STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195630	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Lake Charles	2335 Oak Park Blvd Lake Charles, LA 70601

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 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** 41868 Based on record review and interview, the facility failed to accurately code the resident's Minimum Data Set (MDS) assessment for Hospice care for 1 (Resident #83) out of 29 sampled residents. Findings: Review of Resident # 83's electronic health record revealed he was admitted to the facility on [DATE]. Further review of his record revealed a Physician's order dated 06/06/2024 for Admit to Hospice with terminal diagnosis of End Stage Neural Vascular Dementia. Review of Resident #83's Quarterly MDS assessment, with an ARD (Assessment Reference Date) of 09/09/2024, revealed: Section O for Special Treatments, Procedures, and Programs .K1. Hospice Care . B. While a Resident . Coded as No. On 09/25/2024 at 08:45 a.m., an interview and record review was conducted with S2LPN (Licensed Practical Nurse). She confirmed that Resident #83 was admitted to hospice care on 06/06/2024. She then reviewed Resident #83's Quarterly MDS, with ARD of 09/09/2024 and confirmed that hospice care was coded inaccurately as not receiving while a resident.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44418 Based on record review and interview, the facility failed to refer a resident with a diagnosed mental disorder to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 1 (#19) of 1 (#19) residents investigated for PASARR in a final sample of 29 residents. Findings: Review of Resident #19's electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Major Depressive Disorder and Dementia; with Psychotic Disorder with Delusion added on 09/19/2023. Review of Resident #19's Level I PASARR dated 08/04/2023 revealed section III, Question #1 Do you suspect the applicant has, or has the applicant ever been diagnosed as having a mental illness? Include mental disorders that may lead to chronic disability. If yes, please check the diagnosis below. Answer checked was No. Further review of Resident #19's records revealed no evidence that Level II PASRR had been submitted to the appropriate state-designated authority with those psychiatric diagnoses identified. On 09/23/2024 at 12:45 p.m., an interview was conducted with S3LPN (Licensed Practical Nurse, Admissions Nurse). She reported she was responsible for the PASARR's for residents at the facility. S3LPN reviewed Resident #19's EMR diagnosis list and confirmed the resident did have a diagnosis of Major Depressive Disorder on 08/14/2024 and Psychotic Disorder on 09/19/2023. S3LPN then reviewed the Level I PASARR and confirmed the diagnosis of Major Depressive Disorder and Psychotic Disorder were not identified on the Level I screening. S3LPN also confirmed the Level I should have been resubmitted with the new diagnoses for a Level II determination and was not.

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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 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** 44418 Based on observations, interview, and record review, the facility failed to provide necessary care and services that is in accordance with professional standards of practice as evidenced by failing to ensure the resident's oxygen equipment was stored properly for 1 (#77) out of 2 (#77, #84) residents reviewed for respiratory care, with the potential to effect 14 residents receiving oxygen therapy. Findings: Review of the facility's policy titled Infection Control Oxygen Equipment Cleaning with a revision date of 06/2014, last review dated of 01/24/2024 revealed in part: 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 #77's electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses, not limited to, Acute Respiratory Failure with Hypoxia, Vascular Dementia and Dyspnea. Review of Resident #77's Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 09, indicating a moderately impaired mental status. Review of the physician's orders for Resident #77 revealed an order dated 07/26/2024 for Oxygen at 2 liters/nasal cannula (L/NC), as needed (PRN) for dyspnea. On 09/23/2024 at 9:07 a.m., an observation of Resident #77's oxygen tubing was laying over the oxygen concentrator machine, not in the bag that is hanging off side of machine. On 09/24/2024 at 8:10 a.m., a second observation was made of Resident #77's oxygen tubing laying over the concentrator, not in a storage bag. On 09/24/2024 at 8:30 a.m., an interview was conducted with S4LPN (Licensed Practical Nurse). S4LPN confirmed the oxygen tubing for Resident #77's was laying over the top of the concentrator and should have been stored in the bag. She confirmed the resident's oxygen is PRN and was not used all the time, and unable recall the last time he had used the oxygen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on observations, and interview, the facility failed to store food in accordance with professional standards for food service, and ensure sanitary conditions were maintained in the kitchen as evidenced by: 1. a thick layer of debris on the deep fryer cooking oil collection area; 2. expired foods from the kitchen walk in cooler, and dry storage area; 3. opened food items not labeled with the date and time; and 4. sticky residue with food debris on the cart used to bring food items from one part of the kitchen to another. This deficient practice had the potential to affect the 87 residents who consumed food from the kitchen. Findings: On [DATE] at 8:33 a.m., a tour of the facility's kitchen was conducted with S1DS (Dietary Supervisor), who stated that she was responsible for the day's management of the kitchen. On [DATE] at 8:39 a.m., an observation of the deep fryer was conducted with S1DS that revealed the cooking oil collection area had a thick layer of debris. S1DS stated the deep fryer was last used on [DATE] and confirmed that is was not cleaned after it was used and should have been. On [DATE] at 8:48 a.m., an observation of the walk in cooler was conducted with S1DS and revealed the following: 1. (7) unopened squeeze bottle containers of strawberry jam with an expiration date of [DATE] 2. large opened container of caesar dressing with an expiration date of [DATE] 3. large opened container of mayonnaise tarter dressing with an expiration date of [DATE] 4. opened gallon of milk with an expiration date of [DATE] 5. large container of cherries with the opened date of [DATE] Further observation of the cooler revealed the following items were opened but were not labeled with the date and time they were opened: 1. large bag of garlic bread toast (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. large bag of hot dog buns 3. large container of sour cream S1DS confirmed the food items were expired and should have been removed from the walk in cooler and discarded. She also confirmed the food items listed above were opened, and not labeled with the date and time they were opened, and should have been. On [DATE] at 9:09 a.m., an observation of the dry storage room was conducted with S1DS and revealed the following: 1. plastic gallon bag with an opened bag of blueberry muffin mix dated [DATE] 2. (2) plastic gallon bags with opened bags of white frosting mix, one dated [DATE], and one dated [DATE] 3. plastic gallon bag with an opened bag of cheese cake mix dated [DATE], with an expiration date of [DATE] S1DS confirmed the food items were expired and should have been discarded. On [DATE] at 12:48 p.m., an observation of the food service line was conducted. Food trays were placed on a cart for tray distribution. Further observation of the cart revealed multiple areas of a sticky residue and food debris on both sides and front of the cart. At 12:49 p.m., an interview and cart observation was conducted with S1DS, who stated that the carts were to be cleaned after each use and confirmed the cart was not cleaned from previous use and should have been.