STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195484	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Nursing Center Hammond	42250 North Oaks Dr Hammond, LA 70403

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47191 Based on interviews and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 (#70) resident out of a total of 28 sampled residents. The facility failed to ensure: 1.) Resident #70 was coded accurately for Restraints and Alarms; 2.) Resident #70 was coded accurately for current services provided by the facility. Findings: Review of Resident #70's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/2024 revealed the following: Section O0110: Special Treatments, Procedures and Programs: K1- Hospice Care- b. While a Resident Section P0200: Restraints and Alarms: E. Wander/Elopement Alarm- 0-Not Used Review of Resident #70's Clinical Record revealed she was admitted to the facility on [DATE]. Further review of the electronic health record revealed Resident #70 had a security bracelet placed on 09/12/2024. Review of the Physician Order's from Admission to present revealed no order for Hospice services being provided. On 01/15/2025 at 3:45 p.m. an interview was conducted with S4MDS. S4MDS confirmed Resident #70 currently had a security bracelet as part of the plan of care. S4MDS further confirmed Resident #70 had never received Hospice services. S4MDS reviewed the above MDS and confirmed it was coded inaccurately on the aforementioned Assessment Reference Date. On 01/15/2025 at 3:55 p.m. an interview was conducted with S1CN and S2DON. S1CN and S2DON reviewed the above MDS and Physician Orders and stated Resident #70 should have been coded for having a security bracelet in place and should not have been coded for receiving Hospice services. S1CN and S2DON confirmed the MDS was inaccurately coded to reflect the current services being provided.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Landmark Nursing Center Hammond		STREET ADDRESS, CITY, STATE, ZIP CODE 42250 North Oaks Dr Hammond, LA 70403	

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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 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** 46975 Based on observations, interviews, and record reviews, the facility failed to ensure interventions for falls were implemented as identified on the care plan for 1 (#31) of 2 (#31 and #105) residents reviewed for falls. Findings: Review of Resident #31's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed the resident had diagnoses which included Unsteadiness on Feet and Encounter for Orthopedic Aftercare. Review of Resident #31's Significant Change MDS with an ARD of 10/16/2024 revealed a BIMS of 10, which indicated she was moderately cognitively impaired. Review of Resident #31's current Care Plan revealed the following: Problem: Potential for further falls related to lack of coordination. Intervention: 01/06/2025 fall in room-turn bed against the wall On 01/14/2025 at 12:30 p.m., an interview was conducted with Resident #31's family member. He stated Resident #31 fell out of her bed last week and had to have surgery on her hip. On 01/14/2025 at 9:47 a.m., an observation was made of Resident #31 in her room. Her bed was not turned against the wall. On 01/15/2025 at 8:33 a.m., an observation was made of Resident #31 in her room. Her bed was not turned against the wall. On 01/15/2025 at 11:27 a.m., an observation was made of Resident #31 in her room. Her bed was turned against the wall. On 01/15/2025 at 12:13 p.m., an interview was conducted with S7CNA. She stated Resident #31 had a history of falling. She stated the nurses were responsible for implementing care plan interventions. She confirmed Resident #31's bed was not placed against the wall until today. On 01/15/2025 at 12:37 p.m., an interview was conducted with S6LPN. She stated Resident #31 had a history of falling. She verified the resident had a fall on 01/06/2025. She stated S3ADON was responsible for adding interventions to residents' care plans who were a fall risk, then S3ADON implemented them. She confirmed Resident #31's bed was not placed against the wall until today. (continued on next page)

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/2025 at 12:51 p.m., an interview was conducted with S3ADON. She stated she was responsible for adding fall interventions to residents' care plans, and she implemented the interventions. She stated she was aware Resident #31 had a fall on 01/06/2025. She stated the intervention put into place on 01/06/2025 was to move the resident's bed against the wall. She confirmed the intervention was not put into place until today, and should have been implemented when the resident returned from the hospital on 01/10/2025. On 01/15/2025 at 1:33 p.m., an interview was conducted with S2DON. S2DON stated care plan interventions should be implemented as soon as possible for a resident. She reviewed Resident #31's current care plan and verified she had a fall on 01/06/2025 with an intervention of placing her bed against the wall. She was notified the bed was not placed against the wall until 01/15/2025. S2DON confirmed Resident #31's bed should have been placed against her wall after she returned from the hospital on 01/10/2025.