STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195550	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camelot Brookside	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)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record reviews, the facility failed to have a system in place to ensure coffee was served at a safe temperature to prevent scalds/burns for 1 (#79) resident. 112 residents consumed meals and beverages prepared by the facility's kitchen.Findings:Review of the American Burn Association Scald Injury Prevention Educator's Guide revealed in part: The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. Older adults, identified as a high risk group, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications .Scald injuries result in considerable pain, prolonged treatment, possible lifelong scarring, and even death. Third degree burns can occur within 1 second with hot water temperatures at 155 degrees Fahrenheit (F), within 2 seconds at 148 degrees F, within 5 seconds at 140 degrees F, within 15 seconds at 133 degrees F, and within 1 minute at 127 degrees F.On 04/19/2026, a review of the facility's policy titled, Safety of Hot Liquids with a revised date of October 2014 read in part: Policy Statement: Residents risk factors for safety concerns and potential for injury from hot liquids once identified, appropriate precautions will be implemented to maximize choice of beverages while minimizing the potential for injury. Policy interpretation and implementation: 1. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. 3. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include: a. Maintaining a hot liquids serving temperature of not more than 180 degrees F. 4. Food service staff will monitor and maintain foods temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. A review of the facility's incident report #810, dated 02/24/2026, revealed in part: During med pass, the certified nurse aid notified the nurse that Resident #79 spilled coffee while in bed and arm is red. Upon entering the room, noted empty coffee cup with lid applied .Coffee noted on the resident's bed pad. Assessed resident, redness noted to resident's left arm and buttocks area. The resident states she was trying to get her coffee from the table when she bumped the table and it fell. Non spill cup to be given to the resident for coffee. The dietary manager made aware. Coffee temp analysis performed and within policy .On 04/19/2026 at 10:17 a.m., an interview was conducted with Resident #79. She stated that she had burns on her left forearm and left hip after she spilled hot coffee on herself when she was placing the Styrofoam cup with a lid on her over the bed table. On 04/20/2026 at 1:30 p.m., during an interview, S1ADM stated that on 02/24/2026 at 2:00 p.m., after learning about the Resident #79's burn, a test pot of coffee was brewed into a thermal insulated carafe, with the spigot, and the lid. Coffee temperatures were obtained from 2:30 p.m. to 4:30 p.m. The coffee temperature at 2:30 p.m. was 160 degrees and continued to lower to 118 degrees by 4:30 p.m. In response to the incident, a non-spill cup was given to resident #79 for her coffee. He reported that no further coffee temperatures were taken after the day of the incident.On 04/19/2026 at 2:00 p.m., an interview and observation was conducted with S2DM. S2DM was asked if the kitchen staff documented coffee temperatures prior to providing coffee to the residents. She stated that the staff did not check the temperatures of the coffee prior to sending the coffee out to the floor to be served (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to the residents. S2DM brewed a canister of coffee and the temperature was obtained. The reading was 158.1 degrees F (Fahrenheit). S1DM replaced the lid on the canister and set it aside to go out to the floor.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to honor and accommodate food preferences for 1 (#68) out of 9 residents reviewed for dining. This deficient practice had the potential to affect 112 residents who consumed meals from the kitchen.Review of Resident #68's medical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, unspecified dementia and unspecified protein-calorie malnutrition. Review of the facility's policy titled Resident Food Preferences, with a last review date of 10/29/2025, read in part, Policy Statement: Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. Review of Resident #68's most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 12, indicating her cognition was moderately impaired. Review of Resident #68's meal ticket, read in part, Special Notes: dislikes breakfast sausage.On 04/20/2026 at 8:18 a.m., and observation and interview was conducted with Resident #68. Resident #68 was observed to have a breakfast sausage patty cut up on her breakfast plate. Resident #68 stated that she did not eat breakfast sausage. On 04/21/2026 at 8:24 a.m., a second observation and interview was conducted with Resident #68. Resident #68 was again observed to have a breakfast sausage patty cut up on her breakfast plate. Resident #68 stated again that she did not eat breakfast sausage. On 04/21/2026 at 8:39 a.m., an observation of Resident #68's breakfast tray and interview was conducted with S2DM who was responsible for dietary services at the facility. S2DM confirmed that breakfast sausage was listed as a dislike on the resident's meal ticket and had been served on her breakfast tray. She further confirmed that because breakfast sausage was listed as a dislike, it should not have been served to the resident. On 04/21/2026 11:30 a.m., an interview was conducted with S1ADM. S1ADM confirmed that because breakfast sausage was listed as a dislike on Resident #68's meal ticket, she should not have been served breakfast sausage.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record review, observations, and interviews, the facility failed to ensure dishware was clean and stored under sanitary conditions to prevent the likelihood of foodborne illness. This had the potential to affect the 112 residents who ate meals from the facility's kitchen. Findings: Review of the facility's policy, titled Sanitization, with a last revised date of 10/2008, read in part, Policy Statement: The food service area shall be maintained in a clean and sanitary manner. 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair. 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. 16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. On 04/19/2026 at 10:43 a.m., an observation in the kitchen was conducted. An observation of an open shelf next to the food serving line revealed stacked plate warmers, that were all soiled. Many of the plate warmers had grease and pieces of egg and others had fragments of other food items and crumbs. Further observation revealed Styrofoam plates stacked on the top shelf facing up. Observation of the Styrofoam plates revealed the first plate had a piece of egg inside of it. On 04/19/2026 at 10:44 a.m., an observation and interview of the open shelf was conducted with S2DM. S2DM stated the dishwashing staff were responsible for stacking the plates and the plate warmers on the shelf for the lunch meal. Further observation revealed Styrofoam plates which were stored on the top of the open shelf. S2DM removed the Styrofoam plates from the top shelf and observed a piece of egg inside the unused Styrofoam plate. S2DM confirmed that the plate warmers were soiled with grease, pieces of egg, crumbs from other food items and should have been sanitized prior to stacking them on the clean shelf. She also confirmed the Styrofoam plates should have been stored face down.