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	12/16/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident's comprehensive care plan was revised for 1 (Resident #2) out of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. The facility failed to ensure that the comprehensive care plan was updated to include accurate advance directive code status for Resident #2. Findings:A review of the facility's policy titled Care Plan Process with a review date of [DATE], read in part: Baseline Care Plan and Summary: The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged, and must be consistent with each resident's written plan of care. A review of the facility's policy titled Advance Directives with a review date of [DATE], read in part: Purpose: To support the implementation of the Patient Self-Determination Act within the framework of state and federal law and facility policies. All staff providing care for the resident will review the Advance Directive and clarify any discrepancies between the Directive and current treatment plan. Review of Resident #2's electronic medical record revealed an admission date of [DATE] with diagnoses that included in part, Alzheimer's disease, cerebral vascular disease, and cerebral infarction. Review of Resident #2's Order Summary Report revealed a physician order DNR (Do not Resuscitate) dated [DATE].Review of Resident #2's Advanced Directive Consent dated [DATE] revealed DNR was selected in the code status category. Review of Resident #2's Louisiana Physician Order for Scope of Treatment (LaPOST) dated [DATE] revealed that DNR/Do Not Attempt Resuscitation (Allow Natural Death) was selected under Cardiopulmonary Resuscitation (CPR). Review of Resident #2's Care Plan Report revealed Focus: Full Code, Date Initiated: [DATE], Revision on: [DATE]. On [DATE] at 12:11 p.m., an interview and review of Resident #2's electronic medical record was conducted with S2MDS (Minimum Data Set). She confirmed that Resident #2's Care Plan Report was inaccurate, stating Full Code. She further confirmed that the Care Plan Report should have been revised to reflect the resident's DNR status, as documented in the resident's physician orders and LaPost. On [DATE] at 12:34 p.m., an interview and review of Resident #2's electronic medical record was conducted with S1DON (Director of Nursing). S1DON confirmed that Resident #2's Care Plan Report was inaccurate, stating Full Code. She further confirmed that the Care Plan Report should have been revised to reflect the resident's DNR status, as documented in the resident's physician orders and LaPost.

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