

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Landmark of Plaquemine		STREET ADDRESS, CITY, STATE, ZIP CODE  59355 River West Drive Plaquemine, LA 70764	

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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41876</b></p> <p>Based on record reviews, observation, and interviews, the facility failed to ensure a resident's continuous enteral feeding (intake of food through a tube placed into the stomach) was not stopped and restarted by a certified nursing assistant (CNA) for 1 (Resident #228) of 2 (Resident #10 and Resident #228) sampled residents investigated for enteral feeding.</p> <p>Findings:</p> <p>Review of Resident #228's record revealed, in part, an admitted [DATE] and diagnoses including mild protein-calorie malnutrition and failure to thrive.</p> <p>Review of Resident #228's Minimum Data Set with an Assessment Reference Date of 07/02/2024 revealed, in part, Resident #228 required enteral feeding through a gastrostomy tube (an artificial hole in the stomach to deliver enteral feedings).</p> <p>Review of Resident #228's July 2024 Physician's Orders revealed, in part, an order for Isosource 1.5 calories (a type of enteral feeding formula) at 40 milliliters an hour continuously via a feeding pump. Further review revealed an order to check the placement of Resident #228's gastrostomy tube prior to the administration of feedings.</p> <p>Review of Resident #228's care plan revealed, in part, Resident #228 was care planned to be at risk for malnutrition related to poor appetite and enteral feedings with an intervention to administer enteral feedings as ordered by the physician.</p> <p>Observation on 07/08/2024 at 10:35 a.m. revealed Resident #228 was being assisted with care by S7CNA. Further observation revealed Resident #228's enteral feeding pump was on hold and alarming. Observation then revealed S7CNA restarted Resident #228's enteral feeding pump.</p> <p>In an interview on 07/10/2024 at 10:39 a.m., S8Licensed Practical Nurse (LPN) indicated CNAs were not supposed to manipulate a resident's enteral feeding pump at all during care of the resident. S8LPN indicated the CNAs were supposed to have the nurse stop, pause, or restart the enteral feeding pump.</p> <p>(continued on next page)</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/11/2024 at 1:02 p.m., S7CNA indicated during care of a resident who was being administered enteral feedings, S7CNA paused the enteral feeding pump in order to lower the head of the bed. S7CNA stated once the resident's care was completed, S7CNA would elevate the HOB and restart the enteral feeding pump.</p> <p>In an interview on 07/11/2024 at 1:40 p.m., S7CNA confirmed she paused and restarted Resident #228's tube feeding pump while providing care on 07/08/2024. S7CNA stated she should have asked the nurse to turn off the enteral feeding pump and then restart it.</p> <p>In an interview 07/11/2024 1:55 p.m., S9Corporate Registered Nurse confirmed a CNA should not manipulate a resident's enteral feeding pump.</p> <p>In an interview on 07/11/2024 at 1:59 p.m., S2Director of Nursing (DON) indicated only a nurse should pause and restart a resident's enteral feeding pump. S2DON confirmed a CNA should not operate a resident's tube feeding pump.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49562</p> <p>Based upon observations, record reviews, and interviews, the facility failed to assess a resident's respiratory status and provide oxygen (O2) accordingly for 1 (Resident #12) of 1 (Resident #12) sampled residents reviewed for respiratory care.</p> <p>Findings:</p> <p>Observation on 07/08/2024 at 12:03 p.m. revealed Resident #12 was wearing a nasal cannula (NC) connected to an oxygen concentrator at 2.5 liters per minute (lpm).</p> <p>Observation on 07/09/2024 at 10:10 a.m. revealed Resident #12 was wearing a nasal cannula (NC) connected to an oxygen concentrator at 2.5 liters per minute (lpm).</p> <p>Observation on 07/10/2024 at 11:31 a.m. revealed Resident #12 was wearing a nasal cannula (NC) connected to an oxygen concentrator at 2.5 liters per minute (lpm).</p> <p>Review of Resident #12's electronic medical record (EMR) revealed an order dated 04/23/2024 for oxygen at 2 lpm via NC as needed (PRN) for saturations less than 93 Further review revealed instructions to check and record oxygen saturation levels.</p> <p>Review of Resident #12's electronic medication administration record (EMAR) for May, June, and July 2024 revealed the oxygen saturation was only documented for the PRN O2 order once; on 05/24/2024 at 7:07 p.m. , the measurement was 93%.</p> <p>In an interview on 07/10/2024 at 12:19 p.m., S3Licensed Practical Nurse (LPN) indicated Resident #12 was always on O2 when she entered the room. S3LPN indicated she believed Resident #12 was supposed to be on continuous O2.</p> <p>In an interview on 07/10/2024 at 12:25 p.m., S8LPN indicated Resident #12 had an order for PRN oxygen at this time. In order to administer O2 as PRN in computer, the special requirement for oxygen saturation measurement must be met and recorded; but Resident #12 was wearing O2 continuously, so the last recorded saturation was on 05/24/2024. S8LPN indicated the Resident #12's oxygen saturation should have been taken and recorded before administering oxygen.</p> <p>In an interview on 7/11/2024 at 10:55 a.m., S2DON indicated Resident #12's oxygen order was unclear, and the nurses should have been measuring the O2 saturations and documenting them. S2DON further indicated the O2 should have only been given to the resident if saturations were less than 93%, and Resident #12 had been wearing the O2 continuously and should not have been.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>30587</p> <p>Based on observation and interviews the facility failed to ensure expired medications were not available for use for 1 (Medication Room a) of 1 (Medication Room a) medication rooms observed during medication storage observations.</p> <p>Findings:</p> <p>Observation on 07/09/2024 at 2:17 p.m. of Medication Room a revealed the following, in part, a bottle of Aspirin 325 milligrams (mg) with an expiration date of 04/2024. Further observation revealed four boxes of Influenza Flud Quadrivalent (injectable medication use to prevent the flu) with an expiration date of 06/30/2024.</p> <p>In an interview on 07/09/2024 at 2:20 p.m., S3Licensed Practical Nurse (LPN) indicated the above mentioned medications should not have been available for resident use.</p> <p>In an interview on 07/09/2024 at 2:55 p.m., S2Director of Nursing (DON) indicated the above mentioned medications should not have been available for use.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45877</p> <p>Based on observation, and interviews, the facility failed to ensure staff removed gloves and perform hand hygiene prior to exiting a resident's room for 1 (S6Housekeeper) of 1 (S6Housekeeper) housekeepers observed for infection control.</p> <p>Findings:</p> <p>Observation on 07/10/2024 at 1:05 p.m. revealed S6Housekeeper exited the elevator on the first floor by the dining room with her gloves on. Observation further revealed she was the only person on the elevator.</p> <p>In an interview on 07/10/2024 at 1:10 p.m., S6Housekeeper indicated she forgot to take her gloves off after cleaning a resident's room on the second floor.</p> <p>In an interview on 07/10/2024 at 1:15 p.m., S5Housekeeping Supervisor indicated staff should take off gloves and perform hand hygiene when exiting resident rooms.</p> <p>In an interview on 07/10/2024 at 2:27 p.m., S4Assistant Director of Nursing/Infection Preventionist indicated gloves should be removed and hand hygiene performed when exiting resident rooms.</p> <p>In an interview on 07/10/2024 at 3:50 p.m., S2Director of Nursing confirmed gloves should be removed prior to leaving a resident room.</p>		