

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Landmark of Baton Rouge		STREET ADDRESS, CITY, STATE, ZIP CODE 9105 Oxford Place Drive Baton Rouge, LA 70809	
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 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. (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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 1 (#1) of 3 sampled residents reviewed for witnessed falls. The facility failed to ensure nursing staff accurately documented Resident #1's witnessed fall. Findings: Review of the facility's policy dated 09/2025 and titled, Documentation, revealed the following, in part:1. Documentation shall be completed for residents on acute, observational, and incidental frequency Acute (Once per shift)Observational (Daily)Incidental (As needed)5. Whenever there is an update regarding a resident's behavior, condition, or other relevant information, it shall be documented in the resident's chart.9. It is the policy of this facility to maintain accurate medical records. Review of the facility's policy dated 09/2025 and titled, Accident/Incident Reports revealed the following, in part:7. Information regarding accidents/incidents that involve a resident will be recorded in the resident's medical record in the nurses' notes. Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included, Cerebrovascular Disease, Hemiplegia and Hemiparesis following Cerebral Infraction affecting right dominant side. Review of Resident #1's Quarterly MDS with an ARD of 11/06/2025 revealed Resident #1 had a BIMS score of 3 which indicated she had a severe cognitive impairment. Further review revealed Resident #1 was dependent on staff assistance for the completion of ADL's. Review of the Resident #1's Care Plan, dated 11/06/2025 through 11/25/2025 revealed the following in part: Resident lifting Plan: Red-Stop-Total LiftResident ADL assistance: Dependent on staff for transfers from bed to chair, bed mobility position changes every two hours, side railsPotential for falls: Follow facility fall protocol Review of the facility's Incident/Accident Log dated 10/01/2025 through 11/24/2025 revealed Resident #1 had a witnessed fall on 11/14/2025. Review of Resident #1's nurses' notes dated 11/14/2025 revealed the following in part: 11/14/2025 at 6:04 p.m.: Resident #1 to be sent out for evaluation and treatment. RP present and notified. Entered by S2LPNR. 11/14/2025 at 7:18 p.m.: Resident #1 transported via emergency medical services to the emergency room of record for evaluation and treatment. Entered by S2LPNR. Further review of the nurses' notes revealed no entries by S2LPNR pertaining to the witnessed fall involving Resident #1 on 11/14/2025. An interview was conducted on 11/25/2025 at 2:30 p.m. with S2LPNR via telephone. S2LPNR stated she was responsible for Resident #1's care on the morning of 11/14/2025. She stated around 9:00 a. m., S3CNA yelled for assistance from Resident #1's room. S2LPNR stated when she entered the room, S3CNA was holding Resident #1 up on the edge of the bed. S2LPNR stated her and S3CNA lowered Resident #1 to the floor. S2LPNR stated S4CNA assisted them in returning Resident #1 back into bed using 3-persons to manually lift Resident #1. S2LPNR confirmed she did not report the incident to administration, S5FNP or Resident #1's RP. S2LPNR further confirmed she did not document the incident nor file an incident report because she did not believe the incident was a fall. An interview was conducted on 11/25/2025 at 2:40 p.m. with S1DON. S1DON stated on 11/14/2025 around 1:30 p.m. Resident #1's RP inquired about discoloration and bruising on the right side of Resident #1's body. She stated the incident was initially identified as an injury of unknown origin because no staff had reported an accident. S1DON stated Resident # 1 was immediately assessed and S5FNP notified around 2:30 p.m. On 11/17/2025 S1DON stated she became aware S3CNA and S2LPNR assisted Resident #1 to the floor on 11/14/2025 and called for additional assistance. S4CNA entered the room and assisted them return Resident#1 back to bed using 3-person lifting. S1DON stated guiding Resident #1 to the floor would be considered a fall. S1DON confirmed S2LPNR failed to document the incident in the nurses' notes and failed to complete an incident report and should have.		