STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195592	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camelot of Broussard	418 Albertson Parkway Broussard, LA 70518

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on interviews and record review, the facility failed to ensure a resident's change in condition was immediatley reported for 2 (#1, #2) residents out of 3 (#1, #2, #3) sampled residents as evidenced by: 1. S8VD/CNA (Van Driver/Certified Nursing Assistant) failing to report complaints of pain for Resident #1 and; 2. S6RN (Registered Nurse) failing to notify Resident #2's responsible party (RP) and physician of a significant change in Resident #2's physical condition. Findings: Review of the facility's policy titled Change in Resident's Condition or Status, with a last reviewed date of 12/27/2023, read in part .Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician Nurse Practitioner and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the resident's Attending Physician, Nurse Practitioner, or physician on call when there has been a(n): d. significant change in the resident's physical, emotional, mental condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self- limiting); 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. There is a significant change in the resident's physical, mental, or psychosocial status. Resident #1 Review of Resident #1's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Alzheimer 's Disease, Pain, and Dorsalgia. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 2, indicating her cognition was severely impaired. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's transportation log revealed Resident #1 had a MD (Doctor of Medicine) appointment on 09/16/2024 at 1:30 p.m. Review of Resident #1's progress notes revealed a note dated 09/16/2024 by S4NurseAuditor that read in part, resident was being propelled in wheelchair with footrest present from elevator into hallway when her left leg slipped onto the ground. She complained of left lower leg pain once in her room. Hall nurse assessed and noted with left knee swelling, no bruising or discoloration noted but was unable to palpated d/t (due to) resident stating, It hurts. NP (Nurse Practitioner) notified with new order for x-ray to left knee. Prn (as needed) Pain med administered but pain was unrelieved. MRI of left knee ordered and carried out which showed a nondisplaced fracture of proximal tibia . Review of Resident #1's care plan revealed a focus that read in part, The resident had a bone fracture r/t (related to) left leg . Review of Witness Statement by S8VD/CNA dated 09/16/2024, read in part, We had went to the doctor we got back I was pushing her to her room in the elevator. Both of her legs was on the leg rest in the elevator. When we got back to out the elevator she was complaining her leg was hurting . On 10/07/2024 at 9:21 a.m., a telephone discussion was conducted with Resident #1's RP (Responsible Party). He stated that Resident #1 resided upstairs and to get to her room she utilized the elevator with assistance from staff. He stated on 09/16/2024 after lunch, he called Resident #1 to see how her physician's appointment went. He said as soon as Resident #1 answered the phone, she was crying and stated that her leg was hurting. Resident #1 notified her RP when the van driver was backing her out of the elevator her foot fell off and was caught under the wheelchair. He stated that Resident #1 said the van driver was supposed to go get help, but no one came into the room to help her. On 10/07/2024 at 11:25 a.m., an interview was conducted with S9LPN (Licensed Practical Nurse). She stated she was the nurse caring for Resident #1 on 09/16/2024. She stated Resident #1 went to a MD appointment and when she arrived back S8VD/CNA wheeled Resident #1 to her room and walked out. S9LPN stated she stopped the S8VD/CNA in the hall and retrieved Resident #1's paperwork from the MD appointment. She stated she was never notified from S8VD/CNA that anything abnormal happened with transferring Resident #1 back to her room, or that Resident #1 told her that she was in pain. S9LPN stated she went on lunch break and was relieved by S5StaffDeveloper. S9LPN stated that Resident #1 was able to let you know when something is wrong. S9LPN spoke to Resident #1 when she was off her lunch break, and Resident #1 informed her when she was getting off the elevator her left foot fell off the foot rest and went back and she heard something pop, and she told S8VD/CNA and also told her that she was in pain. S9LPN confirmed that S8VD/CNA failed to report Resident #1's new onset of pain to her from the incident that caused her left leg to fall off the foot rest. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/07/2024 at 12:34 p.m., an interview was conducted with S10CNA (Certified Nursing Assistant). She stated on 09/16/2024 she heard Resident #1's room number being called overhead and she went in the room to see what Resident #1 needed. She stated that Resident #1 told her she was ready to get in the bed and at the same time was rubbing her left knee. S10CNA stated she moved Resident #1's wheelchair and the resident started screaming in pain. She stopped moving the wheelchair and asked Resident #1 what was wrong and she stated her knee popped while the van driver was getting her off the elevator and she told the van driver she was in pain. She stated the van driver was supposed to get help but she never did. S10CNA stated she was never notified by S8VD/CNA that Resident #1 was in pain. She confirmed if a resident reports any type of change in condition such as new pain the nurse should be notified right away. On 10/07/2024 at 1:14 p.m., an interview was conducted with S8VD/CNA. She stated when she was taking Resident #1 off the elevator her legs were on the footrest and then she heard Resident #1 scream in pain and when she looked down she saw Resident #1's left leg was off the footrest. She stated she noticed this before she got to the nurse's station. She stated she put the resident's leg back on the footrest and wheeled her to her room. She stated she brought her paperwork back to the nurse's station, but did not notify S9LPN that Resident #1's left leg fell off of the wheelchair's foot rest or that she screamed in pain. On 10/07/2024 at 2:11 p.m., an interview was conducted with S2DON (Director of Nursing). She stated Resident #1 was returning from an appointment and when the resident was being pushed to her room in her wheelchair her leg slipped off the foot rest and she started experiencing knee pain with swelling. She stated a MRI of her left leg was done and she was diagnosed with a left tibia fracture. She stated she reviewed video camera surveillance and it was seen that S8VD/CNA was a few feet from coming out of the elevator and Resident #1's foot slipped off of the foot rest. S2DON stated, Yes and no if she should have notified the nurse, and on S8VD/CNA point of view it could have been confusing on her part to notify the nurse of the resident's pain. On 10/07/2024 at 2:45 p.m., an interview was conducted with S1ADM (Administrator). S1ADM stated Resident #1 and S8VD/CNA came off the elevator and she made a turn facing the camera, and Resident #1's leg fell off the foot rest and got caught under the wheelchair. He stated S8VD/CNA stopped and put her leg back on the foot rest. S8VD/CNA stopped at the nurse's station and then she pushed Resident #1 to her room. S1ADM stated, In hindsight 20/20 yeah she should have reported it to the nurse but the resident could have reported her own pain. On 10/07/2024 at 3:49 p.m., an interview was conducted with Resident #1. She stated that her left lower leg was broken and she had a brace on it. She stated it happened a few weeks ago when she was coming back from her MD appointment and her foot fell off the foot rest and got caught under the wheelchair. She stated she heard a pop, and immediately screamed and notified S8VD/CNA that she was in pain. She stated she was wheeled into her room and S8VD/CNA told her she was going to get help, but never came back to her room and no one else came into her room until she called for help. Resident #2 Review of Resident #2's EHR (Electronic Health Record) revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, Overactive Bladder, Cognitive Communication Deficit, and Acute Cystitis without Hematuria. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's nursing progress notes revealed a note written by S6RN (Registered Nurse) on 09/13/2024 at 9:07 p.m., that read in part: Summoned to resident's room by aide concerning resident having a high temperature of 102.0 accompanied with chills. Arrived to resident's room and assessed vitals BP (Blood Pressure) 164/80, Pulse 83, T (Temperature) 102.8, O2 (Oxygen) 89%. Resident was placed on O2 concentrator via NC (Nasal Cannula) on 1 liter to elevate O2 levels .Two Tylenol 325 mg (milligrams) tablets were administered PO (by mouth) at 1945(7:45 p.m.) for fever Care ongoing. Further review of Resident #2's progress notes failed to reveal documented evidence that the resident's family or physician was notified of the resident's change in condition. On 10/07/2024 at 9:05 a.m., a phone interview was conducted with Resident #2's family member who stated that they were surprised to learn that the resident was placed on oxygen over the weekend prior to her hospitalization on [DATE]. She stated that neither she nor the resident's RP were notified that the resident had been placed on oxygen. Attempts were made to conduct a phone interview with S6RN on 10/07/2024 at 1:41 p.m. and 3:57 p.m. with no response. On 10/07/2024 at 2:05 p.m., an interview was conducted with S2DON (Director of Nursing). S2DON stated the resident began experiencing shortness of breath and had a fever on the night of 09/13/2024. S6RN administered Tylenol for the resident's fever, and placed the resident on oxygen. S2DON stated that in her opinion, S6RN did not think to call the physician or nurse practitioner (NP) because she believed the resident improved. S2DON confirmed the resident's family member's assertion that Resident #2 remained on supplemental oxygen over the weekend. S2DON further confirmed that the resident's family, NP, nor physician were not notified. S2DON stated the resident's family and attending physician should have been notified of the resident's change in condition.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record reviews and interviews, the facility failed to develop and/or implement a comprehensive person-centered plan of care and/or physician's orders for 2 (#1 and #3) out of 3 (#1, #2, and #3) sampled resident as evidence by failing to: 1. implement a physician's order to monitor for changes post incident for Resident #1; and 2. develop appropriate interventions to prevent future falls from occurring for Resident #3. Findings: On 10/08/2024, a review of the facility's policy titled, Assessing Falls and Their Causes with a last reviewed date of 12/27/2023, read in part, Documentation: When a resident fall, the following information should be recorded in the resident's (electronic medical record): . 6. Appropriate interventions taken to prevent future falls . Resident #1 Review of Resident #1's record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Alzheimer 's Disease, Pain, and Dorsalgia. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 2, indicating her cognition was severely impaired. Review of Resident #1's progress notes revealed a note dated 09/16/2024 by S4NurseAuditor that read in part, resident was being propelled in wheelchair with footrest present from elevator into hallway when her left leg slipped onto the ground. She complained of left lower leg pain once in her room. Hall nurse assessed and noted with left knee swelling, no bruising or discoloration noted but was unable to palpated d/t (due to) resident stating, It hurts. NP (Nurse Practitioner) notified with new order for x-ray to left knee. Prn (as needed) Pain med administered but pain was unrelieved. MRI of left knee ordered and carried out which showed a nondisplaced fracture of proximal tibia . Review of Resident #1's physician's orders revealed an order dated 09/16/2024 with an end date of 09/19/2024 that read, Acute Charting: Accident/Incident/Fall follow up - assess resident for change in condition, change in ROM (Range of Motion) and Pain Q (every) shift X (for) 72 hours post incident. Notify MD (Doctor of Medicine) of any acute changes identified upon assessment. Document findings in progress notes. Every shift for 3 days. Document abnormal findings in progress notes; Notify MD and Family of any abnormal findings if/when identified upon assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of September 2024 MAR (Medication Administrator Record) failed to reveal documentation for accident/incident/fall follow up assessment for Resident #1 on the evening shift of 09/17/2024 and 09/18/2024. On 10/07/2024 at 3:28 p.m., an interview and review of Resident #1's September 2024 MAR and other areas in the EHR (Electronic Health Record) was conducted with S2DON (Director of Nursing). She stated that the Acute Charting: Accident/Incident/Fall follow up was ordered by Resient #1's Nurse Practitioner for the nurse's to monitor the resident for changes after the resident had an incident on 09/16/2024. S2DON confirmed that there was no documentation of post incident monitoring on the evening shift of 09/17/2024 and 09/18/2024, indicating it was not completed by staff as ordered by the Nurse Practitioner. Resident #3 Review of Resident #3's EHR revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Cerebral Infarction, Cognitive Communication Deficit, Abnormalities of Gait and Mobility, and Muscle Weakness. Review of Resident #3's progress notes revealed a note dated 07/18/2024 by S7LPN (Licensed Practical Nurse) that read in part, Summoned to resident room by aid. Resident observed lying in supine position on to of dresser . Ask resident what happened resident stated I was trying to get in my chair. Resident has a nodule to the back left side of her head . Send to ER (emergency room) . Review of Resident #3's care plan revealed a focus that read, The resident has had an actual fall Poor Balance with interventions that read in part, . fall on 07/18/2024 ER visit, all scans negative. New order for labs and UA (Urinalysis) inserted by S4NurseAuditor. On 10/08/2024 at 1:30 p.m., an interview was conducted with S4NurseAuditor she stated that she did insert an intervention in the care plan after Resident #3 had a fall on 07/18/2024. She stated after the fall Resident #2 had labs and a urinalysis completed and she was placed on antibiotics for approximately 5 days. She confirmed there were no interventions put into place to prevent future falls. On 10/08/2024 at 2:46 p.m., an interview was conducted with S2DON (Director of Nursing) she confirmed that after a fall, new interventions are put into place in the care plan to prevent future falls from happening. She stated Resident #3 had a fall in July 2024 and it was determined the fall was possibly due to a Urinary Tract Infection. She confirmed that after Resident #3 fell in July 2024, the interventions of new labs and UA were put in place to prevent future falls from happening. She confirmed no other non-pharmacological person centered interventions were developed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on interviews and record review, the facility failed to effectively monitor a resident's intake and output, consistent with the resident's assessed needs and goals, to maintain acceptable parameters of hydration status for 1 resident (#2) out of 3 (#1, #2, #3) sampled residents. Findings: Review of Resident #2's EHR (Electronic Health Record) revealed the resident was admitted to the facility on [DATE] and had diagnoses including, but not limited to, Overactive Bladder, Cognitive Communication Deficit, and Acute Cystitis without Hematuria. Review of Section H of Resident #2's MDS (Minimum Data Set) assessment dated [DATE] revealed the resident was frequently incontinent of bladder. Review of Resident #2's progress notes revealed a visit note written by S11NP (Nurse Practitioner) on 09/16/2024 that read in part: .labs obtained today, labs are reviewed and does show acute elevation of creatinine at 5 (Reference range 0.7 to 1.4) .Plan: .Acute kidney injury: Will transfer to ER for evaluation . Review of Resident #2's care plan revealed the following in part: The resident has Acute Cystitis-Interventions: Check at least every 2 hours for incontinence .Monitor intake and output. Date initiated: 08/12/2024 for CNA (Certified Nursing Assistant), LPN (Licensed Practical Nurse, RN (Registered Nurse). Review of Resident #2's health record failed to reveal documented evidence that the resident's fluid intake and/or output was being effectively monitored. On 10/08/2024 at 2:50 p.m., an interview and record review was conducted with S2DON (Director of Nursing) and S3QI (Quality Insurance Nurse). S2DON confirmed Resident #2 had a care plan focus that read: Resident has Acute Cystitis and intervention to monitor intake and output. S2DON was asked if there was a specific area in the resident's medical record where nurses or CNAs (Certified Nursing Assistants) documented the resident's intake and output. Both S2DON and S3QI stated that there was not a specific place in the resident's medical record where the nurse or CNAs documented the number of times the resident voided or the number of brief changes. S2DON was then asked how the resident's intake was being monitored in relation to hydration. She stated that this was monitored with the percentage of meal intake as the resident had fluids with her meals. S2DON proceeded to show the resident's percentage of meal intake documentation for the month of September 2024 which did not include a separate area for fluid intake. She stated that there was no specific area in the medical record where CNAs or nurses specifically monitored the resident's fluid intake with meals or throughout each shift.