

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER Grand Cove Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 W McNeese St. Lake Charles, LA 70605	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to develop and/or implement a comprehensive person-centered plan of care and/or physician's orders for (#2) out of 11 (#1, #2, #3, #4, and #R1-#R7) sampled resident as evidenced by failing to identify and implement interventions for refusal of care for Resident #2. Findings: Review of Resident #2's EHR revealed she was admitted to the facility on [DATE] with diagnoses that included in part, schizoaffective disorder, unspecified, unspecified dementia, moderate, with other behavioral[MC1], anxiety disorder and major depressive disorder. Review of Resident #2's complex alert documentation report from 07/01/2025 to 09/08/2025 revealed resident refused hygiene care every day in July 2025, and on 08/13/2025, 08/15/2025, 08/25/2025, 09/01/2025 and 09/02/2025. Review of Resident #2's hospice records revealed aide visit notes from 07/14/2025 to 08/29/2025 unable to document: patient refused nail care, nurse notified. Review of Resident #2's care plan revealed no evidence of with refusal of nail care and hygiene. On 09/29/2025 at 2:40 p.m., an interview was conducted with S6LPN (Licensed Practical Nurse), she stated the hospice CNA (Certified Nursing Assistant) had reported to her on multiple occasions the resident refused a bath and nail care and the facility staff did try to encourage the resident to bathe and provide nail care to which the resident continued to refusal care. On 09/30/2025 at 11:02 a.m., an interview was conducted with S7LPN, she stated the resident had history of mental illness and would at times refuse care. S7LPN stated the last few months she would refuse care often, almost daily, and she was at times difficult to redirect. On 09/30/2025 at 12:37 p.m., an interview was conducted with S5MDS (Minimum Date Set) nurse. She reported she was responsible for completing MDS and updating the care plan for Resident #2. She confirmed the care plan did not identify the refusal of care nor interventions for the refusals of care for the resident, but should have. [MC1]</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
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to revise a comprehensive person-centered plan of care for 1 (#1) out of 11 (#1, #2, #3, #4, and #R1-#R7) sampled resident as evidenced by failing to revise a care plan with changes in ADL (activities of daily living) care. Findings: Review of Resident #1's EHR (electronic health record) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, congestive heart failure, anxiety and depression. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 13, indicating her cognition was intact. Further review of the MDS revealed resident was independent with eating, oral hygiene, toileting, dressing, transfers; and supervision or touch assistance for shower/bathe. Review of Resident #1's care plan date initiated: 06/23/2025 revision on: 08/19/2025 revealed resident needs partial/moderate assist with bathing/showering. Resident needs supervision to transfer to and from a bed to a chair/wheelchair. Resident needs assist with toileting. On 09/29/2025 at 1:00 p.m., an interview was conducted with Resident #1, she stated she was able to do everything for herself, except for shower/bathing, they will help if needed. On 09/30/2025 at 3:15 p.m., an interview was conducted with S2CRN (Corporate Registered Nurse), she reviewed the care plan for Resident #1 and confirmed the care plan had not been updated to reflect the current ADL status of the resident and should have been.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide services to meet professional standards in accordance with the resident's written plan of care by failing to administer daily medication on time as ordered for 3 (#1, #R1 and #R2) out of 11 (#1- #4 and #R1 - #R7) sampled residents. The deficient practice had the potential to effect a census of 87. Findings: Review of the facility's policy titled, Administration of Medication with last revision date 03/2025, read in part, purpose: to administer medications in accordance with best practice. Procedure: 3. Drugs and biologicals are administered no more than one hour before or no more than one hour after the dosage time is ordered. Resident #1 Review of Resident #1's EHR (electronic health record) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, congestive heart failure, anxiety and depression. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 13, indicating her cognition was intact. Review of Resident #1's MAR (Medication Administration Record) for September 2025 reviewed resident received her p.m. (evening) medications on 09/04/2025 from S4LPN (Licensed Practical Nurse). The insulin injection revealed the 8:00 p.m. medication was administered at 10:25 p.m. Review of the resident's medication administration history report revealed: Medications due at 8:00 p.m. included: 1. Humalog insulin per sliding scale, 2. Mupirocin external ointment 2% (percent), 3. Lantus 20 units, 4. Metformin 500mg (milligrams), 5. Mirtazapine 7.5mg, 6. Timolol Maleate Ophthalmic Solution 0.5% Medications due at 9:00 p.m. included: 1. Atorvastatin 40mg 2. Lantanoprost Solution 0.005% eye drops, On 09/02/2025, Resident #1's medications were documented as administered at 10:14 p.m. On 09/04/2025, the resident received Lantus 20 units, Metformin 500mg, Mirtazapine 7.5mg, and Timolol Maleate Ophthalmic Solution 0.5% at 10:25 p.m. However, these medications were due at 8:00 p.m. The resident was also administered Atorvastatin 40mg and Lantanoprost Solution 0.005% eye drops at 10:25 p.m., but these medications were due at 9:00 p.m. On 09/29/2025 at 1:00 p.m., an interview was conducted with Resident #1 who stated she did not get her medications when she was supposed to. On 09/30/2025 at 12:45 p.m., an interview was conducted with S1DON (Director of Nursing). She reviewed the September 2025 MAR for Resident #1 and confirmed the night medications that were due at 8:00 p.m. and 9:00 p.m. on 09/02/2025 and 09/04/2025, were administered late and should have been administered within an hour before to after the scheduled time of administration. Resident #R1 On 09/30/2025 at 11:36 a.m., an observation was made of S3LPN administering medication to Resident #R1 which included the following medications that were due at 9:00 a.m.: 1. Aspirin 81 mg 2. Diltiazem 60mg 3. Eliquis 5mg 4. Hydralazine 25mg 5. Lactobacillus 4 capsules 6. Lasix 20 mg 7. Losartan potassium 25mg 8. Metoprolol Tartrate 37.5mg 9. Pantoprazole 40mg 10. Theophylline ER 300mg The above medications for Resident #R1, were administered at 11:36 a.m. S3LPN, confirmed the medications were administered late. Resident #R2 On 09/30/2025 at 11:25 a.m., an interview was conducted with S3LPN who stated she was still passing morning medications that were due at 8:00 a.m. and 9:00 a.m. She confirmed the medications would be administered greater than 1 hour past the time they should have been administered. On 09/30/2025 at 11:43 a.m., an observation was made of S3LPN administering Resident #R2's medications at this time: Aspirin EC 81mg and Clopidogrel 75mg due at 8:00 a.m.; and Lasix 20mg due at 9:00 a.m. S3LPN, confirmed the medications were being administered late.</p>		