

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Camelot of Broussard		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39319</p> <p>Based on record review and interview, the facility failed to ensure that services were provided to meet professional standards of quality as evidenced by S2LPN (Licensed Practical Nurse) borrowing medication from one resident to give to 1 (Resident #1) out 3 (Resident #, d+[DATE]) sampled resident investigated during a complaint survey. This deficient practice had the potential to affect the 127 residents in the nursing home.</p> <p>Findings:</p> <p>Review of Resident #1's clinical record revealed he was admitted on [DATE]. His diagnoses included in part, Generalized Osteoarthritis, Morbid Obesity, Muscle Weakness, Essential Hypertension and Benign Prostatic Hyperplasia with lower urinary tract symptoms. He expired on [DATE].</p> <p>Review of the Resident #1's [DATE] MAR (Medication Administration Record) revealed an order dated [DATE] for Zofran (nausea medication) 4mg (milligram) by mouth three times a day for nausea until [DATE]. The start date was [DATE].</p> <p>Review of a list of medications available in the facility's medication pyxis machine (an automated dispensing system that helps clinicians safely and effectively provide right medications to the right patient at the right time) provided revealed that Zofran 4mg was available in the pyxis machine.</p> <p>On [DATE] at 12 p.m., a phone interview was conducted with S2LPN. S1DON (Director of Nursing) was present. S2LPN was asked if she obtained the Zofran from the facility's medication pyxis machine, she replied, I don't remember if I did. She stated that she was more concerned with getting the resident the medication quickly to relieve his symptoms and she borrowed the medication from another resident's medication. When asked if she knew that Zofran was available in the medication pyxis machine, she stated she knew but she wanted to give the resident the Zofran as quickly as possible and repeated that she had borrowed the medication from another resident's medication.</p> <p>On [DATE] at 12:05 p.m., an interview was conducted with S1DON. She confirmed that Zofran was available in the facility's medication pyxis machine. She confirmed that S2LPN should have used the Zofran in the emergency medication pyxis machine and should not have borrowed another resident's medication.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39319</p> <p>Based on record review and interview, the facility failed to assure the accurate administering of a medication for 1 (Resident #1) out of 3 (Resident #,d+[DATE]) sampled residents investigated during a complaint survey. This deficient practice has the potential to affect the 127 resident in the nursing home.</p> <p>Findings:</p> <p>Review of Resident #1's clinical record revealed he was admitted on [DATE]. His diagnoses included in part, Generalized Osteoarthritis, Morbid Obesity, Muscle Weakness, Essential Hypertension and Benign Prostatic Hyperplasia with lower urinary tract symptoms. He expired on [DATE].</p> <p>Review of the facility's Documentation of Medication Administration policy with a revision date of [DATE] read the following in part .The facility shall maintain a medication administration record to document all medication administered. A Nurse .shall document all medications administered to each resident on the resident's medication administration record (MAR). Administration of medication must be documented after (never before) it is given. Documentation must include, at a minimum .d. date and time of administration .f. signature and title of the person administering the medication and resident response to the medication, if applicable.</p> <p>Review of the Resident #1's [DATE] MAR (Medication Administration Record) revealed an order dated [DATE] for Zofran (nausea medication) 4mg (milligram) by mouth three times a day for nausea until [DATE]. The start date was [DATE]. Further review of the MAR revealed there was no documentation that the resident was administered Zofran after S2LPN (Licensed Practical Nurse) called the NP (Nurse Practitioner) on [DATE] at 3:42 a.m. and no documentation of the resident's response to the medication.</p> <p>On [DATE] at 11:50 a.m., an interview and record review was conducted with S1DON (Director of Nursing). S1DON reviewed Resident #1's [DATE] MAR and confirmed that S2LPN had failed to document on the Resident #1's MAR and/or in his progress notes for [DATE] the date and time she administered the Zofran and a follow up of the resident's symptoms after he received the Zofran. She confirmed that S2LPN did not follow proper procedure for medication administration and had not accurately documented in the resident's clinical record.</p> <p>On [DATE] at 12 p.m., a phone interview was conducted with S2LPN (Licensed Practical Nurse). S1DON (Director of Nursing) was present. S2LPN stated on [DATE], she called the on-call NP and received an order for Zofran 4mg by mouth TID (3 times/day) x (for) 3 days for the resident's complaint of nausea. She stated that she administered the Zofran as ordered to the resident. She confirmed that she did not follow the correct procedure for the administration of the Zofran by not documenting on the resident's MAR and/or nurse's notes and not documenting a follow-up of the resident's response to the medication. She confirmed that she should have documented on the MAR the administration of the Zofran and documented in the nurse's notes a follow-up on the resident's symptoms.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50950</p> <p>Based on record reviews and interviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices for 1 (#1) out of 3 (#2 and #3) sampled residents. S2LPN failed to accurately document on the EMAR (Electronic Medication Administration Record) and/or nurse's notes the administration of a medication. This deficient practice had the potential to affect the 127 residents in the nursing home.</p> <p>Findings:</p> <p>On 12/10/2024, a review of the facility's policy titled Documentation of Medication Administration with a last revision date of April 2007, read in part, Policy Interpretation and Implementation: A Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's EMAR (electronic medication administration record). The policy also indicated that the following information is to be documented in the resident's medical record: Name and strength of the drug, dosage, method of administration, date and time of administration, reason(s) why a medication was withheld, not administered, or refused, signature and title of the person administering the medication, and resident response to the medication.</p> <p>Resident #1's medical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Generalized Osteoarthritis, Morbid Obesity, and BPH (Benign Prostatic Hyperplasia) with Lower Urinary Tract Symptoms.</p> <p>A review of Resident #1's progress notes documented by S2LPN (Licensed Practical Nurse) indicated on 10/30/2024 at 3:42 a.m., resident complained of nausea and vomited twice. S2LPN called the Nurse Practitioner and received a new order for Zofran (nausea medication) 4 mg (milligrams) every 8 hours for 3 days .</p> <p>Review of a telephone order dated 10/30/2024 written by S2LPN revealed an order for Zofran 4mg po (by mouth) TID (three times a day) x (for) 3D (days).</p> <p>A review of Resident #1's October 2024 EMAR failed to reveal documentation that Zofran 4 mg was administered on 10/30/2024 by S2LPN. The review also failed to reveal documentation that S2LPN conducted a follow up on the resident's response to the medication.</p> <p>On 12/10/2024 at 11:55 a.m., an interview and record review was conducted with S1DON (Director of Nursing). A review of Resident #1's October 2024 EMAR and S2LPN's nurse's note from 10/30/2024 at 3:42 a.m. was conducted with S1DON. S1DON confirmed that S2LPN had failed to document on Resident #1's EMAR and/or in his nurse's notes that she administered the resident Zofran and the resident's response to the medication. S1DON stated that S2LPN should have documented the administration of the Zofran and the resident's response to the medication on the resident's EMAR, or at least in the nurse's notes. S1DON agreed that S2LPN had not accurately documented in the resident's clinical record.</p>		