing at 200 mLs every 4 hours. S8LPN reviewed Resident #49's current Physician's Orders and confirmed water flush infusion rate should have been infusing at 275 mLs every 4 hours and was not. On 06/24/2026 at 11:45 a.m., an interview was conducted with S2DON. S2DON reviewed Resident #49's current Physician's Orders and confirmed enteral water flushes should have been infusing at 275 mLs every 4 hours. She stated she expected water flushes to be infused at the ordered rate.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility failed to ensure that drugs were stored and labeled properly in accordance with current accepted professional principles. The facility failed to ensure insulin pens containing multiple doses of insulin were clearly labeled with a puncture date for 1 (#67) of 2 residents observed during insulin administration. Findings: Review of the facility's policy titled Insulin Policy dated 11/02/2023 revealed in part, the following: Insulin pens will be dated when first punctured. Puncture date will be written on the labels already attached to insulin pens. An observation was made on 06/22/2026 at 11:39 a.m. of S5LPN during insulin administration for Resident #67. Observed 1 opened, partially filled Humalog insulin pen for Resident #67, without a puncture date. An interview was conducted on 06/22/2026 at 11:40 a.m. with S5LPN. S5LPN confirmed the Humalog insulin pen for Resident #67 was opened and partially used. S5LPN stated it was nurses' responsibility to label all insulin pens with a puncture date. S5LPN confirmed the insulin pen was undated and should have had a puncture date on it. An interview was conducted on 06/23/2026 at 3:00 p.m. with S2DON. S2DON stated she expected nursing staff to date insulin pens with the puncture date.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interviews, the facility failed to ensure garbage and waste were properly contained in the outdoor trash dumpster. This deficient practice had the potential to affect the 73 residents currently residing in the facility. Findings: Review of the facility's policy titled Waste Management dated 11/2022, revealed in part, the following: Policy: The facility will dispose of non-medical waste in a clean manner. 3. Waste is properly contained in dumpsters with lids or otherwise covered. 4. Areas used for garbage disposal are maintained to prevent pests. An observation was made on 06/22/2026 at 1:34 p.m. of garbage dumpster area outside of the facility. Observed in part, the following, on the ground outside of the garbage dumpster: 6 filled, white garbage bags; 8 empty, saturated cardboard boxes; 5 open, disposable food boxes with food contents remaining; 3 filled, large black garbage bags; and large amount of scattered trash items. An interview was conducted on 06/22/2026 at 1:39 p.m. with S4FSD. She observed the garbage dumpster area, and stated the amount of garbage located on the ground was unacceptable. She stated if the garbage dumpster was full, all staff should utilize a large grey bin for garbage overflow. She stated garbage should not be located on the ground. An interview was conducted on 06/22/2026 at 1:40 p.m. with S6MT. He stated maintenance makes rounds to ensure all garbage is picked up. He stated garbage should not be located on the ground. An interview was conducted on 06/22/2026 at 1:45 p.m. with S1ADM. He stated maintenance makes rounds to ensure all garbage is picked up. He stated staff should not be placing garbage on the ground.		

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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 maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. Nursing staff sanitized insulin pen rubber seal prior to extracting insulin for 2 (#30 and #67) of 2 residents observed for insulin administration. 2. Nursing staff disinfected the glucometer between resident use for 1 (#67) of 2 residents observed during blood glucose monitoring. Findings: Review of Novolog and Humalog Insulin Pen Manufacturer's Inserts revealed in part, the following: Step 2: Wipe the pen tip rubber seal with an alcohol swab. Then apply new needle. Review of the facility's untitled and undated policy, revealed in part, the following: Disinfect the glucometer between each patient to prevent infection. 1. Resident #30 Review of Resident #30's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #30's current Physician's Orders revealed in part, the following: Novolog Insulin 100 unit/mL subcutaneously before meals and at bedtime per sliding scale. An observation was made on 06/22/2026 at 11:29 a.m. of S5LPN administering Novolog Insulin 100 unit/mL to Resident #30. S5LPN applied the insulin pen needle without sanitizing the insulin pen rubber seal. S5LPN administered the insulin. Resident #67 Review of Resident #67's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #67's current Physician's Orders revealed in part, the following: Humalog Insulin 100 unit/mL subcutaneously before meals and at bedtime per sliding scale. An observation was made on 06/22/2026 at 11:40 a.m. of S5LPN administering Humalog Insulin 100 unit/mL to Resident #67. S5LPN applied the insulin pen needle without sanitizing the insulin pen rubber seal. S5LPN administered the insulin. 2. An observation was made on 06/22/2026 at 11:27 a.m. of S5LPN performing a blood glucose check on Resident #30. S5LPN then placed the glucometer on the top of the medication cart without using disinfectant. Observed the glucometer remain on the top of the medication cart without being disinfected. An observation was made on 06/22/2026 at 11:39 a.m. of S5LPN removing the glucometer from the top of the medication cart, without disinfecting the glucometer, and perform a blood glucose check on Resident #67. S5LPN then placed the glucometer on the top of the medication cart without using disinfectant. An interview was conducted on 06/22/2026 at 11:40 a.m. with S5LPN. S5LPN confirmed she did not clean the glucometer with a disinfectant between resident use for Resident #30 and Resident #67 and should have. S5LPN confirmed she did not sanitize the insulin pen rubber seal prior to applying the insulin pen needle before Resident #30 and Resident #67's insulin administration and should have. An interview was conducted on 06/23/2026 at 3:00 p.m. with S2DON. S2DON stated she expected nursing staff to disinfect the glucometer with the appropriate disinfectant wipes between resident use. S2DON stated she did not expect nursing staff to sanitize the insulin pen rubber seal prior to applying the insulin pen needle.		