STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195487	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Acadiana	1710 Smede Hwy Saint Martinville, LA 70582

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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 - Some	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 observations, record reviews and interviews, the facility failed to develop and/or implement a comprehensive person-centered plan of care and/or follow physician's orders for 3 (Resident #82, Resident #11, Resident #13) out of 40 sampled residents as evidenced by:1.failing to implement the comprehensive plan of care for a floor mat when in bed for Resident #82;2.failing to develop a comprehensive plan of care for antipsychotic use for Resident #11; and3.failing to follow physician's orders for PEG (Percutaneous endoscopic gastrostomy) tube water flush for Resident #13. Findings: Resident #82: Review of Resident #82's clinical record revealed he was admitted to the facility on [DATE] with diagnoses that included but were not limited to, other specified fracture of left acetabulum, subsequent encounter for fracture with routine healing, dementia, cognitive communication deficit and hypertension. Review of Resident #82's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/16/2025 revealed in Section C – Cognitive 0500 that Resident #82 had a BIMS (Brief Interview for Mental Status) of 06, indicating he was severely, cognitively impaired. Review of the facility's incident reports revealed Resident #82 had falls on 08/10/2025, 08/26/2025, and two falls on 09/13/2025. Review of Resident #82's care plan report revealed a focus that read The resident is at risk for falls related to gait/balance problems, fracture to right pubis, dementia and muscle weakness. Date Initiated: 08/08/2025. Interventions read in part, 09/13/2025 floor mat when in bed. Date initiated: 09/18/2025. On 02/09/2026 at 10:38 a.m., an observation was made of Resident #82 lying in bed. There was no floor mat near his bed or in his room. On 02/10/2026 at 2:16 p.m., an interview was conducted with S5CNA (Certified Nursing Assistant). She stated that she was familiar with Resident #82 and provided care for him. S5CNA stated that interventions in place to prevent falls included things such as, mat for his wheelchair and assisting him to the bathroom. She confirmed that Resident #82 did not have a floor mat in his room. On 02/10/2026 at 2:25 p.m., an interview was conducted with S4LPN (Licensed Practical Nurse). She stated that she was familiar with Resident #82 and provided care for him. She stated that there were interventions in place that prevented Resident #82 from falls, but he did not have a floor mat in his (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. On 02/10/2026 at 3:15 p.m., a second interview and observation of Resident #82's room was conducted with S5CNA. S5CNA confirmed that there was not a floor mat in the resident's room. She stated that she was responsible for getting Resident #82 to bed around 8 p.m. and there was never a floor mat in his room. Resident #11 Resident #11 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing; vascular dementia, unspecified severity, with other behavioral disturbance; and anxiety disorder. Review of Resident #11's Quarterly Minimum Data Set (Set) dated 01/26/2026, revealed in Section N0450 that the resident received antipsychotics on a routine basis. Review of Resident #11 current physician orders revealed the following orders in part: On 01/19/2026, Quetiapine Fumarate Tablet (atypical antispychotic) 50 MG (milligram) Give 1 tablet by mouth in the evening. On 02/11/2026, Risperidone Tablet (atypical antipsychotic) 0.25 MG Give 0.125 mg by mouth one time a day. Review of Resident #11's current care plan revealed the resident was not care planned for antipsychotic use. On 02/11/2026 at 3:21 p.m., an interview and review of Resident #11's current physician orders and care plan was conducted with S10MDS (Minimum Data Set). She stated she was responsible for developing Resident #11's care plan. S10MDS confirmed the resident was not care planned for her use of antipsychotics and stated that she should have been. Resident #13 A review of the facility's policy titled, Tube Feedings, with a last reviewed date of 12/2015, read in part, All tube feedings will be administered in accordance with verified medical necessity, established infection control policies and procedures and physician's orders. A review of Resident #13's record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery and encounter for attention to gastrostomy. A review of Resident #13's physician orders read in part, start date: 09/23/2025 enteral feed. flush PEG (Percutaneous Endoscopic Gastrostomy) tube with 180 cc (cubic centimeters) of water every 4 hours. On 02/10/2026 at 12:32 p.m., an observation was conducted of S3LPN (Licensed Practical Nurse), who administered 360 cc's of water flush to Resident #13's PEG tube. An interview and record review (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were conducted with S3LPN, who stated Resident #13's physician orders stated to flush Resident #13's PEG tube with 180 cc's of water. S3LPN confirmed she flushed Resident #13's PEG tube with 360 cc's of water and should have only administered 180 cc's of water. On 02/10/2026 at 1:12 p.m., an interview and record review were conducted with S2DON (Director of Nursing). S2DON confirmed Resident #13's physician orders stated to flush Resident #13s PEG tube with 180 cc's of water. S2DON confirmed physician's orders should be followed, and Resident #13's PEG tube should have only been flushed with 180 cc's of water not 360 cc's.

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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, record review, and policy review; the facility failed to maintain an effective infection prevention and control program, by failing to ensure:1. Proper infection control techniques were practiced during catheter care for Resident #87; and2. Reusable equipment was sanitized prior to and after resident use.The facility census was 120.Findings: 1.Resident #87: Review of the facility's policy titled Perineal Care, with a last reviewed date of 01/2024, revealed in part, Purpose: to cleanse the perineum and to prevent irritation or infection. Review of Resident #87's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, in part, retention of urine, urinary tract infection, and overactive bladder. On 02/11/2026 at 8:43 a.m., an observation was made of S8CNA (Certified Nursing Assistant) providing catheter care for Resident #87. S8CNA donned a gown and gloves and wiped Resident' #87's perineal area and indwelling catheter with a wet towel that contained perineal cleanser. S8CNA used a clean wet towel and rinsed Resident #87's perineal area and indwelling catheter. S8CNA then used a clean dry towel and dried Resident #87's perineal area and indwelling catheter. S8CNA did not change her gloves or perform hand hygiene in between cleansing, rinsing and drying Resident #87's perineal area and indwelling catheter. On 02/11/2026 at 8:50 a.m., an observation was made of Resident #87's indwelling catheter drainage bag resting on the floor while S8CNA was providing catheter care. On 02/11/2026 at 9:00 a.m., a second observation and interview was conducted with S8CNA of Resident #87's catheter drainage bag resting on the floor. S8CNA confirmed that Resident #87's indwelling catheter drainage bag was on the floor and she stated it should not have been. On 02/11/2026 at 9:10 a.m., an interview was conducted with S8CNA. S8CNA confirmed that she had not removed her gloves or performed hand hygiene between cleaning, rinsing and drying Resident #87's perineal area and indwelling catheter and she should have. On 02/11/2026 at 11:41 a.m., an interview was conducted with S7RN/IP (Registered Nurse/Infection Preventionist). S7RN/IP confirmed that Resident #87's indwelling catheter drainage bag should not have been on the floor. S7RN/IP further confirmed that S8CNA should have changed her gloves and sanitized her hands in between cleaning, rinsing and drying Resident #87's perineal area and indwelling catheter. 2. On 02/11/2026, a review of Centers for Disease Control and Prevention (CDC), Recommendations for Disinfection and Sterilization in Healthcare Facilities dated 12/07/2023 revealed in part: 4.b. Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA (Environmental Protection Agency)-registered hospital disinfectant using the label's safety precautions and use directions. 4.c. Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient.). On 02/10/2025 at 7:33 a.m., an observation and an interview was conducted with S9LPN (Licensed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse) during medication pass on Hall W. S9LPN removed a re-usable blood pressure cuff and a reusable pulse oximeter from one of her medication cart drawers and entered Resident # 86's room. S9LPN recorded the resident's blood pressure and pulse with the equipment. S9LPN returned the blood pressure cuff and oximeter to the same drawer on her cart from which they were removed without cleaning them. S9LPN confirmed she did not clean the above equipment after use. On 02/10/2026 at 8:02 a.m., an interview was conducted with S7RN/IP (Registered Nurse/Infection Preventionist). S7RN/IP stated the equipment should have been cleaned right after S9LPN used them on the resident and then stored them.

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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** Based on observation, record review, and interviews, the facility failed to ensure the minimum data set (MDS) assessment accurately reflected the oral status of 1 (Resident #99) of 40 sampled residents. Review of Resident #99's clinical record revealed he was admitted to the facility on [DATE] with diagnoses that included but were not limited to diabetes mellitus, hypertension, dysphagia and bradycardia.A review of Resident #99's Comprehensive MDS assessment with an ARD (Assessment Reference Date) of 09/30/2025 was conducted. Section C - Cognitive Patterns 0500 revealed Resident #99 had a BIMS (Brief Interview for Mental Status) of 15, which indicated he was cognitively intact. Further review of Resident #99's MDS revealed in section L - Oral/Dental Status - L0200D, Obvious or likely cavity or broken natural teeth, not checked.On 02/09/2026 at 9:44 a.m., an interview and observation was conducted with Resident #99. He stated that he had only a few teeth in his mouth and would like to see a dentist, but had never been offered. At this time, it was observed that Resident #99 had multiple missing teeth; three broken, discolored teeth in his upper mouth and one tooth that was discolored on the bottom. There were no other teeth in Resident #99's mouth.On 02/11/2026 at 8:53 a.m., a record review, interview, and observation was conducted with S6MDS. She confirmed that she was the MDS nurse responsible for Resident #99's assessment. S6MDS confirmed that Resident #99's MDS assessment did not include any missing, broken, or discolored teeth. When Resident #99's oral status was assessed with this surveyor, S6MDS confirmed that Resident #99 had missing, broken and discolored teeth. S6MDS confirmed that the MDS assessment was not accurately coded for Resident #99's dental status.On 02/11/2026 at 09:18 a.m., an interview and observation was conducted with S2DON (Director of Nursing). She confirmed that Resident #99 had missing, broken, and discolored teeth and had been coded inaccurately on his comprehensive MDS assessment.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices for 1 (#13) out of 40 sampled residents by failing to ensure EMAR (Electronic Medication Administration Record) was accurately documented for Resident #13.Findings:A review of the facility's policy titled, Documentation, with a last reviewed date of 09/2025, read in part, It is the policy of this facility to maintain accurate medical records.A review of Resident #13's record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery and encounter for attention to gastrostomy.A review of Resident #13's physician orders read in part, start date: 09/23/2025 enteral feed. flush PEG (Percutaneous Endoscopic Gastrostomy) tube with 180 cc (cubic centimeters) of water every 4 hours.A review of Resident #13's February 2026 EMAR revealed documentation that Resident #13's enteral feed flush PEG tube with 180 cc of water every 4 hours was administered on 02/10/2026 at 8:15 a.m. by S3LPN (Licensed Practical Nurse).On 02/10/2026 at 1:04 p.m., an interview and record review were conducted with S3LPN. S3LPN stated she did not administer Resident #13's 8:00 a.m. enteral feed water flush due to Resident #13's PEG tube residual being close to 200 cc's and he was coughing. A review of Resident #13's EMAR from February 2026 was conducted with S3LPN, and she confirmed should not have signed off on Resident #13's enteral feed water flush being administered at 8:15 a.m. On 02/10/2026 at 1:12 p.m., an interview and record review were conducted with S2DON (Director of Nursing). A review of Resident #13's physician's orders and February 2026 EMAR was conducted with S2DON. S2DON stated nurses were supposed to document medications and procedures that were administered on the EMAR. S2DON stated that since S3LPN did not administer Resident #13's enteral feed water flush at 8:00 a.m., it should not have been documented on the EMAR, and it was inaccurate documentation.