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	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Rayne	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews, observations, and interviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices when staff failed to immediately sign out narcotic medications on the narcotic record form at the time they were administered for the for 5 residents (#23, #29, #71, #76 and #77). Findings: A review of the facility's policy titled Drug- Controlled Substances with a last review date of 01/29/2026, read in part, Regulation requires that the community has a system in place to account for the receipt, usage, disposition, and reconciliation of all controlled medications. These systems include the following: Controlled medications are to be signed out on the Individual Resident Narcotics Record (Form NS-618) at the time they are administered. Review of Resident #23's physician orders revealed an order dated 04/17/2024 for Acetaminophen w/ Codeine Tab (Tablet) 300-30 MG (milligrams), Give 1 tablet by mouth two times a day related to other chronic pain. Review or Resident #23's MAR (Medication Administration Record) for May 2026 revealed that Acetaminophen w/ Codeine 300-30 MG (milligrams), 1 tab was administered at on 05/13/2026 at 8:00 a.m. Review of Resident #29's physician orders revealed an order dated 05/06/2024 for Alprazolam tab (tablet) 0.5 mg (Milligrams), Give 1 tablet by mouth four times a day related to anxiety disorder. Review or Resident #29's MAR (Medication Administration Record) for May 2026 revealed that Alprazolam 0.5 mg tablet, 1 tablet was administered on 05/13/2026 at 9:00 a.m. and at 1:00 p.m. Review of Resident #71's physician orders revealed an order dated 10/29/2025 for Lacosamide oral tablet 100 mg, give 1 tablet by mouth two times a day related to epilepsy, unspecified, not intractable, without status epilepticus. Review or Resident #71's MAR (Medication Administration Record) for May 2026 revealed that Lacosamide 100 mg, 1 tab was administered at on 05/13/2026 at 8:00 a.m. Review of Resident #76's physician orders revealed an order dated 08/27/2024 for Xanax oral tablet 0.25 mg, give 1 tablet by mouth four times a day related to generalized anxiety disorder. Review or Resident #76's MAR (Medication Administration Record) for May 2026 revealed that Xanax 0.25mg (Alprazolam), 1 tab was administered on 05/13/2026 at 8:00 a.m. and at 12:00 p.m. Review of Resident #77's physician orders revealed an order dated 09/24/2025 for Xanax oral tablet 0.25mg (Alprazolam), give 1 tab by mouth two times a day for anxiety. Review or Resident #77's MAR (Medication Administration Record) for May 2026 revealed that Xanax 0.25mg (Alprazolam), 1 tab was administered on 05/13/2026 at 2:00 p.m. On 05/13/2026 at 1:13 p.m., S11LPN was approached to conduct a narcotic reconciliation of MC1. S11LPN offered that she had not signed out any of the narcotics that she had administered on the Individual Resident Narcotics Record yet. She stated that per facility policy, she should have signed out those narcotics on the Individual Resident Narcotics Record at the time the medications were administered. S1DON was requested to perform the narcotic reconciliation. On 05/13/2026 at 1:45 p.m., an interview was conducted with S1DON and S3RNS. Both confirmed that S11LPN should have signed out on the Individual Resident Narcotic Record any controlled medications she had administered at the time of administration. On 05/13/2026 at 1:47 p.m., a complete narcotic count was performed on MC1 with S3RNS which revealed the following inaccurate narcotic counts: Resident #23's Individual Resident Narcotics Record revealed a count of 42 tablets with the last dose (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented on 05/12/2026 at 8:00 p.m. The current count of tablets observed was 41. Review of Resident #29's Individual Resident Narcotics Record revealed a count of 46 tablets with the last dose documented on 5/12/26 at 9:00 p.m. The current count of tablets observed was 44. Review of Resident #71's Individual Resident Narcotics Record revealed a count of 44 tablets for this medication with the last dose documented on 5/12/26 at 8:00 p.m. The current count of tablets observed was 43. Review of Resident #76's Individual Resident Narcotics Record revealed a count of 68 tablets for this medication with the last dose documented on 5/12/26 at 8:00 p.m. The current count of tablets observed was 66. Review of Resident #77's Individual Resident Narcotics Record revealed a count of 19 tablets for this medication with the last dose documented on 05/12/2026 at 8:00 p.m. The count of tablets observed was 18. On 05/13/2026 at 2:00 p.m, S3RNS confirmed that S11LPN had not signed out the controlled medications that she had administered on the day shift of 05/13/2026 on the designated Individual Resident Narcotics Record form and this caused the narcotic count to not be accurate.

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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 observations, record review, and interview, the facility failed to accurately assess 1 (#27) of 3 residents investigated for dental out of 55 sampled residents.Findings:Record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including, but not limited to, schizophrenia, depression, bipolar, type 2 diabetes, chronic obstructive pulmonary disease, and obesity. Her Brief Interview for Mental Status (BIMS) score was 15, indicating she was cognitively intact.On 05/11/2026 at 1:03 p.m., an observation of Resident#27's oral cavity revealed she had one decayed tooth on the top front and one decayed tooth on the bottom front. The rest of her teeth were broken and decayed at the gums. At this time, the resident stated her teeth were in this condition when she was admitted on [DATE].Record review of section L. Dental Status of Resident #27's admission MDS (Minimum Data Set) assessment dated [DATE] read in part:D. Obvious or likely cavity or broken natural teeth was not checked.E. Inflamed or bleeding gums or loose natural teeth was not checked.F. Mouth or facial Pain, Discomfort or difficulty with chewing was not checked.Z. None of the above were present was checked indicating none of the above was present. Record review of Resident #27's Dental Evaluation conducted by a dentist dated 01/22/2026 read in part: D. Obvious or likely cavity or broken natural teeth, E. Inflamed or bleeding gums or loose natural teeth. These boxes were checked, indicating the resident's dental status. On 05/12/2026 at 2:37 p.m., as assessment of Resident #27's oral cavity was conducted with S5LPN. S5LPN assessed Resident#27's oral cavity and confirmed the resident had one decayed tooth on the top front and one decayed tooth on the bottom front, and the rest of her teeth were broken off and decayed at the gums.On 05/12/2026 at 2:43p.m., review of Resident #27's dental evaluation dated 01/22/2026 and admission MDS assessment dated [DATE] was conducted with S4RN/AN who was responsible for completing MDS assessments. She confirmed she inaccurately assessed Resident #27 on her admission assessment dated [DATE]. S4RN/AS confirmed the resident had broken and decayed natural teeth on admission.

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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** Based on observations, record reviews, and interviews, the facility failed to implement a person-centered care plan for 1 (#6) of 55 sampled residents.Findings:Record review of Resident #6's electronic record revealed she was admitted on [DATE] with diagnosis not limited to dementia, traumatic subdural hemorrhage, encephalopathy, chronic kidney disease-Stage 3, dysphagia, and depression, and bowel and bladder incontinence. Her brief interview of mental status score was 5, indicating severely impaired cognition. The resident's responsible party was identified as her daughter.Record review Resident #6's care plan dated 08/01/2024 read in part, The resident has bladder incontinence. Under task description read in part, Staff do not use perineal-wash on this resident due to sensitivity.On 05/11/2026 at 10:00 a.m. an observation revealed Resident #6 was lying in bed grimacing and holding her perineal area. The resident stated her private area was irritated and was aggravated to the point she could not tolerate it. Further observation revealed signs posted above her headboard, on the closet, and on the wall next to the door that read, Do not use perineal wash on this resident.On 05/11/2026 at 10:05 a.m., Resident #6's daughter entered the room and stated her mother's perineal area was severely irritated and was causing discomfort. She stated she had posted signs throughout the room when she realized the perineal wash irritated her mother, instructing the staff not to use perineal wash on her mother because she was extremely sensitive to the cleanser. She further stated her mother's perineal area would become irritated approximately every three months, and usually occurred when agency Certified Nursing Assistants (CNA) were utilized on the night shift.On 05/11/2026 at 10:21 a.m., an observation of Resident #6's perineal area was conducted with S9TN and S10CNA present. S9TN confirmed the resident's left groin and inner thigh was red, irritated, and raised. S10CNA confirmed she removed a bottle of perineal-wash from the resident's nightstand today when she came on her shift. She stated an agency CNA had left the perineal wash in the resident room after providing care. S10CNA further confirmed staff were not to use perineal wash on the resident due to the resident's sensitivity to the product and the resulting skin irritation.On 05/12/2026 at 9:36 a.m., an interview with S2ADON revealed CNA's were instructed to use a cleanser provided by the family and not to use perineal wash on Resident #6. S2ADON confirmed Resident #6's CNA that cared for the resident the previous night was an agency CNA.On 05/12/2026 at 9:42 a.m., an interview with S6LPN revealed she was Resident #6's assigned nurse. She confirmed the resident was allergic to perineal wash and developed a bright red rash to the groin and inner thigh areas when the product was used. On 05/12/2026 at 2:55 p.m., an interview with S1DON confirmed the C.N.A.'s were to follow the resident's plan of care and not use perineal wash on Resident #6 due to the resident's sensitivity to the product.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure a resident who was assessed as an unsafe smoker received adequate supervision while smoking for 1 (#24) out of 3 (#2, #11, #24) residents investigated for accidents. Findings:Review of the policy with a review date of 01/29/2026, titled Smoking Policies and Regulations read in part, residents identified as needing supervision shall have designated staff or approved visitors assist them while smoking.Review of Resident #24's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting right dominant side, alcohol abuse with unspecified alcohol induced disorder, other psychoactive substance abuse with psychoactive substance induced psychotic disorder with delusions, and cognitive communication deficit.Review of Resident #24's modified significant change MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 04/17/2026 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 3, indicating his cognition was severely impaired. Further review of Resident #24's MDS assessment revealed the resident was coded for current tobacco use. Review of Resident #24's care plan revealed a focus with an initiation date of 01/12/2026 which read in part: The resident is a smoker - (Supervised x (times) 1 staff member at all times). Interventions in part: The resident requires SUPERVISION while smoking. Review of Resident #24's smoking screening dated 01/26/2026 revealed he was a smoker and smoked cigarettes. Further review revealed the resident could not get to the designated smoking areas independently and was not able to follow smoking policies. Continued review revealed smoking recommendations that Resident #24 required 1:1 supervision while smoking. On 05/12/2026 at 11:45 a.m., S3RNS was observed wheeling Resident #24 in his wheelchair from the dining room to the smoking patio. S3RNS left Resident #24 on the smoking patio and re-entered the dining room. There was no staff or visitors observed on the smoking patio. On 05/12/2026 at 11:58 a.m., Resident #24 was observed on the smoking patio with a lit cigarette in his left hand. There were no staff or visitors present on the smoking patio. On 05/12/2026 at 12:01 p.m., S2ADON was summoned to the smoking patio. She removed the cigarette from Resident #24's left hand and informed him that he should not be smoking without supervision. S2ADON confirmed that Resident #24 was on the smoking patio unsupervised and should have been supervised by staff while smoking. On 05/12/2026 at 12:35 p.m., an interview was conducted with S3RNS. He confirmed that he had wheeled Resident #24 out onto the smoking patio and left him unsupervised while other residents smoked. S3RNS stated that he was aware that Resident #24 required supervision.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5%. A total of 25 opportunities were observed with 2 medication errors which resulted in a medication error rate of 8.00%. The facility failed to: 1. Administer Resident #38's Budesonide per manufacturer's instructions. 2. Administer Resident #98's Cholecalciferol per physician's ordersFindings:A review of the facility's policy titled Administration of Medications which was last reviewed on 01/29/2026, read in part, Purpose: To administer medications in accordance with best practice; Oral Medication Administration Procedure: 3. Verify the physician order, comparing the medication label to the MAR (Medication Administration Record) to verify the following: a. Right Medication, b. Right dosage, c. Right route, d. Right time, e. Right resident.Resident #38Review of Resident #38's health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to chronic obstructive pulmonary disease and bipolar disorder.Review of Resident #38's physician orders revealed an order dated 03/24/2026 for Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG (micrograms)/ACT (actuation) (Budesonide-Formoterol Fumarate Didydrate) 2 puff inhale orally in the morning related to chronic obstructive pulmonary disease. Review of manufacturer instructions included in the inhaler box for Resident #38, read in part, Instructions for Use, Using your Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler: 7. Breathe out fully (exhale). Hold the Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler up to your mouth. Place the white mouthpiece fully into your mouth and close your lips around it. Make sure that Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler is upright and that the opening of the mouthpiece is pointing towards that back of your throat. 8. Breathe in (inhale) deeply and slowly through your mouth. Press down firmly and fully on the top of the counter on the Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler to release the medicine. 9. Continue to breathe in (inhale) and hold your breath for about 10 seconds, or for as long as is comfortable. Before you breathe out (exhale), release your finger from the top of the counter. Keep the Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler upright and remove from your mouth. 10. Shake the Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler again for 5 seconds and repeat steps 7 to 9. On 05/12/2026 at 8:19 a.m., and observation was made of S6LPN administering medication to Resident #38. S6LPN was observed handing Resident #38's Budesonide inhaler to her. Resident #38 asked the nurse Two puffs right? for which S6LPN responded yes. No other instruction was given to the resident on the administration of the inhaler. Resident #38 inhaled two puffs, one after the other, without pausing during inhalation, or shaking the inhaler between puffs. Medication fumes were noted exiting the resident's mouth after each puff. On 05/12/2026 at 8:25 a.m., an interview and review of the manufacturer's Instructions for Use for Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler for Resident #38 was conducted with S6LPN. She confirmed that she had not instructed Resident #38 on the manufacturer's instructions for use of the inhaler, and she should have per facility protocol. She further confirmed that Resident #38's Budesonide inhaler had not been administered per manufacturer's instructions. On 05/12/2026 at 1:30 p.m., a phone interview and review of the manufacturer's instruction for use of a Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler was conducted with S7PC. He confirmed that the standard practice for Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler was to follow the manufacturer's instructions. He confirmed that if the resident was not instructed to hold her breath for 10 seconds, or as long as comfortable while using the inhaler, or shake the inhaler for 5 seconds between puffs, this medication was not administered per the standard practice. Resident #98Review of Resident #98's health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to unspecified dementia and low vitamin D.Review of Resident (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#98's physician orders revealed an order dated 07/08/2025 for Cholecalciferol tablet 1000 unit, give 2 tablets by mouth one time a day for low vitamin D. On 05/12/2026 at 7:35 a.m., an observation was made of S8LPN administering medications to Resident #98. S8LPN was observed administering only 1 tablet of Cholecalciferol 1000 units. On 05/12/2026 at 9:47 a.m., an interview and review of Resident #98's MAR was conducted with S8LPN. She confirmed that she had only administered 1 tablet of Cholecalciferol 1000 units and she should have administered two tablets per Resident #98's physician order. On 05/12/2026 at 5:00 p.m., an interview, review of Residents #38 and #98's MAR, and review of Budesonide and Formoterol Fumarate Dihydrate Inhalation Aerosol inhaler manufacturer Instructions for Use, was conducted with S1DON. S1DON confirmed that Resident #98 should have received 2 tablets of Cholecalciferol 1000 units per her physician orders. S1DON further confirmed that Resident #38 should have been instructed on the use of her Budesonide inhaler during administration per the manufacturer's instructions. She further confirmed Resident #38 having taken two puffs without inhaling for 10 seconds or as long as comfortable, and not shaking the inhaler between puffs did not follow the standard practice for administration of this medication.

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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 observation, interview, and record review, the facility failed to ensure the nurse performed hand hygiene and changed gloves while administering wound care treatments for 1 resident (#17) out of 2 residents reviewed for pressure ulcer/injury out of a final sample of 55 residents.Findings:Review of the facility's policy titled Dressing Change Police and Procedure, with a last reviewed date of 01/29/2026, revealed in part: Steps in the procedure.11. Remove dressing. Pull gloves over dressing and discard.12. Perform hand hygiene. Put on disposable gloves. 13. Irrigate/cleanse the skin area as ordered.16. Perform hand hygiene. Apply disposable gloves.18. Dress the area with the prescribed dressing, date and initial the dressing.Review of Resident #17's Electronic Health Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part, Hemiplegia and hemiparesis following cerebral infarction, pressure ulcer of left buttock, stage 2, and pressure ulcer of right buttock, stage 2. Review of Resident #17's Physician's Orders revealed an order dated 04/28/2026 that read: Cleanse stage 2 pressure injury on left inner buttocks with wound cleanser, pat dry, apply collagen and dry dressing every day. Further review revealed an order dated 05/05/2026 that read: Cleanse stage 2 pressure injury to right buttocks near sacrum with wound cleanser, apply collagen, skin prep to periwound and cover with dry dressing daily and as needed until resolved. On 05/13/2026 at 1:12 p.m., an observation was conducted of S3RNS performing wound care for Resident #17. S3RNS performed hand hygiene and donned a gown and gloves prior the entering the resident's room. S3RNS sprayed wound cleanser on gauze and used the gauze to clean Resident #17's sacral wound. S3RNS did not remove his gloves or perform hand hygiene after cleansing the resident's wound. S3RNS then opened collagen from the package and placed the collagen on Resident #17's sacral wound. S3RNS did not remove his gloves or perform hand hygiene. S3RNS then opened a dressing from the package and placed the dressing over the collagen on Resident #17's sacral wound and labeled the dressing with a marker. S3RNS did not perform hand hygiene or change gloves at any time during the procedure. On 5/13/2026 at 1:19 p.m., an interview was conducted with S3RNS. S3RNS stated he did not have taken his gloves off nor sanitized his hands between cleaning Resident #17's wound and applying the dressing. S3RNS stated it is customary to remove gloves and sanitize hands and put new gloves on after cleaning a resident's wound and before applying a dressing. On 05/13/2026 at 2:40 p.m., an interview was conducted with S1DON. S1DON stated the Infection Control nurse was out of the facility today and she was the acting Infection Control nurse in her absence. S1DON stated S3RNS should have removed his gloves and performed hand hygiene after cleansing the resident's wound and he should have donned new gloves before applying the collagen and dressing.