STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195494	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Baton Rouge	9105 Oxford Place Drive Baton Rouge, LA 70809

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review, and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 2 (Cart A and Cart B) of 3 medication carts reviewed. Review of the facility's policy titled Medication Storage with a revision date of 11/2017 revealed, the following, in part: Medication storage shall meet all applicable federal, state and local guidelines. On 02/23/2026 at 11:40 a.m., an observation was made of Cart B with S6LPN, which revealed fifteen loose and unlabeled pills on the bottom of the cart's drawers. On 02/23/2026 at 11:52 a.m., an interview was conducted with S6LPN. She stated the nurses should check the medication carts daily for loose medications. S6LPN confirmed the above pills were loose and unlabeled in the cart and should not have been. On 02/23/2026 at 12:07 p.m., an observation was made of Cart A with S7LPN, which revealed one loose and unlabeled pill on the bottom of the cart's drawer. On 02/23/2026 at 12:23 p.m., an interview was conducted with S7LPN. She stated the nurses should check the medication carts daily for loose medications. S7LPN confirmed the above pills were loose and unlabeled in the cart and should not have been. On 02/23/2026 at 2:15 p.m., an interview was conducted with S2DON. She stated she expected the nursing staff to perform medication cart checks on each shift, which included checking for any loose medications in the cart's drawers. She confirmed medications should not be loose and unlabeled in the cart.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record reviews and interviews, the facility failed to ensure dietary services were provided in accordance with professional standards for food service safety for the 117 residents served a meal tray from the kitchen. The facility failed to ensure:Staff routinely performed temperature checks on the food served to residents; and Thawing of meat in the refrigerator, in a drip-proof container.1.Review of facility's Policy titled Sanitary Conditions of the food service department with a revision date of 05/2018 revealed the following, in part: Policy: Facilities and equipment used in the preparation and serving of food provided to residents are safe and sanitary. Review of the facility's policy titled, Monitoring temperatures of cooked foods, last reviewed 02/2022, revealed the following in part: Policy: The temperature of potentially hazardous cooked foods will be monitored to insure that the foods are not in the danger zone for more than 6 hours.Procedure: 2. The temperature of each potentially hazardous food will be taken at the following times. a.) when the cooking process is completed. 3. Cooking, holding and storage temperatures should be recorded on Food Temperature Monitoring Log. These logs should be maintained at least three months. Review of food temperature log binder, as of 02/23/2026 at 9:00 a.m., revealed missing food temperature logs on the following meal dates: 02/18/2026 - lunch, 02/19/2026 - breakfast and lunch, 02/21/2026 - dinner, and 02/22/2026 - dinner. On 02/23/2026 at 8:44 a.m., an interview was conducted with S3DPM. S3DPM confirmed the above food temperature logs were missing and should have been documented. On 02/23/2026 at 1:38 p.m., an interview was conducted with S4DM. S4DM confirmed the above food temperature logs were missing and should have been documented. 2.Review of the Weekly Cleaning Schedule revealed the refrigerators should be cleaned by the dishwashers as needed. On 02/23/2026 at 8:37 a.m., a tour was conducted of the facility kitchen with S3DPM. There were dark red meat drippings on the main refrigerator floor. On 02/23/2026 at 8:44 a.m., an interview was conducted with S3DPM. S3DPM confirmed the meat drippings should not be on the floor of the refrigerator. On 02/23/2026 at 1:37 p.m., a tour was conducted with S4DM. S4DM showed us the refrigerator and the dark red meat drippings were still on the floor. On 02/23/2026 at 1:38 p.m., an interview was conducted with S4DM. S4DM confirmed the meat drippings should not be on the floor of the refrigerator.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure resident's room were clean and maintained in a sanitary manner for 1 (#15) of 3 (#15, #23, and #34) sampled residents investigated for environment. The facility failed to ensure Resident #15's room was properly cleaned.A review of Resident #15's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Hemiplegia And Hemiparesis Following Cerebrovascular Disease Affecting Left Dominant Side, Dysphagia, Cognitive Communication Deficit and Aphasia On 02/24/2026 at 1:58 p.m., an observation was conducted of Resident #15's bathroom. Resident #15's bathroom was noted with the following: one foot in front of the commode was a clear wet liquid with a dried brown substance approximately 4 cm in length. Adjacent to the commode base was a large dried brown substance approximately, one foot in length and 6 inches in width. The paper towel dispenser was noted to be covered with a dry white substance. The wall next to the trim exiting the bathroom was noted to have two dry brown markings approximately 2-3 cm in length, and the light switch plate had 4 markings of a dried brown substance.On 02/25/2026 at 10:00 a.m., an observation was conducted of Resident #15's room. Surveyor entered Resident #15's room and noted wet floors. Resident #15 shook his head, indicating housekeeping had recently cleaned his room. Resident #15's bathroom was noted with the following: one foot in front of the commode was a clear wet liquid with a dried brown substance approximately 4 cm in length. Adjacent to the commode base was a large dried brown substance approximately, one foot in length and 6 inches in width. The paper towel dispenser was noted to be covered with a dry white substance. The wall next to the trim exiting the bathroom was noted to have two dry brown markings approximately 2-3 cm in length, and the light switch plate had 4 markings of a dried brown substance.On 02/25/2026 at 11:08 a.m., an interview was conducted with S10HK. She confirmed she had cleaned and sanitized Resident #15's room and bathroom this morning.On 02/25/2026 at 11:40 a.m., an observation and interview was conducted with S8AADM and S9HKS. They both confirmed the above observations in Resident #15's room and the bathroom. They both confirmed Resident #15's room and bathroom were not clean and sanitary.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards of practice. The facility failed to ensure oxygen tubing was labeled for 1 (#14) of 26 residents reviewed in the final sample. Findings: Review of the facility's policy titled Infection Control Oxygen Equipment Cleaning, with a revision date of 03/18 revealed the following:Use disposable tubing, masks, and cannulas for patients receiving oxygen therapy.7. Tubing should be replaced every 7 days.10. When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date. Review of Resident #14's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Pneumonia and Atrial Fibrillation.Review of Resident #14's admission MDS with an ARD of 02/05/2026 revealed Resident #14 had a BIMS of 11, which indicated moderate cognitive impairment. Review of Resident #14's current Physician Orders revealed the following, in part: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 MG/3ML. 1 vial inhale orally every 6 hours as needed for Dyspnea related to Pneumonia. On 02/23/2026 at 11:22 a.m., an observation was made of Resident #14's room. The tubing connected to Resident #14's nebulizer and the tubing connected to Resident #14's portable oxygen canister were not labeled. On 02/24/2026 at 8:33 a.m., an interview was conducted with S12LPN. S12LPN observed and confirmed the tubing connected to Resident #14's nebulizer and the tubing connected to Resident #14's portable oxygen canister were not labeled and should have been. On 02/24/2026 at 3:55 p.m., an interview was conducted with S2DON. S2DON confirmed all nebulizer and oxygen tubing should be labeled with the date it was changed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services, including services that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident. The facility failed to ensure a resident had a physician's order before being allowed to self-administer medication, including routine medication, for 1 (#51) of 26 residents reviewed in the final sample.Findings:Review of the facility's policy titled Self-Administration of Medication, with a revision date of 11/2017, revealed the following, in part:A resident will be allowed to self-administer medications only if:a) the attending physician writes or gives a verbal order that the resident may keep a medication at the bedside for the purpose of self-administration2.) All medications are kept in a locked cabinet or box in the resident's room.Review of Resident #51's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Diabetes Mellitus Type 2 and Dermatitis.Review of Resident #51's Annual Minimum Data Set with an Assessment Reference Date of 11/28/2025 revealed a Brief Interview for Mental Status of 15, which indicated Resident #51 was cognitively intact.Review of Resident #51's current Physician's Orders revealed no evidence of a written order for self-administration of medication.On 02/23/2026 at 12:26 p.m., an observation was made of a bottle of generic Benadryl sitting on Resident #51's bedside table.On 02/24/2026 at 8:33 a.m., an interview was conducted with S12LPN. S12LPN stated residents should not have medications, including over the counter, kept at their bedside without a physician's order to self-administer. She further stated medications should be kept in a locked compartment in the resident's room if they were able to self-administer.On 02/24/2026 at 10:35 a.m., an observation was made of a bottle of Benadryl tablets on Resident #51's bedside table.On 02/24/2026 at 12:50 p.m., an observation and interview was conducted with S11LPN. S11LPN stated residents should have a doctor's order for self-administration of medications and medications should be kept in a locked compartment in the resident's room if they were able to self-administer. S11LPN observed the bottle of generic Benadryl on Resident #51's bedside table. She confirmed Resident #51 did not have an order to self-administer medications and should not have had medications in her room.On 02/24/2026 at 3:55 p.m., an interview was conducted with S2DON. S2DON stated a resident must have a Physician's Order to keep medication at their bedside to self-administer and medications had to be locked in a drawer/compartment. She confirmed Resident #51 did not have a self-administration order and should not have had medications in her room.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure it was free of significant medication errors for 1 (#126) of 11 residents reviewed for medication administration. Review of Resident #126's clinical record revealed he was admitted to the facility on [DATE] with a diagnosis of Sepsis due to Methicillin Resistant Staphylococcus Aureus (MRSA). Review of Resident #126's admission MDS with an ARD of 02/24/2026 revealed it was still in progress and the BIMS had not been completed. Review of Resident #126's Discharge Orders from a local hospital dated 02/19/2026 revealed the following antibiotic order:Daptomycin-Sodium Chloride Intravenous Solution. Inject 1000 mg into the vein in the morning for 19 days. Indication: Bacteria in the blood. Review of Resident #126's Physician Orders since admission revealed, in part: Start date 02/20/2026. Daptomycin-Sodium Chloride Intravenous (IV) Solution 1000-0.9 mg/ml. Review of Resident #126's MAR dated February 2026 revealed the following, in part:Daptomycin charted as administered on 02/20/2026 by S7LPN;Daptomycin charted as a 9 on 02/21/2026 and 02/22/2026 by S13LPN; Daptomycin charted as administered on 02/23/2026 by S7LPN; and Further review of the MAR revealed a 9 indicated Other, See Progress Notes. Review of Resident #126's Progress Notes dated February 2026 revealed the following, in part:02/21/2026 at 7:23 a.m. - Daptomycin-Sodium Chloride Intravenous Solution 1000-0.9 mg/ml. Medication not available. Signed, S13LPN; and02/22/2026 at 7:36 a.m. - Daptomycin-Sodium Chloride Intravenous Solution 1000-0.9 mg/ml. Medication not available. Signed, S13LPN. On 02/23/2026 at 9:24 a.m., an interview was conducted with Resident #126. He stated he acquired a post-operative surgical infection and was admitted to the facility for IV antibiotics on 02/19/2026. He stated he was supposed to receive the antibiotic every morning. He stated he did not receive the antibiotic over the weekend on 02/21/2026 and 02/22/2026. He stated he was told by S13LPN, she could not find the antibiotic. He stated he received the antibiotic on the morning of 02/20/2026 and this morning, so he did not understand why the nurse told him she could not find it over the weekend. On 02/25/2026 at 9:57 a.m., an interview and observation was conducted with S7LPN. She stated Resident #126 was admitted on [DATE] for IV antibiotic therapy. She stated he was oriented and could make his needs known. She stated she administered the first dose of the antibiotic on Friday 02/20/2026. She stated Resident #126's antibiotics were stored in Medication Room A's refrigerator. She stated when she administered the antibiotic on 02/20/2026, there were multiple doses in the refrigerator. She stated when she returned to work on Monday 02/23/2026, she was told Resident #126 did not receive his antibiotic over the weekend due to it not being available. She stated when she administered Resident #126's antibiotic on 02/23/2026, the antibiotics were still in the refrigerator. She confirmed the antibiotic should have been administered to Resident #126 on 02/21/2026 and 02/22/2026. At that time, an observation was made of the refrigerator in Medication Room A with S7LPN. There was a bag of Resident #126's Daptomycin antibiotics in the door of the refrigerator. The antibiotic label was observed with S7LPN, and she confirmed there was an issue date of 02/19/2026 on the pharmacy label. There were three antibiotics left in the bag. On 02/25/2026 at 10:25 a.m., an interview was conducted with S13LPN. She stated she was assigned to Resident #126 on 02/21/2026 and 02/22/2026. She stated Resident #126 had an antibiotic ordered once a day to be given in the morning. She stated she could not find Resident #126's Daptomycin to administer to him on 02/21/2026 and 02/22/2026. She stated over the weekend, the facility did not have pharmacy services to deliver medications. She stated she did not notify any other staff that she could not find Resident #126's antibiotic. She confirmed the antibiotic should have been given if it was available. On 02/25/2026 at 11:06 a.m., an interview was conducted with a local Pharmacist. He confirmed his pharmacy serviced the facility. He verified the pharmacy sent Resident #126's antibiotics to the facility on [DATE]. He confirmed seven antibiotic doses were sent to the facility on [DATE]. On 02/25/2026 at 11:57 a.m., an interview was conducted with S2DON. She verified the facility had (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy services on the weekend, and further stated there was also an on-call pharmacy service who delivered to the facility on weekends when needed. S2DON confirmed Resident #126 should have received his antibiotic on 02/21/2026 and 02/22/2026. She further stated the nurse should have notified other facility staff when she could not find Resident #126's antibiotic.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 prevention and control program designed to provide a safe, sanitary environment to help prevent the development and transmission of infections for 1 (#15) of 2 residents reviewed for having a feeding tube. The facility failed to ensure staff wore proper Personal Protective Equipment (PPE) when providing care to Resident #15, who was on Enhanced Barrier Precautions (EBP).A review of Resident #15's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included, gastrostomy status. A review of Resident #15's current Physician Orders revealed the following, in part: Order Start Date: 07/01/2024 Enhanced Barrier Precautions - gown and gloves to be worn during high contact resident care activities (device care - feeding tube). On 02/23/2026 at 1:15 p.m., an observation of the Enhanced Barrier Precautions sign posted on the outside of Resident #15's door revealed the following, in part: Providers and staff must wear gloves and a gown for high-contact resident care activities. Device care or use: feeding tube. On 02/23/2026 at 1:15 p.m., an observation was made of S5LPN administering a bolus tube feeding to Resident #15. S5LPN did not wear a gown while administering the bolus tube feeding. On 02/23/2026 at 1:21 p.m., an interview was conducted with S5LPN. She stated she did not have to wear a gown when administering Resident #15's bolus tube feeding. She stated Resident #15 was currently on enhanced barrier precautions. She stated she did not have to wear a gown while administering tube feeding. On 02/24/2026 at 12:21 p.m., an interview was conducted with S2DON. S2DON confirmed she expected all nurses to follow Enhanced Barrier Precautions which included wearing a gown and gloves when administering tube feeding.