

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Lake Charles Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Ernest Street Lake Charles, LA 70601	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the provider failed to carry out activities of daily living (ADL) for 1 (#9) of 2 (#5, #9) residents reviewed for ADL's out of a sample of 36 residents. Findings: Record review of the facilities policy titled, Activities of Daily Living (ADL's) Supporting with a revision date of 03/2025 read in part, Residents who are unable to carry out ADL independently will receive the services necessary to maintain good grooming .Appropriate care and services will be provided for residents who are unable to carry out ADL's independently .in accordance with the plan of care. Including appropriate support and assistance with: a. Hygiene (Grooming) Record review of Resident #9's electronic record revealed he was admitted to the facility on [DATE]. He had diagnosis not limited to, Chronic Pain, Insomnia, Renal Dialysis, Chronic Kidney Disease Stage 4, and Quadriplegia. The resident's quarterly Minimum Data Set assessment dated [DATE] revealed he had a Brief Interview of Mental Status was 15. Meaning he was cognitively intact. Record review of Resident #9's Care Plan read, Self-care deficit related to, needs assistance with ADL's, decreased mobility, diagnosis of functional quadriplegia. Resident will be clean and well-groomed daily this quarter. Assist with ADL's as need (C.N.A (Certified Nursing Assistant)). Personal Hygiene-Dependent Shave as needed (C.N.A.). Record review of Resident #9's Documentation Survey Notes from the facility for June 2026 revealed he was bathed on 06/06/2026 and 06/08/2026. On 06/08/2026 at 2:38 p.m., an observation revealed Resident #9's facial hair was overgrown. At this time the resident stated he would like to be shaved daily. On 06/09/2026 at 9:58 a.m., an observation revealed Resident #9's facial hair remained overgrown. Resident #9 stated he wanted to be shaved daily. He stated he asked the CNA to shave him this morning and she told him she would shave him this evening. On 06/10/2026 at 7:55 a.m., an observation revealed Resident #9's facial hair was still overgrown. The resident stated he would like to be shaved. On 06/10/2026 10:50 a.m., S12CNA observed and confirmed Resident #9's hair on his face was overgrown. She stated he was to be bathed on Tuesdays, Thursdays and Saturdays and the CNAs were to shower and shave him on these days. On 06/10/2026 at 11:05 a.m., S6ADON confirmed Resident #9 could express his needs and if he wanted to be shaved, the CNA should shave him. At this time she reviewed Resident #9's care plan and stated he was dependent on staff for all his ADL's. She stated the CNA's were to shave him when they shower him.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 195413	If continuation sheet Page 1 of 1