

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Landmark South Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18180 Jefferson Hwy Baton Rouge, LA 70817	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure a resident's call light was within reach for 2 (R1 and R2) of 5 (#1, #2, #3, R1, R2) residents reviewed.</p> <p>Findings:</p> <p>Review of the facilities policy, Call Light/Bell, dated 01/2024, revealed the following, in part:</p> <p>Purpose: To provide the resident a means of communication with staff members</p> <p>Procedure 1. Ensure resident has call light in reach when in resident room</p> <p>7. Place the call light within the resident's reach before leaving the room.</p> <p>Resident R1</p> <p>A review of Resident R1's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included the following, in part: Alzheimer's disease, Urinary Tract Infections, and Cognitive Communication Deficit.</p> <p>A review of Resident R1's current Care Plan revealed the following:</p> <p>Onset: 05/30/2019</p> <p>Problem: Resident was at risk for injury from falls.</p> <p>Interventions: Place call light within reach.</p> <p>On 05/20/2024 at 9:40 a.m., an observation was conducted of Resident R1. She was observed resting in her bed with her call light noted on the floor and not in reach.</p> <p>Resident R2</p> <p>A review of Resident R2's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included the following, in part: Systemic Lupus, Cognitive Communication Deficit, and Dementia.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident R2's current Care Plan revealed the following:</p> <p>Onset 04/02/2023</p> <p>Problem: Resident was at risk for falls.</p> <p>Interventions: Place call light within reach.</p> <p>06/14/2023- Call don't fall sign placed in bathroom and room;</p> <p>06/22/2023- Staff in-serviced on keeping call light within reach and clipped to bed or recliner; and 07/21/2023- Educated resident on importance of using the call light.</p> <p>On 05/20/2024 at 10:02 a.m., an observation was conducted of Resident R2. She was observed sitting up in her wheelchair with her call light behind her on the floor and not in reach.</p> <p>On 05/20/2024 at 10:02 a.m., an interview was conducted with Resident R2. She stated she was not able to transfer without assistance. She stated she would press the button for assistance, but she was not able to reach the call light. She stated would like to get in her recliner but was not able to call for assistance.</p> <p>On 05/20/2024 at 10:29 a.m., an observation was conducted of Resident R2. She was noted sitting in her wheelchair and her call light was not in reach of the resident.</p> <p>On 05/20/2024 at 10:29 a.m., an interview was conducted with S5LPN. She confirmed Resident R2 utilized her call light and it should be within reach. She further confirmed the call light was on the floor and Resident R2 was not able to reach it.</p> <p>On 05/21/2024 at 10:39 a.m., an interview was conducted with S3ADON. She stated she was not sure if Resident R1 would use the call light because she normally would yell out but the call light should be placed within reach. She confirmed Resident R2 was able to use her call light and it should be placed within reach when staff exited the room.</p> <p>On 05/21/2024 at 1:00 p.m., an interview was conducted with S4ADON. She stated she was not sure if Resident R1 would use the call light but the call light should be placed within reach. She confirmed Resident R2 was able to use her call light and it should be placed within reach when staff exited the room.</p> <p>On 05/21/2024 at 1:26 p.m., an interview was conducted with S2DON. She stated she expected when staff exited the residents room to leave the call light within reach.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42681</p> <p>Based on record review and interviews, the facility failed to ensure an injury of unknown origin was reported immediately, but not later than 2 hours after the incident, to the facility Administrator and to the State Survey Agency within the specified timeframe for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for accidents.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Incident Investigation and Reporting, reviewed on 05/21/2024, dated 10/2022, revealed in part:</p> <p>Purpose: To provide guidance to the facility for investigation and reporting incidents of abuse, neglect, exploitation, misappropriation of property and/or reportable incidents as required by state and federal requirements.</p> <p>2. Relevant Terms: Injury of unknown origin:</p> <p>a. Source of injury was not observed by any person and</p> <p>b. The source of injury could not be explained by the resident and</p> <p>c. The injury is suspicious due to the extent or location of the injury or the number of injuries at one time or the incidence of injury over time.</p> <p>3. The administrator shall report no later than 2 hours after forming the suspicion, if the events that cause the suspicion involve abuse or result in serious bodily injury</p> <p>5. Additional incidents that must have a thorough investigation and may require reporting .</p> <p>D. Unwitnessed Falls-consider abuse or neglect</p> <p>Review of Resident #1's clinical record revealed, resident was admitted to the facility on [DATE] with diagnosis which included Parkinson's Disease, Dementia, Cognitive Communication Deficit, Hallucinations, Fracture of Upper Left Humerus and Fracture of Superior Right Rim of Left Pubis.</p> <p>Review of Resident #1's Quarterly MDS with an ARD of 05/14/2024 revealed the provider assessed Resident #1 as having a BIMS of 11, indicated resident exhibited moderate cognitive impairment. Further review of the facility's assessment revealed Resident #1 required total dependence for all ADLs and transfer.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's nurse's note dated 02/12/2024 by S6LPN revealed, in part, S6LPN was summoned to Resident #1's room when CNA found Resident #1 on the floor. Further review revealed, upon entering Resident #1's room, Resident #1 was noted to be face down on the floor to the right side of the bed with her head next to the foot of the bed and her feet towards the head of the bed. S6LPN's assessment revealed Resident #1 had a protruding knot above the left eyebrow with bruising noted to the left side of the scalp; abrasions to the left knee, the left lateral great toe, and the smaller toes on the right foot; Resident #1 complained of pain to the left arm; the left shoulder appeared increased in size with some surrounding edema; and Resident #1 was unable to lift the left arm without crying. Further review also revealed, Resident #1 was confused and unable to answer direct, simple questions.</p> <p>A review of Resident #1's Incident/Accident report dated 02/12/2024 at 4:00 p.m. revealed, in part:</p> <p>Incident Type: found on floor</p> <p>Incident Level: Non-Witnessed</p> <p>Reported to Supervisor: Yes</p> <p>Resident Condition at Time of incident: Mobility-bedfast, no independent movement; Mental-disoriented-not follow commands</p> <p>Review of Resident #1's hospital records dated 02/15/2024 revealed the following X-Ray results:</p> <p>Pelvis: acute left superior and inferior pubic rami fracture.</p> <p>Left shoulder: acute displaced/impacted surgical neck proximal humeral fracture.</p> <p>On 05/21/2024 at 12:34 p.m., an interview was conducted with S6LPN. S6LPN stated she was the floor nurse for Resident #1 on 02/12/2024. S6LPN further stated she had not observed Resident #1 attempting to transfer out of the bed independently prior to the incident. S6LPN stated prior to the unwitnessed fall, Resident #1 had a temperature of 100.7F and was very confused. S6LPN stated she was called to Resident #1's room by a CNA when Resident #1 was found on the floor. S6LPN stated she reported the incident to S4ADON immediately. S6LPN stated Resident #1 had altered mental status prior to the incident. S6LPN stated Resident #1 was confused and could not verbalize how she got on the floor.</p> <p>On 05/21/2024 at 1:24 p.m., an interview was conducted with S2DON. S2DON confirmed she was immediately made aware Resident #1 had an unwitnessed fall, resulting in an injury with fractures on 2/12/2024. She stated S1ADM was made aware of that incident the day of the incident or within 24 hours during morning meetings.</p> <p>On 05/21/2024 at 1:45 p.m., an interview was conducted with S1ADM. S1ADM stated he was aware Resident #1 had an unwitnessed fall, resulting in injuries on 2/12/2024. He verified he did not report the unwitnessed incident which resulted in fractures to the state agency. He stated it was his understanding that unwitnessed falls did not need to be reported.</p>		