STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195438	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANDMARK NURSING & REHAB CTR	**1611 WELLERMAN ROAD WEST MONROE, LA 71291**

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 and interview the facility failed to ensure the resident's environment remains as free of accident hazards as is possible by not attempting new approaches after a resident sustained [REDACTED].#41) of 8 (#41, #66, #71, #83, #85, #90, #95 and #111) residents reviewed for falls. Findings: Review of the medical record for sampled resident #41 revealed [DIAGNOSES REDACTED]. Review of the March 2020 physician orders [REDACTED]./21/2019 - toilet every hour and as needed; [DATE]19 - resident is on falling star program; and 10/03/2017 - positioning bars to left side of bed. Review of the Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status score of 8 which indicated moderate cognitive impairment for daily decision making. The resident required extensive assistance with one person physical assist with bed mobility, toileting and hygiene and extensive assistance with two or more persons physical assistance with transfers, dressing and eating. Review of the care plan with a start date of 02/20/2015 revealed the resident was at risk for falls related to muscle weakness, age related debility and [MEDICAL CONDITION]. Review of the care plan approaches revealed the following: - keep the bed in lowest position; - make sure pathways are clear; - assist with transfers as needed; - assist with walking as needed; - encourage to call for assistance; - ensure proper footwear; - fall mat on floor on left side of the bed; - falling star in place; - keep assistive devices in reach; - call light in reach; - non skid shoes; - pharmacist to evaluate medications; - wheelchair for ambulation; - [DATE] self releasing seatbelt while in wheelchair; - socks with grips to be worn, - toilet every two hours while awake; - 06/13/2019 staff to assist to toilet every hour; - 08/20/2019 keep in view of staff while in wheelchair; - 10/01/2019 bed in lowest position; - 10/11/2019 counsel Certified Nursing Assistant (CNA); - 10/11/2019 remind resident to call for assist; - 10/14/2019 floor bed; - 10/15/2019 medication evaluation; - 10/19/2019 toilet after meals and every hour; - 12/06/2019 counsel CNA and encourage resident to call for assist; - 0[DATE] stop strip alarm to bathroom door; - 0[DATE] self releasing alarming seatbelt; - 01/18/2020 resident to be sitting in wheelchair for all meals; - 02/06/2020 counsel CNA; - 02/14/2020 repair self releasing alarming seatbelt; - 03/06/2020 educate staff on importance of safety equipment; and - 03/07/2020 educate CNAs - do not leave resident unattended without safety equipment. Review of the facility Incident Log revealed the resident had 16 falls from 10/01/19 - 03/07/2020. Review of the Resident Incident Report dated 11/01/2019 at 2:00PM revealed the activity at that time - from chair without assist. Further review of the report revealed the resident was found by staff on the floor. A small knot was noted to the back of her head. No complaints of pain voiced and neuro checks started. Assisted resident back to wheelchair and she moved extremities with ease and without complaints. The immediate post-incident action was for self releasing seat belt. Review of the Resident Incident Report dated 11/20/19 at 2:30PM revealed the activity at the time of incident was the resident moved from chair without assistance. Further review of the report revealed the resident was found on the floor in the bathroom, she denies pain at this time and no skin issues were noted. The resident revealed she was trying to go to the bathroom. The actions taken were to remind and encourage resident to use call light for assistance and to counsel the CNA. Review of the Resident Incident Report dated 01/18/2020 at 7:20AM revealed the resident was sitting up on side of bed eating breakfast, started leaning to the side and was unable to regain balance and fell on the floor hitting face on the non skid mat. A small bruised area was noted beside her left eye. Review of the immediate post - incident action revealed the resident to be in the wheelchair for all meals. Review of the Resident Incident Report dated 02/06/2020 at 9:00AM revealed the resident was found lying on the floor. The resident's tray was on table in front of where she was lying on the floor. The resident was sitting up on the side of the bed eating and fell forward. Review of the immediate post- incident action revealed to counsel CNA and the resident should be in the wheelchair for all meals. Review of the Resident Incident Report dated 03/06/2020 at 6:50PM revealed the activity at the time of the incident was the resident moved from chair without assistance. Further review of the report revealed the resident was found on floor in the dayroom with no injuries noted. Review of the immediate post- incident action revealed to educate CNA on resident safety measures. Review of the Resident Incident Report dated 03/07/2020 at 7:35PM revealed the activity at the time of the incident was the resident moved from the chair without assistance. Further review of the report revealed the ward clerk notified the nurse that the resident was on the floor in the main lobby with her feet under chair in lobby. The resident denied hitting head, no hematoma noted, neuro checks in progress, and an old skin tear was bleeding. No bleeding or bruising noted elsewhere. Review of the immediate post- incident action revealed don't leave unattended without safety equipment. On 0[DATE] at 9:15AM an interview S1DON (Director of Nursing) confirmed no new approaches were attempted after each fall.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to obtain laboratory services to meet the needs of its residents by failing to obtain a Complete Blood Count (CBC) as ordered for 1 (#101) of 5 (#101, #206, #212, #217, #306) residents reviewed for unnecessary medications. Findings: Review of the medical record for resident #101 revealed [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set ((MDS) dated [DATE] revealed the resident scored a 14 on the Brief Interview for Mental Status), which indicated the resident had independent cognition for daily decision making and required assistance with activities of daily living. Review of the March 2020 physician orders [REDACTED]. Review of the medical record revealed the CBC was not obtained every month as ordered. On 0[DATE] at 3:20PM an interview with S1DON (Director of Nursing) confirmed the CBC was not drawn monthly as ordered.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.