STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195573	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camelot Rehabilitation at Magnolia Park	1511 Dulles Drive Lafayette, LA 70506

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to ensure that services were provided to meet professional standards of quality for safe administration of medications evidenced by the staff nurse leaving 20 medications unattended at the bedside for 1 (#74) out of 32 initial pool residents.Findings:Review of Resident #74's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, gout, epilepsy, peripheral vascular disease, and diabetes mellitus.A review of Resident #74's Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.Review of Resident #74's March 2026 MAR (Medication Administration Record) revealed S6ALPN had initialed that the following medications had been administered on the morning of 03/02/2026: Amiodarone HCl (hydrochloride) oral tablet 200 mg (milligram); Ascorbic Acid tablet 500 mg; Cholecalciferol oral tablet 50 mcg (microgram); Fexofenadine HCl oral tablet 60 mg; Furosemide oral tablet 40 mg; Multivitamin oral tablet; Omeprazole capsule delayed release 40 mg; Oxybutynin Chloride oral tablet extended release 15 mg; Zinc sulfate 220 mg; Allopurinol oral tablet 100 mg; Colace oral capsule 100 mg; Cranberry oral tablet 450 mg; Duloxetine HCl oral capsule delayed release particles 60 mg; Eliquis oral tablet 5 mg; Ferrous Gluconate oral tablet 324 mg; Levetiracetam oral tablet 500 mg; Metformin HCl oral tablet 500 mg; Mucinex oral tablet extended release 600 mg; Oxcarbazepine oral tablet 150 mg; and Senna Plus oral tablet 8.6-50 mg.On 03/02/2026 at 10:02 a.m., an observation was conducted of Resident #74's room that revealed 20 oral medications, in the forms of tablets and capsules, were observed on a small tray resting on Resident's 74's chest. No nurse was present in the resident's room. Resident #74 stated the nurses always left the medications with her for her to take herself.On 03/02/2026 at 10:05 a.m., S1DON entered Resident #74's room and observed the 20 oral medications, in the forms of tablets and capsules, on a small tray resting on the resident's chest.On 03/02/2026 at 10:07 a.m., and interview was conducted with S1DON who confirmed medications should not have been left unattended in Resident #74's room. Review of Resident #74's electronic medical record failed to reveal documentation that Resident #74 had been assessed or authorized to self-administer mediations.On 03/04/2026 at 11:49 a.m., another interview and record review was conducted with S1DON. S1DON reviewed Resident #74's March 2026 MAR and confirmed the 20 medications listed above had been documented as administered and were left unattended at the resident's bedside.S1DON confirmed all medications should be administered to the resident before the nurse leaves the resident's room. S1DON also confirmed Resident #74 had not been assessed or authorized to self-administer mediations.

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 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 and procedure reviews, the facility failed to:1. Maintain a clean and sanitary kitchen; and 2. Store food in accordance with professional standards for food service safety;This had the potential to affect 101 residents who ate meals prepared from the facility's kitchen. The facility's census was 125.Findings: Review of the facility's policy, Sanitization, with a last review date of 10/13/2025, revealed in part: Policy Statement: The food service area shall be maintained in a clean and sanitary manner. 1. All kitchen, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary to sanitize using hot water and/ or chemical sanitizing using solutions. Review of the facility's policy, Food Receiving and Storage, with a last review date of 10/13/2025, revealed in part: Foods shall be received and stored in a manner that complies with safe food handling practices. 6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in - first out system. An initial tour of the kitchen was conducted on 03/02/2026 at 08:50 a.m. with S2KS and revealed the following:1. Inspection of the Culitek Tilt Skillet revealed a metal gas pipe and shut off valve covered in a yellow, black, greasy, sticky substance. 2. Inspection of the flooring around and beneath the Culitek Tilt Skillet also revealed a black sticky substance with crumbling debris. 3. Dry storage area revealed a clear plastic container with white granulated substance inside. Inspection of the container revealed no label indicating what was in the container and use by date. 4. The reach-in refrigerator contained 16 individual single serve containers of Jello. Upon inspection, the expiration date on all 16 containers read 02/21/2026. Immediately after conducting the kitchen observations, an interview was conducted with S2KS. S2KS confirmed the metal gas pipe and shut off valve were covered in a yellow, black, greasy, sticky substance and should have been cleaned. S2KS confirmed the flooring around and beneath the tilt skillet had a black sticky substance with crumbling debris and should have been cleaned. S2KS confirmed the clear plastic container located in the dry storage area contained a white granulated substance and was not labeled with name and use by date and should have been labeled with name and use by date. S2KS confirmed the reach-in refrigerator contained 16 single serve containers of Jello with an expiration date of 02/21/2026 and these food items should have been discarded on their expiration date.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure individual financial records were provided to the resident through quarterly statements for 1 (Resident #68) out of 1 (Resident #68) resident investigated for personal funds.Findings:Review of Resident #68's electronic medical record revealed she was admitted to the facility on [DATE].A review of Resident #68's Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.A review of Resident #68's admission Record under the Contacts section revealed Resident #68's name, contact type: Responsible Party (RP), and relationship: self.On 03/02/2026 at 11:07 a.m., an interview was conducted with Resident #68. Resident #68 stated she did not receive quarterly statements for her personal funds account.On 03/04/2026 at 8:50 a.m., an interview was conducted with S5BM. S5BM stated financial statements for personal fund accounts were sent out quarterly. She stated if a resident is his or her own RP then the statement is given to the resident. S5BM confirmed Resident #68 is her own RP. S5BM could not provide any documentation or evidence that quarterly statements were given to Resident #68 for the following statement dates: March 31, 2025; June 30, 2025; and September 30, 2025.

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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) assessment was completed accurately for 3 (Resident #12, Resident # 74, and Resident #91) out of 37 sampled residents, as evidenced by:Inaccurate coding of administration of Insulin injections and orders for insulin in Section N- Medications for Resident #12 and Resident #74, and Inaccurate coding for serious mental illness in Section A for Resident #91.Findings:Resident #12 Review of Resident #12's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses including diffuse traumatic brain injury with loss of consciousness, encephalopathy, gastrostomy status, tracheostomy status, dysphagia, aphasia and persistent vegetative state. Further review of the record revealed no evidence the resident was diabetic and receiving insulin. Review of Resident #12's February 2026 eMAR (electronic Medication Administration Record) revealed the resident was not administered insulin. Review of Section I of Resident #12's quarterly MDS (Minimum Data Set) assessment dated [DATE] included resident's active diagnoses which did not include diabetes or use of insulin. Further review of Resident #12's quarterly MDS assessment Section N, revealed the resident was coded as receiving 7 days of insulin injections. On 03/03/2026 at 12:45 p.m., an interview was conducted with S5LPN. S5LPN stated she was familiar with Resident #12 and confirmed the resident did not have diabetes and had never received insulin injections. On 03/04/2026 at 3:16 p.m., an interview was conducted with S4MDS. S4MDS confirmed she completed Sections I and N on Resident #12's quarterly MDS assessment dated [DATE]. After reviewing Resident #12's EHR, S4MDS confirmed the resident had not received insulin injections and inaccurately coded Section N. Resident #74 A review of Resident #74's electronic health record (EHR) revealed she was admitted to the facility on [DATE] with a diagnosis that included in part, type 2 diabetes mellitus. A review of Resident #74's February 2026 Physician orders and Medication Administration Record (MAR) revealed the resident did not receive insulin or have insulin order changes at any time in the month of February 2026. A review of Resident #74's Quarterly MDS with an Assessment Reference Date (ARD) of 02/17/2026 revealed the following in part: Section N0350 Insulin. A. Insulin Injections. Record the number of days that insulin injections were received during the last 7 days. (Enter days = one). B. Orders for insulin. Record the number of days the physician changed the resident's insulin orders during the last 7 days. (Enter days = one). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/2026 at 4:30 p.m., an interview and review of Resident #74's EHR was conducted with S1DON. She confirmed that Resident #74 did not receive an injection of insulin nor have any changes to an insulin order in the 7 days prior to the Quarterly MDS, ARD of 02/17/2026. She further confirmed that the coding for Section N0350, A and B was inaccurate. Resident #91 Review of Resident #91's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] and had diagnoses including bipolar disorder, unspecified psychosis due to a substance or known physiological condition, and major depressive disorder. Review of Section A of Resident #91's significant change MDS (Minimum Data Set) assessment dated [DATE] revealed the following in part: Section A1500: Preadmission Screening and Resident Review PASRR -Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Response- No. Section A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions disabled due to answer of no in section A1500. Review of Resident #91's care plan revealed the following in part: The resident has been identified as having PASRR positive related to severe mental illness. Review of Resident #91's EHR revealed the resident had a PASRR Level II Evaluation Summary and Determination notice dated 11/18/2025. Further review of the notice revealed following statement: Evaluation Placement Recommendations - The individual has a serious mental illness and is recommended nursing home admission. On 03/04/2026 at 9:48 a.m., an interview was conducted with S3MDS who confirmed she completed Resident #91's MDS assessment dated [DATE]. S3MDS confirmed Resident #91 had diagnoses of bipolar disorder, unspecified psychosis due to a known physiological condition, and major depressive disorder. She also confirmed that these diagnoses are considered serious mental illnesses. Resident #91's MDS assessment dated [DATE] was reviewed with S3MDS. She confirmed that the resident's MDS assessment was coded incorrectly and Section A1500 should have been coded as yes for serious mental illness.