STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195438	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Nursing & Rehabilitation Ctr of West Mon	1611 Wellerman Road West Monroe, LA 71291

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. The facility failed to 1) Identify Resident #14 had a MDRO infection and implement contact precautions, and 2) implement EBP for Resident #23 and #94.Findings:Resident #14 Review of the facility's undated Infection Control Precautions (Isolation) Policy revealed the following in part: Policy: Prevent the spread of infection Equipment: Provided by infection control coordinator Procedure: 5. All residents placed in isolation, for suspected or confirmed infections, shall have isolation precautions implemented in accordance with procedures established in the CDC Guidelines for Isolation Precautions in Hospitals. Review of the record for Resident #14 revealed an admission date of 04/02/2025 with diagnoses that included cerebral infarction, dementia, hypertension, and stage 3 pressure ulcer. Review of the quarterly MDS assessment dated [DATE] revealed Resident #14 had an unhealed stage 3 pressure ulcer. On 03/09/2026 at 9:13 a.m., interview with S9LPN revealed Resident #14 was on EBP due to the presence of a PEG tube and a pressure ulcer. On 03/09/2026 at 12:40 p.m., interview with S2DON and S10LPN revealed Resident #14 received IV antibiotics for a wound infection. Review of the physician orders revealed an order dated 02/26/2026 for Meropenem 1 gram IV reconstituted solution was ordered every 8 hours for 8 days due to sacral wound infection. Review of Resident #14's sacral wound culture results revealed detection of antibiotic resistant organisms present. On 03/09/2026 at 5:07 p.m., interview with S11RN/Infection Preventionist confirmed contact (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions had not been implemented for Resident #14. On 03/10/2026 at 9:12 a.m., interview with S2DON and S11RN/Infection Preventionist revealed the culture report was received on 02/25/2026. S2DON and S11RN/Infection Preventionist further confirmed contact precautions should have been implemented for Resident #14. On 03/10/2026 at 9:30 a.m., S2DON was informed of findings related to failure to implement contact precautions for Resident #14. Review of the provider's Enhanced Barrier Precautions policy and procedure dated 08/12/2024 revealed the following in part: It is the policy of this facility to implement Enhanced Barrier Precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). Definitions: Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and gloves use during high-contact resident care activities for residents known to be colonized or infected with MDRO, as well as, those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices.) Wound in relation to this guidance, generally includes resident with chronic wounds, and not those with only shorter-lasting wounds, such as skin tears covered with Band-aid or similar dressing. Examples of chronic wounds include, but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers. Resident #23 Record review revealed Resident #23 was admitted to the facility on [DATE] with diagnoses of proximal atrial fibrillation, malignant neoplasm of upper lobe unspecified bronchus or lung, carcinoma in stitu of left bronchus and lung, essential hypertension, pleural effusion, pneumonia, chronic obstructive pulmonary disease, peripheral vascular disease, anemia, weakness, chronic respiratory failure with hypoxia, dependence on oxygen, and urinary retention. Review of Resident #23's current March 2026 physician orders revealed the following:1) 03/07/2026: change 16 french foley catheter routinely (every 30 days); 2) 16 french catheter care with soap and water every shift; 3) monitor urine color every shift; and 4) 16 french catheter monitor condition of urine every shift. On 03/08/2026 at 9:50 a.m., an observation of Resident #23 revealed an indwelling urinary catheter with drainage bag was secured to the bed frame on left side of bed. Further observation revealed no EBP signage on the door or outside Resident #23's room. On 03/09/2026 at 1:10 p.m., S2DON was informed of observation on 03/08/2026 which revealed Resident #23 had a urinary catheter in place and there was no signage indicating EBP in place. S2DON confirmed Resident #23 should be on EBP related to the indwelling catheter, and there should have been a sign posted outside Resident #23's door indicating he was on EBP. Resident #94 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed Resident #94 was readmitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus without complications, restless leg syndrome, encounters for orthopedic aftercare following surgical amputation, generalized anxiety disorder, paroxysmal atrial fibrillation, muscle wasting and atrophy multiple sites, ventricular tachycardia, pain unspecified, resistance to multiple antibiotics, essential hypertension, obstructive sleep apnea, primary generalized osteoarthritis, constipation, anemia, atherosclerotic heart disease of native coronary artery without angina pectoris. Review of current March 2026 Physician orders revealed the following orders: 1) 01/13/2025 for Enhanced Barrier Precautions utilized when performing high contact resident care activities; 2) 03/08/2026 for left shin arterial ulcer: Cleanse with wound cleanser, and pat dry with gauze. Cover with bag balm ointment, secure with border gauze dressing. Change every other day or until resolved; 3) 03/08/2026 for left ankle arterial ulcer: cleanse with wound cleanser and pat dry with gauze. Cover with bag balm ointment. Cover with gauze. Secure with kerlix and tape. Chance every other day or until resolved; 4) 03/08/2026 for left plantar foot arterial ulcer: cleanse with wound cleanser and pat dry with gauze, Cover with bag balm ointment. Cover with gauze. Secure with kerlix and tape. Change every other day or until resolved; and 5) 03/08/2026 left dorsum 2nd digit arterial ulcer: cleanse with wound cleanser and pat dry with gauze. Cover with bag balm ointment. Cover with gauze. Secure with kerlix and tape. Change every other day or until resolved. On 03/08/2026 at 9:45 a.m., an observation of Resident #94 revealed a dressing that was dry and intact to the left ankle and foot. Resident #94 reported being moved to this room about a week ago. Further observation revealed no EBP signage noted on the door or outside Resident #94's room indicating EBP were in place. On 03/09/2026 at 1:10 p.m., S2DON confirmed EBP precautions should be in place for Resident #94 due to chronic arterial wounds. S2DON was informed EBP signage was not observed on 03/09/2026 for Resident #94

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to assess residents for self-administration of medications for 1 (#51) of 1 sampled residents observed for medications available at the bedside. Findings: Review of the facility's undated Medication Storage in the Facility policy revealed the following, in part: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing or medical personnel and pharmacy personnel. Review of the medical record for Resident #51 revealed an admission date of 01/28/2026. Resident #51 had diagnoses that included depression, schizophrenia, cognitive communication deficit, hemiplegia, and presbyopia. Review of the admission MDS assessment dated [DATE] revealed Resident #51 had a BIMS score of 13 which indicated intact cognition for daily decision making. On 03/08/2026 at 9:00 a.m., and 12:10 p.m., observations of Resident #51's room revealed a bottle of Zaditor eye drops was on the bedside table. Review of Resident #51's March 2026 physician orders revealed no documented evidence of an order for Zaditor eye drops. Interview with Resident #51 on 03/08/2026 at 12:45 p.m. revealed she uses the eye drops in her eyes when they feel dry, and she administers the eye drops by herself. On 03/08/2026 at 3:30 p.m., observation of Resident #51's room with S2DON revealed a bottle of Zaditor eye drops was on the bedside table. S2DON confirmed Resident #51 should not have medications for use at the bedside.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and interviews, the facility failed to ensure residents have the right to a clean, comfortable and homelike environment for 3 (#16, #29 and #51) of 3 residents reviewed for environment by 1) having unsanitary overbed tables for resident use (#16 and #29) and having an air conditioner unit in need of repair for resident #51. Findings: Resident 16 On 03/08/2026 at 11:15 a.m., 4:03 p.m. and on 03/09/2026 at 1:45 p.m. observations of Resident #16's overbed table revealed spills and splatters on top of the table. On 03/09/2026 at 2:05 p.m. observation of Resident #16's overbed table with S4Housekeeping Supervisor revealed spills and splatters on top of the table. Interview with S4Housekeeping Supervisor on 03/09/2026 at 2:10 p.m. confirmed Resident #16's overbed table was dirty and needed to be cleaned. Resident 29 On 03/08/2026 at 11:15 a.m., 4:03 p.m. and on 03/09/2026 at 1:45 p.m. observations of Resident #29's overbed table revealed spills and splatters on top of the table. On 03/09/2026 at 2:05 p.m. observation of Resident #29's overbed table with S4Housekeeping Supervisor revealed spills and splatters on top of the table. Interview with S4Housekeeping Supervisor on 03/09/2026 at 2:10 p.m. confirmed Resident #29's overbed table was dirty and needed to be cleaned. Resident #51 On 03/08/2026 at 3:53 p.m., and on 03/09/2026 at 1:55 p.m. observations of Resident #51's air conditioner unit revealed the unit was not secured to the wall and a gap was noted on each side of the unit. On 03/09/2026 at 2:00 p.m. observation of Resident #51's air conditioning unit with S5Maintenance Supervisor revealed the unit was not secured to the wall and a gap was noted on each side of the unit. On 03/09/2026 at 2:05 p.m. interview with S5Maintenance Supervisor confirmed the air conditioner unit should have been secured to the wall and a gap was noted on each side of the unit.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the provider failed to ensure MDS assessments were completed and submitted timely for 3 (#3, #96, and #107) of 3 sampled residents reviewed for assessments.Findings: Resident #3Review of Resident #3's record revealed an admission date of [DATE] and resident expired in the facility on [DATE]. Review of Resident #3's MDS assessments revealed a discharge (death in facility) MDS assessment dated [DATE] was not completed and transmitted to CMS until [DATE]. An interview on [DATE] at 1:10 p.m. with S7MDS/LPN confirmed Resident #3 expired in the facility on [DATE]. S7MDS/LPN revealed she failed to complete and transmit Resident #3's discharge (death in facility) MDS assessment dated [DATE] to CMS within 7 days ([DATE]). Resident #96 Review of Resident #96's record revealed an admission date of [DATE] and a discharge date of [DATE]. Review of Resident #96's MDS assessments revealed no documented evidence a discharge MDS assessment was completed or transmitted to CMS for the resident. An interview on [DATE] at 1:10 p.m. with S7MDS/LPN revealed Resident #96 was discharged from the facility on [DATE]. S7MDS/LPN confirmed she failed to complete and transmit a discharge MDS assessment to CMS within 14 days ([DATE]). Resident #107Review of Resident #107's record revealed an admission date of [DATE]. Review of Resident #107's MDS assessments revealed an annual MDS assessment dated [DATE] was not completed and transmitted to CMS until [DATE]. An interview on [DATE] at 1:10 p.m. with S7MDS/LPN confirmed Resident #107's annual MDS assessment dated [DATE] was not completed and transmitted to CMS until [DATE]. S7MDS/LPN confirmed this assessment should have been transmitted to CMS by [DATE]. An interview on [DATE] at 2:45 p.m. with S2DON confirmed the MDS assessments were not completed and transmitted to CMS in a timely manner for Resident #3, Resident #96, and Resident #107.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interview, the facility failed to develop a comprehensive person-centered care plan for 1 (#99) of 2 sampled resident reviewed for ADLs. The provider failed to develop an ADLs care plan for Resident #99.Findings:Record review revealed Resident #99 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus without complication, stage 2 pressure ulcer sacral region, chronic obstructive pulmonary disease, need for assistance with personal care, lack of coordination, muscle wasting and atrophy not elsewhere specified right shoulder, major depressive disorder, generalized anxiety disorder, peripheral vascular disease, hypertensive heart disease with heart failure, personal history of venous thrombosis and embolism, obstructive sleep apnea, and obesity. Review of the current March 2026 Physician orders revealed an order dated 12/24/2025: requires x1 person assist with ADLs. Review of the comprehensive care plan revealed no evidence to support Resident #99's need for assistance with ADLs was addressed. Observations of Resident #99 on 03/08/2026 at 8:20 a.m. and 03/09/2026 at 9:35 a.m. revealed, the fingernails were long with a dark brown colored grimy substance under the fingernails on both hands. On 03/09/2026 at 10:00 a.m., observation of Resident #99 with S2DON revealed Resident #99's fingernails were long with a dark brown grimy substance under the fingernails on both hands. S2DON confirmed Resident #99's fingernails needed to be cleaned and trimmed. On 03/09/2026 at 12:15 p.m., interview with S2DON confirmed a care plan had not been developed related to ADLs for Resident #99. S2DON further confirmed there was no care plan that specified who would trim and clean Resident #99's finger nails or how often nail care would be done.

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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, interviews, and record reviews, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good personal hygiene. The facility failed to ensure residents' fingernails were clean and trimmed in a timely manner for 1 (#99) of 2 residents reviewed for activities of daily living. Findings:Record review revealed Resident #99 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus without complication, stage 2 pressure ulcer sacral region, chronic obstructive pulmonary disease, need for assistance with personal care, lack of coordination, muscle wasting and atrophy not elsewhere specified right shoulder, major depressive disorder, generalized anxiety disorder, peripheral vascular disease, hypertensive heart disease with heart failure, personal history of venous thrombosis and embolism, obstructive sleep apnea, and obesity. Review of the current March 2026 Physician orders revealed an order dated 12/24/2025: requires x1 person assist with ADLs. Observations of Resident #99 on 03/08/2026 at 8:20 a.m. and 03/09/2026 at 9:35 a.m. revealed, the fingernails were long with a dark brown colored grimy substance under the fingernails on both hands. On 03/09/2026 at 10:00 a.m., observation of Resident #99 with S2DON revealed Resident #99's fingernails were long with a dark brown grimy substance under the fingernails on both hands. S2DON confirmed Resident #99's fingernails needed to be cleaned and trimmed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure that the nursing staff are able to demonstrate competency in skills necessary to care for the resident needs for 1 (#6) of 5 residents sampled for the unnecessary medication review. This was evidenced by the nurses failing to administer as needed blood pressure medication as ordered for Resident #6.Findings:Review of Resident #6's record revealed an admission date of 07/18/2020 with readmission of 11/23/2024. Resident #6 had the following diagnoses chronic systolic congestive heart failure, shortness of breath, chest pain, angina pectoris, atrial fibrillation, and essential hypertension. Review of Resident #6's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated moderate cognitive impairment. Review of Resident #6's March 2026 Physician's Orders revealed an order dated 02/10/2026 for Clonidine HCL oral tablet 0.1 mg give 1 tablet by mouth every 12 hours as needed for hypertension, and parameters for blood pressure included to give 1 tablet if systolic was greater than 160 or if diastolic was greater than 90. Review of Resident #6's February 2026 MAR revealed 9 times that the resident's diastolic blood pressure was greater than 90 and the nurses failed to document administration of Clonidine HCL as ordered. Review of Resident #6's March 2026 MAR revealed 3 times that the resident's diastolic blood pressure was greater than 90 and the nurses failed to document administration of Clonidine HCL as ordered. An interview on 03/10/2026 at 2:24 p.m. with S6LPN, during the review of Resident #6's current physician's orders and her February 2026 MAR, confirmed that she worked with the resident on 02/11/2026. S6LPN confirmed the resident's diastolic blood pressure was greater than 90, and she failed to administer Clonidine HCL as per the resident's orders. An interview on 03/10/2026 at 2:45 p.m. with S2DON confirmed the nurses failed to administer Clonidine HCL (as needed blood pressure medication) 9 times during February 2026 and 3 times in March 2026, when Resident #6's diastolic blood pressure was greater than 90.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to monitor for edema while a resident was receiving a diuretic for 1 (#92) of 5 residents reviewed for unnecessary medications. Findings: Review of the medical record for Resident #92 revealed an admission date of 10/22/2024. Resident #92 had diagnoses that included edema, Parkinson's disease, and dementia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #92 had a BIMS score of 5 which indicated severe cognitive impairment for daily decision making and required assistance with ADLs. Review of Resident #92's March 2026 physician orders revealed an order dated 03/04/2026 for Lasix (diuretic) 20 mg, give one tablet by mouth one time a day related to edema. Review of the March 2026 MAR and nurses notes revealed no documented evidence the nurses monitored Resident #92 for edema. Interview on 03/10/2026 at 10:10 a.m. with S3LPN confirmed there was no documented evidence that Resident #92 was monitored for edema. Interview on 03/10/2026 at 10:20 a.m. with S2DON confirmed there was no documented evidence of monitoring for edema while taking Lasix (diuretic) for Resident #92.