STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195544	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Rayne	2021 Crowley Rayne Highway Rayne, LA 70578

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269 Based on record review, observations and interview, the facility failed to ensure that residents received the necessary treatment consistent with professional standards of practice to identify, prevent and promote the healing of a pressure area for 2 residents (#2 and #3) out of a total of 6 (#1, #2, #3, #R4, #R5 and #R6) sampled residents. This deficient practice was evidenced by the facility staff failing to: 1. Conduct weekly body audits for Resident #3; 2. Identify a Stage 2 Pressure Ulcer for Resident #3; and 3. Provide ordered treatments for Resident #2. Findings: A review of the facility's policy titled, Weekly Body Audit, with a latest review date of 08/2021 revealed, in part: To be completed weekly for all residents to identify any new alterations in skin integrity. On a designated day of the week, per facility schedule as developed by the DON (Director of Nursing), a body audit will be performed. The Licensed Nurse completes a head to toe inspection of the skin with notation of no new problem or new problem noted. If a new issue is noted, additional documentation in the nurse notes is required. The Licensed Nurse proceeds forward per policy if a change in the resident's condition is noted. Communicate to Interdisciplinary Team, Physician/ NP (Nurse Practitioner) and family/designee any changes in skin integrity. 1. Resident #3 Resident #3 was admitted to the facility on [DATE] with the following pertinent diagnoses: COPD (chronic obstructive pulmonary disease), type 2 DM (diabetes mellitus) w/ diabetic neuropathy, paranoid schizophrenia, bipolar disorder, pulmonary nodule, vitamin b12 deficiency anemia, adult failure to thrive, weakness, dependence on supplemental oxygen, anxiety and major depressive disorder and protein-calorie malnutrition. Review of the Admission MDS (Minimum Data Set) assessment dated [DATE] revealed under Section M, Skin Conditions, Resident #3 was assessed at risk for developing pressure ulcers. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER: Landmark of Rayne		STREET ADDRESS, CITY, STATE, ZIP CODE: 2021 Crowley Rayne Highway Rayne, LA 70578	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's care plan revealed the resident had an intervention to conduct weekly body audits as scheduled. Further review of Resident #3's EHR failed to include evidence that weekly body audits were conducted the weeks of: 11/03/2024, 11/10/2024, 12/15/2024, 12/29/2024, 01/12/2025, 01/19/2025 and 01/26/2025. 2. Review of Significant Change MDS assessment dated [DATE] revealed under Section M, Skin Conditions, Resident #3 was assessed at risk for developing pressure ulcers. Further review of Resident #3's EHR revealed the last weekly body audit to identify any new skin issues was last conducted on 01/11/2025 which revealed no skin issues. There were no furher records of weekly body audits after this date. Review of Resident #3's EHR (Electronic Health Record) revealed the resident was sent to the emergency roiagnom on [DATE] and admitted inpatient from 02/05/2025 through 02/08/2025. Hospital records revealed visual evidence via photo of a Stage 2 pressure ulcer to Resident #3's sacral spine which was present on admission to the hospital measuring length (l) x width (w) x depth (d) in centimeters (cm) 1.5cm x 1.5 cm x 0. 2 cm. On 03/11/2025 at 2:00 PM, an interview was conducted with S3TxLPN (Treatment Licensed Practical Nurse) who stated weekly body audits were completed by the floor nurses and any new skin conditions or skin changes identified were reported to her. On 03/12/2025 at 4:10 PM, an interview was conducted with S1CN (Corporate Nurse) and S2DON (Director of Nursing). S1CN was unable to provide documentation that weekly body audits were conducted for the weeks of 11/03/2024, 11/10/2024, 12/15/2024, 12/29/2024, 01/12/2025, 01/19/2025 and 01/26/2025. S1CN was also unable to provide documentation of Resident #3's weekly body audit being conducted prior to Resident #3 being hospitalized week of 02/02/2025. 39319 3. Resident #2 Review of Resident #2's electronic medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included the following in part, unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing, protein-calorie malnutrition, cerebral infarction, atrial fibrillation, anxiety disorder, major depressive disorder, hypertension, and, muscle weakness. Further review revealed the resident had a facility acquired pressure ulcer identified on her left heel on 01/04/2025. Review of Resident #2's February 2025 TAR (Treatment Administration Record) revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An order with a start date: 01/24/2025 and stop date: 02/04/2025: Stage II to left heel apply collagen powder and cover with foam dressing daily. Further review revealed missed wound care treatments on 02/01/2025 and 02/02/2025. An order with a start date: 02/05/2025 and stop date: 02/13/2025. Stage II to left heel paint with betadine and dry dressing until resolved every day shift. Further review revealed missed wound care treatments on 02/08/2025, 02/09/2025 and 02/12/2025. An order with a start date 02/14/2025: Stage II to left heel paint with betadine, non-adherent pad and dry dressing until resolved every day shift. Further review revealed missed wound care treatments on 02/15/2025, 02/18/2025, 02/22/2025, and 02/23/2025. Review of the resident's March 2025 TAR revealed the following: An order with a start date: 02/14/2025: Stage II to left heel paint with betadine, non-adherent pad and dry dressing until resolved. Further review revealed missed wound care treatments on 03/03/2025, 03/08/2025, and 03/09/2025. On 03/12/2025 at 4:20 PM, an interview was conducted with S2DON (Director of Nursing). She stated that they were aware of the missed wound care treatments for Resident #2. She stated the treatments should have been done as ordered.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44269 Based on record review and interview, the facility's Quality Assurance and Performance Improvement (QAPI) Program failed to measure its success and track performance after identifying an area of improvement as evidenced by failing to have documented evidence of monitoring the effectiveness of the proposed plan of action. This deficient practice had the potential to affect a census of 98 residents. Findings: Review of the facility's form titled, Corrective Action Plan, dated 02/12/2025 revealed: 1. Problem Identified: Tasks not firing correctly due to facility changed from 12 hour shifts to 8 hour shifts. 12 hour shifts continued to fire to tasks in addition to 8 hours. Several time code discrepancies resulted in facility wide tasks audit to make corrections. 2. Plan of Action: Immediate action of Task audits of each resident correcting each task time code. Audit of Every individual task for each resident audited and corrected. Nursing staff were in-serviced on task time codes (8 hours) and correct body audit schedules must be verified on each new admit and hospital return/readmission. Projected completion date: 02/14/2025. 3. Monitoring: DON (Director of Nursing)/ designee to randomly audit 5 resident tasks 3 times weekly to ensure time codes are accurately reflecting 8 hour shifts and body audits are set up weekly per schedule. Hospital returns are to be audited within 24-72 hours of return to ensure any cancelled tasks that still apply to resident are reactivated. 4. Follow- up for Effectiveness: Section remained blank and failed to include a resolved date. On 03/12/2025 at 4:30 PM, a review of the facility's corrective action plan and an interview was conducted with S1CN (Corporate Nurse) and S2DON (Director of Nursing). There was no documented evidence that the actions implemented were measured or that performance of the action plans were tracked from 02/12/2025 through 03/10/2025. There was also no evidence of data collection and analysis. S1CN and S2DON confirmed there was no documented evidence of monitoring, or performance tracking conducted from 02/12/2025 thru 03/10/2025.