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	09/10/2025

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 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 observations, interviews, and policy review, the facility failed to maintain a clean and sanitary kitchen. This deficient practice had the potential to affect 88 residents who ate out of the kitchen. The facility's census was 97.Findings:Review of the facility's policy, Sanitary Conditions of the Food Service Department, with a last review date of 01/15/2025, revealed the following in part: Policy: Facilities and equipment used in the preparation and serving of food provided to residents are safe and sanitary. h. Cleaning and Sanitizing: a. Food contact surfaces are washed, rinsed and sanitized: i. After each use, iv. At four hour intervals while the kitchen is in use; 2. Cleaning Program, a. The Director of Food and Nutrition Services develops a master cleaning schedule that includes: i. what should be cleaned, ii. Who should clean it., iii. When it should be cleaned, iv. How it should be cleaned, b. The Director of Food and Nutrition Services supervises the daily cleaning and monitors the completion of all cleaning tasks. An initial tour of the kitchen was conducted on 09/08/2025 at 8:40 a.m. with S1DM (Dietary Manager) who observed and confirmed the following: 1. The rolling cart containing clean trays was observed with crumbs on the trays and on the bottom shelf of the cart.2. Crumbs were on the bottom shelf of the steam table.3. Crumbs and dried food debris were on the top shelf of clean dish storage shelving.4. The side of the oven/stove was observed with dried grease.5. Yellow, wet food debris was observed on the clean counter side of the dishwasher with clean trays drying in a rack placed on top of the food debris.6. A thick layer of black residue was noted on the floor/baseboard and the lower wall behind the dishwasher.7. Brown, dried food splatter residue was on the wall over/behind the microwave.8. Thick, black dried residue and white debris was on the floor behind the clean dishes shelving unit located next to the steam table. On 09/08/2025 at 3:05 p.m., an interview was conducted with S1DM. She confirmed that there should be a cleaning schedule for staff in the kitchen. She further stated that there was no cleaning schedule in use and that a cleaning schedule had not been established.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to notify the State's Long-Term Care Ombudsman of emergency transfers in writing for 1 (#24) of 2 (#24 and #102) sampled residents reviewed for transfer and discharge requirements.Findings:On 09/10/2025, a review of the facility's policy titled, Discharge Transfer and Planning, with a revision date of 08/2025, read in part.Ombudsman Notification: The community shall notify the resident and the resident's representative(s) of the transfer or discharge and the notices must be sent to the representative of the Office of the State Log-Term Care (LTC) Ombudsman. Review of Resident #24's Electronic Medical Record (EMR) revealed in part, Resident #24 was admitted to the facility on [DATE] with diagnoses that included in part, respiratory failure, unspecified with hypoxia and unspecified combined systolic (congestive) and diastolic (congestive) heart failure. Further review of the EMR revealed Resident #24 had an emergency transfer to a local hospital on [DATE]. Review of the facility's Emergency Transfer Log noting notification to the Ombudsman for transfers dated 05/01/2025-07/31/2025 failed to reveal documentation of Resident #24's transfer to the hospital on [DATE].On 09/09/2025 at 1:38 p.m., an interview was conducted with S2AM (Accounts Manager). S2AM confirmed Resident #24 was not identified on the emergency transfer log for an emergency transfer on 05/25/2025 therefore notification was not made to the Ombudsman, and should have been.

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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 record review and interview, the facility failed to ensure the resident's Minimum Data Set (MDS) was completed accurately for 2 (#25 and #27) out of 42 sampled residents. The deficient practice had the potential to affect a total census of 97 residents. Findings:On 09/10/2025, a review of the facility's policy titled, Resident Assessment, with a last review date of 08/28/2024, read in part. Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed.Resident #25A review of Resident #25's electronic health record (EHR) revealed she was admitted to the facility on [DATE], with diagnoses that included in part, type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction, bipolar disorder, psychotic disorder with delusions, and history of falling.Further review of Resident #25's EHR revealed she had a fall on 08/19/2025 with no injuries.A further review of Resident #25's August 2025 Medication Administration Record (MAR) revealed the resident was administered Rexulti and Seroquel (antipsychotics) daily.A review of Resident #25's Annual Minimum Data Set with an Assessment Reference Date (ARD) of 08/26/2025 revealed the following in part: Section J1900 Number of falls since reentry. A. No injury with 1 (one fall). C. Major injury with 1 (one). Section N0415A High-risk drug classes, antipsychotic was coded with a 1 which indicated the resident was taking medications by the pharmacological classification of antipsychotic, not how it was used. Section N0450A Did the resident receive antipsychotic medications since.reentry was coded no (0). On 09/09/2025 at 12:51 p.m., a record review and review of Resident #25's MDS with ARD date of 08/26/2025 was conducted with S7MDS (Minimum Data Set Nurse). She confirmed J1900C was coded as (1) one. She stated the resident did not have a fall with a major injury and should have been coded as (0) none. During further review, S7MDS confirmed N0450A was coded as (0) no - antipsychotics were not received. S7MDS reviewed Resident #25's August MAR and confirmed the resident received antipsychotic medication. She stated N0450A should have been coded as (1) yes, antipsychotics were received on a routine basis only. On 09/10/2025 at 12:10 p.m., an interview was conducted with S5DON/IP (Director of Nursing/Infection Preventionist). She confirmed Resident #25's MDS with an ARD date of 08/26/2025 was inaccurately coded.Resident #27A review of Resident #27's EHR revealed she was admitted to the facility on [DATE] with diagnoses including in part, end stage Alzheimer's disease.A review of Resident #27's EHR revealed a physician's order dated 08/22/2025, that read in part, Admit to __ Hospice for terminal diagnosis end stage Alzheimer's disease.A review of Resident #27's significant change MDS with an ARD date of 08/28/2025 revealed Section OK1 Hospice care while a resident was coded no. On 09/10/2025 at 11:21 a.m., a review of Resident #27's significant change MDS with an ARD date of 08/28/2025 was conducted with S8MDS. She confirmed Section OK1 Hospice was coded no. She stated the resident did receive hospice services and should have been coded as yes.On 09/10/2025 at 11:38 a.m., an interview was conducted with S5DON/IP. She confirmed Resident #27 received hospice services. She stated the MDS was coded no and should have been coded yes.

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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** Based on record review and interviews, 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 (#24) of 3 (#3, #6 and #24) residents investigated for PASARR in a final sample of 42 residents. Findings:Review of Resident #24's electronic medical record (EMR) revealed she was admitted to the facility on [DATE], with diagnoses that included in part, schizophrenia, unspecified and major depressive disorder, unspecified.Review of Resident #24's Level I PASARR dated 07/06/2009 revealed in Section I, Question #1 A. Approved for Medicaid medical eligibility services effective 06/18/2009. No further documentation nor evidence of a Level II PASARR determination was provided.On 09/09/2025 at 12:45 p.m., an interview was conducted with S3SSD (Social Service Director). She reported she was responsible for residents' PASARRs at the facility. S4SSD stated the admission 142 form was completed for Resident #24 in 2009. She was unable to provide any proof of submission for a Level II PASARR related to the resident's qualifying diagnoses.On 09/10/2025 at 8:10 a.m., an interview was conducted S3ADM (Administrator). S3ADM could not confirm if Resident #24 had a Level II PASARR.

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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 record reviews and interviews, the facility failed to develop a person- centered care plan for 2 (#25 and #27)) out of 42 sampled residents. The deficient practice had the potential to affect a total census of 97 residents. Findings:On 09/10/2025, a review of the facility's policy titled, Care Plan Process, with a last reviewed date of 01/15/2025, read in part, the Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. 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.Resident #25A review of Resident #25's electronic health record (EHR) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, bipolar disorder and psychotic disorder with delusions.A review of Resident #25's physician's orders revealed an order dated 05/29/2025 for Seroquel XR (extended release) 24 hour, give 200 milligrams (mg) by mouth at bedtime related to bipolar disorder, which was discontinued on 08/28/2025. Further review revealed a second order dated 08/28/2025 for Seroquel XR 24 hour, give 300 mg by mouth at bedtime related to bipolar disorder. A review of Resident #25's health record failed to reveal any focus areas or interventions related to bipolar disorder.On 09/09/2025 at 12:51 p.m., a review of Resident #25's health record was conducted with S7MDS (Minimum Data Set Nurse). She confirmed the resident received treatment for bipolar disorder. She also confirmed the resident's care plan did not address bipolar disorder and stated it should have.On 09/10/2025 at 12:10 p.m., an interview was conducted with S5DON/IP (Director of Nursing/Infection Preventionist). She confirmed Resident #25 received treatment for bipolar disorder and the resident's care plan did not address bipolar disorder.Resident #27A review of Resident #27's EHR revealed she was admitted to the facility on [DATE], with diagnosis including in part, end stage Alzheimer's disease.A review of Resident #27's health record revealed the resident had a weight loss. On 08/07/2025, the resident weighed 140 Pounds (lbs.). On 09/03/2025, the resident weighed 117 lbs. which is a -16.43% Loss.Further review of Resident #27's care plan failed to address nutrition or weight loss.On 09/10/2025 at 11:21 a.m., a review of Resident #27's health record was conducted with S8MDS. She confirmed the resident's care plan did not address nutrition and should have.On 09/10/2025 at 11:38 a.m., an interview was conducted with S5DON/IP. She confirmed Resident #27's care plan did not address nutrition and should have.

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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. Based on observation, interview, and policy review the facility failed to establish and maintain an infection prevention and control program designed to help prevent development and transmission of disease and infection as evidence by: failing to ensure glucometer machines were cleaned and disinfected per the facility's policy and manufacturer's guidelines. This deficient practice occurred during 1 of 2 observations of glucose monitoring during medication pass. Findings:On 09/09/2025, a review of policy titled, Blood Glucose Quality Control with last review date of 07/2025 read in part, Maintenance of Blood Glucose Monitoring Systems, Always clean the meter after each use. Gently wipe and clean surface of the meter with an approved disinfectant wipe per facility policy.On 09/09/2025, a review of the manufacturer's guidelines/user instructions manual for the Assure Platinum Glucose Monitoring System read in part: cleaning and disinfecting can be completed by using a commercially available environmental protection agency- registered disinfectant or germicide wipe. On 09/09/2025 at 11:25 a.m., an observation was made of S10LPN (Licensed Practical Nurse) performing a blood glucose check on Resident #1. After checking the resident's blood sugar, S10LPN exited Resident #1's room with the glucometer in hand. S10LPN returned to the medication cart and was not observed obtaining any sort of wipes. S10LPN removed the test strip then placed the used glucometer in the medication cart drawer without cleaning and disinfecting the surface of the glucometer. On 09/09/2025 at 11:29 a.m., an interview was conducted with S10LPN. S10LPN confirmed the glucometer was not disinfected after testing Resident #1's blood sugar before placing it back in the medication cart. S10LPN then insisted she wiped the glucometer with an alcohol wipe, but confirmed did not disinfect the glucometer with a germicidal wipe.On 09/09/2025 at 12:30 p.m., a group interview was conducted with S5DON/IP (Director of Nurses and Infection Prevention Nurse) and S9CN (Corporate Nurse) who both confirmed glucometer machines should be cleaned and disinfected after each use. S5DON/IP further confirmed staff should use Sani Cloth Germicidal Wipes to disinfect the glucometer machines after each use.