

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/29/2024
NAME OF PROVIDER OR SUPPLIER  Camelot Brookside		STREET ADDRESS, CITY, STATE, ZIP CODE  3330 Frontage Road Jennings, LA 70546	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46169</p> <p>Based on observations and interviews, the facility failed to provide a clean, comfortable, and homelike environment for 3 (#1, #2, #3) out of 3 (#1, #2, #3) sampled residents. The deficient practice had the potential to affect a total census of 108.</p> <p>Findings:</p> <p>Resident #1</p> <p>On 10/28/2024 at 11:30 a.m., an observation of Resident #1's bathroom revealed a urinal hanging on the back of the safety bar of the toilet. The urinal was labeled with Resident #1's initials, did not have a lid, and was not stored in a bag.</p> <p>On 10/28/2024 at 12:46 p.m., a second observation of Resident #1's bathroom revealed the same urinal in the same place it was last seen.</p> <p>On 10/29/2024 at 1:55 p.m., an observation of Resident #1's bathroom and urinal was conducted with S6LPN (Licensed Practical Nurse). S6LPN confirmed a urinal with Resident #1's initials was hanging on the back of the toilet safety rail with no lid and was not stored in a bag She stated the urinal should have been stored in a bag.</p> <p>Resident #2</p> <p>On 10/28/2024 at 12:06 p.m., an observation of Resident #2's room was conducted with S5CNA (Certified Nursing Assistant) who confirmed there was bedpan on the floor under the resident's bed. She confirmed the bedpan should have been placed in a bag and stored in the bathroom and not on the floor under the resident's bed.</p> <p>On 10/29/2024 at 9:45 a.m., a second observation was conducted of Resident #2's bathroom. Two bedpans were stacked on the floor between the toilet and the wall. The bedpan on the top was soiled with a yellow liquid, open to air, and were not stored in a bag. Further observation of the bathroom revealed a trash can without a liner that contained soiled incontinence briefs and incontinence underwear. The restroom had a strong urine odor. Further observation revealed a light brown substance on the toilet seat and the rim.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/29/2024 at 9:57 a.m., an observation of the resident's bathroom was conducted with S5CNA. She confirmed two soiled bedpans were on the floor next to the toilet and not stored in a bag. S5CNA confirmed the bedpans should have been stored in a bag with the resident's initials on them. S5CNA also confirmed the trash can contained soiled incontinence briefs and incontinence underwear and there was no trash can liner in the trash can and stated the trash can should have a liner in it. She also confirmed the soiled incontinence briefs and incontinence underwear should have been removed from the bathroom and the toilet seat and the rim should have been cleaned of the light brown substance on it.</p> <p>On 10/29/2024 at 10:05 a.m., an observation of the Resident #2's bathroom was conducted with S1DON (Director of Nursing). She confirmed there were two soiled bedpans on the floor and they were not stored in bags. S1DON confirmed the toilet seat and rim was soiled with a light brown substance and the trash can contained soiled incontinence briefs and incontinence underwear with no trash can liner. She stated the bedpans should be in a bag, the trash should have been removed from the restroom, a liner should have been in the trash can and the toilet seat and rim needed to be cleaned.</p> <p>44418</p> <p>Resident #3</p> <p>On 10/28/2024 at 1:15 p.m., observation of a shared bathroom for Resident #3 and Resident #R6 was done. There were three unlabeled urinals hanging on the hand rail on the side of the toilet. A bedpan that contained stool and toilet paper was sitting on the shower bench in the shower. The bathroom had a strong odor of stool.</p> <p>On 10/28/2024 at 1:30 p.m., an observation and interview was conducted with S5CNA. S5CNA observed and confirmed the the unlabeled urinals hanging in the bathroom on the hand rail should have been labeled and stored in a bag. She also observed and confirmed the dirty bedpan, in the shower. S5CNA stated the urinal and bedpan should have been emptied and cleaned. S5CNA stated she did not know how long the bedpan had been in the shower. She confirmed Resident #R6 was continent of bowel and bladder and uses did not require assistance with toileting. She reported Resident #3 had been out of the facility since last week.</p> <p>On 10/28/2024 at 1:45 p.m., and observation of Resident #3 and Resident #R6's shared bathroom was conducted with S1DON. She confirmed there were three unlabeled urinals that should have been labeled with a name and stored in a bag. She also confirmed there was a bedpan in the shower, with stool and toilet paper in it. She confirmed the dirty bedpan should not have been left in the shower, it should have been emptied, cleaned, and then stored in a bag.</p> <p>On 10/29/2024 at 1:30 p.m., an interview was conducted with Resident #R6, who shared a bathroom with Resident #3. He reported he used the toilet. He reported the bathroom was often dirty, with stool on the floor and the toilet seat. He stated there had been a dirty bedpan in the shower that was causing a foul odor for about a week.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44418</b></p> <p>Based on record reviews, and interviews, the facility failed to implement the resident's comprehensive plan of care to provide the necessary care and services for 1 (#3) out of 3 (#1, #2, and #3) sampled residents as evidenced by the nursing staff failing to administer nine doses of a medication ordered by Resident #3's physician.</p> <p>Findings:</p> <p>Review of Resident #3's EHR (electronic health record) revealed the resident was admitted to the facility on [DATE] with the following diagnoses in part: Osteomyelitis of Vertebra, and Thoracic Region.</p> <p>Review of Resident #3's admission MDS (Minimum Data Set) assessment dated [DATE], revealed under Section C a BIMS (Brief Interview for Mental Status) score of 8, indicating the resident's cognition was moderately impaired.</p> <p>Review of Resident #3's Comprehensive Care Plan revealed on 09/04/2024 the resident was at risk for alteration in comfort with an intervention to administer analgesia (pain medication) as ordered.</p> <p>Review of Resident #3's physician's orders revealed an order entry dated 09/12/2024 for Hydrocodone-Acetaminophen (APAP) 5-325 mg (milligrams) tablet, one tablet by mouth three times a day with a discontinued date of 09/23/2024. Another order was written on 09/23/2024 for Hydrocodone-APAP 5-325 mg tablet one tablet by mouth four times a day.</p> <p>Review of the resident's September 2024 medication administration history for Hydrocodone-APAP 5-325 mg tablet one tablet three times a day with a discontinued date and time of 09/23/2024 at 1:01 p.m., scheduled for morning, late, and HS revealed:</p> <p>09/20/2024 the late and HS (at night) were signed as hold-see progress notes, and other-see progress notes.</p> <p>09/21/2024 morning and HS were signed as other-see progress notes, and late dose was signed as hold-see progress notes.</p> <p>09/22/2024 the late dose was signed as hold-see progress notes and HS dose signed as other-see progress notes,</p> <p>09/23/2024 the morning dose was signed as other-see progress notes.</p> <p>Review of Hydrocodone-APAP 5-325 mg tablet one tablet three times a day with a start date and time of 09/23/2024 at 6:00 p.m. revealed the 6:00 p.m. dose was signed as other-see progress notes.</p> <p>Review of Resident #3's progress notes revealed in part:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>09/20/2024 at 2:16 p.m., Hydrocodone-APAP Oral Tablet 5-325 MG. Give 1 tablet by mouth three times a day for pain (EMAR revealed held - see progress note) signed by S3LPN (Licensed Practical Nurse)</p> <p>09/20/2024 at 8:12 p.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain, On order signed by S8LPN</p> <p>09/21/2024 at 7:07 a.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain, Awaiting from pharmacy. signed by S3LPN</p> <p>09/21/2024 at 2:31 p.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain. Awaiting from pharmacy. signed by S3LPN</p> <p>09/21/2024 at 8:38 p.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain. On order. signed by S8LPN</p> <p>09/22/2024 at 2:01 p.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain, awaiting from pharmacy. signed by S3LPN</p> <p>09/22/2024 at 8:05 p.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain. (Signed as other-see progress notes) signed by S8LPN</p> <p>09/23/2024 at 11:48 a.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain, waiting for medication to come in. signed by S9LPN</p> <p>09/23/2024 at 11:23 p.m., Hydrocodone-APAP Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for Pain, waiting on pharmacy. signed by S10LPN</p> <p>On 10/28/2024 at 1:50 p.m., an interview was conducted with S2LPN (Licensed Practical Nurse). She stated the facility had an emergency drug kit that contained Hydrocodone-APAP 5-325 mg, the pain medication Resident #3 was prescribed, locked in a secured dispensing system. She confirmed that if a medication was needed while waiting on the medication to come from the pharmacy, it could be obtained from the emergency drug kit to be administered to residents.</p> <p>On 10/28/2024 at 2:00 p.m., an interview was conducted with S3LPN. She reported she recalled that Resident #3 ran out of his Hydrocodone-APAP, but did not know the exact date it was out of stock. S3LPN confirmed while waiting on the medication to come from the pharmacy, Resident #3 did not receive the medication as ordered. She confirmed she was knowledgeable about the facility's emergency kit, but she was not aware the Hydrocodone-APAP was available in the emergency drug kit/secured dispensing system for use while waiting on medication from pharmacy.</p> <p>On 10/28/2024 at 2:25 p.m., an interview was conducted with S1DON (Director of Nursing). She stated the secured drug dispensing system was available for medications needed if the resident had a new order, or was out of a medication until the medication could be delivered. S1DON also confirmed the nurses should have been aware of the emergency drug kit and should have utilized it when Resident #3 was out of his Hydrocodone-APAP 5-325mg.</p>		