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	04/15/2026

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 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 interview, record review, and observation, the facility failed to accurately code a resident's MDS (Minimum Data Set) assessment for 1 (#115) out of 38 residents sampled.Findings:Review of Resident #115's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] and had diagnoses including, but not limited to, mild protein-calorie malnutrition, personal history of other venous thrombosis and embolism, benign prostatic hyperplasia with lower urinary tract symptoms, and Alzheimer's disease with late onset. Review of Resident #115's admission MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 05, which indicated severe cognitive impairment. A review of section L - Oral/ Dental Status revealed none of the above were present. On 04/15/2026 at 8:20 a.m., an interview was conducted with Resident #115. Resident #115 was alert and oriented to place and time and able to converse clearly with the surveyor. Resident #115 stated that he had no natural teeth in his mouth and wore upper and lower dentures. On 04/15/2026 at 9:23 a.m., an interview was conducted with S17CNA. S17CNA stated she provided oral care for Resident #115 and confirmed Resident #115 wears upper and lower dentures and has no natural teeth. On 04/15/2026 at 10:00 a.m., an interview was conducted with S15MDS. S15MDS stated she was responsible for coding Resident #115's MDS. S15MDS confirmed that Resident #115's MDS Section L - Oral/ Dental Status was coded incorrectly and should have been coded as B. No natural teeth or tooth fragment(s) (edentulous).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 resident (#115) out of 38 sampled residents as evidenced by failing to develop a plan of care for Resident #115's oral/dental health.Findings:A review of Resident #115's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] and had diagnoses including, but not limited to, Alzheimer's disease with late onset, and mild protein-calorie malnutrition.A review of Resident #115's admission MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 05, which indicated severe cognitive impairment. A review of Resident #115's care plan revealed no focus area related to Dentures, dental/oral care.On 04/15/2026 at 8:35 a.m., an interview was conducted with S14LPN. S14LPN reviewed resident #115's care plan and confirmed he was not care planned for Dentures, dental/ oral care. On 04/15/2026 at 10:25 a.m., an interview was conducted with S16MDS, who stated she was responsible for completing care plans. S16MDS stated that she entered a focus area, goal, and interventions for Resident #115 related to dentures, and oral/dental care health problems on 04/15/2026. She confirmed that she entered this information after it was brought to their attention by the surveyor that Resident #115 wore dentures and had no natural teeth. S16MDS confirmed Resident #115 was not care planned for dentures oral/dental care from admission date 01/22/2026 through 04/14/2026.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident's care plan was accurately updated to reflect the discontinuation of an anticoagulant, a blood thinner medication, for 1 (#114) out of 38 sampled residents. Findings: Review of Resident #114's electronic clinical record revealed the resident was admitted to the facility on [DATE] and his diagnoses included heart disease, peripheral vascular disease, and thrombosis. Review of the resident's physician's orders revealed Eliquis (blood thinner) was ordered on 06/24/2025 and discontinued on 08/21/2025. Review of the resident's current care plan revealed that anticoagulant remained on the resident's care plan and Eliquis was discontinued on 08/21/2025. On 04/14/2026 at 2:40 p.m., an interview was conducted with S10MDS and S11MDS. Both reviewed the resident's physician's orders and confirmed Resident #114's Eliquis was discontinued on 08/21/2025. Both reviewed the resident's care plan and confirmed that anticoagulants remained on the care plan and should have been removed when the anticoagulant was discontinued.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interviews, record and policy review, the facility failed to ensure staff provided services that meet professional standards, as evidenced by nursing staff:Failing to document administration of a PRN (as needed) medication and the resident response to the medication for Resident #76; andLeaving medications at the bedside of Resident #120 who was not approved to self-administer medications. Findings: 1. On 04/15/2026, a review of the facility's policy titled Documentation of Medication Administration with a last reviewed date of 01/21/2026, read in part: Policy Statement: The facility shall maintain a medication administration record to document all medications administered. Policy Interpretation and Implementation: 1. A nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented after .it is given. 3. Documentation must include, as a minimum .f. Signature and title of the person administering the medication; and g. Resident response to the medication, if applicable (e.g., PRN .etc.). Review of Resident #76's records revealed he was admitted to the facility on [DATE], with diagnoses that included, but were not limited to unspecified urethral stricture, muscle weakness, fatigue, malaise and unspecified abnormalities of gait and mobility. The resident was diagnosed with malignant neoplasm of esophagus on 02/20/2026 and received hospice services. Review of Resident #76's Modification of Significant Change Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/25/2026, revealed in Section O that he received hospice care. On 04/13/2026 at 9:44 a.m., Resident #76 was observed sitting on the side of his bed and throwing up in a garbage can. S5LPN walked in the room and stated he gave the resident medication for nausea and vomiting and was waiting for it to work. On 04/15/2026 at 7:50 a.m., an interview and review of Resident #76's medical record was conducted with S5LPN. S5LPN was asked what he gave the resident for nausea and vomiting on 04/13/2026 and if it had worked. He stated he gave the resident Promethazine (a medication used to treat nausea). Review of Resident #76s MAR (Medication Administration Record) with S5LPN revealed no documentation the resident was given Promethazine since 04/01/2026. S5LPN stated he gave the resident the medication on 04/13/2026 and forgot to document it in the resident's MAR. Review of Resident #76's progress notes revealed no documentation of the effectiveness of Promethazine. S5LPN confirmed he did not document the effectiveness of the medication in the resident's progress notes. On 04/15/2026 at 7:55 a.m., an interview was conducted with S9DON. She stated that staff were responsible for documenting PRN medications in the residents' MAR after administering the medication. The MAR then triggers the progress notes that the medication was given and prompts the nurse to follow up with assessing the effectiveness of the medication administered. 2. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Administering Medications, with a last review date of 01/21/2026, read in part, Policy Statement: Medications are administered in a safe and timely manner. Policy Interpretation and Implementation: 23. Resident may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision making capacity to do so safely. Review of Resident #120's EHR (electronic health record) revealed she was admitted to the facility on [DATE] and had diagnoses that included in part, macular degeneration, glaucoma, and major depressive disorder. Review of Resident #120's Quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed the resident's BIMS (Brief Interview for Mental Status) score was 15, indicating her cognition was intact. On 04/13/2026 at 10:02 a.m., an observation was conducted of Resident #120's room that revealed a plastic cup of oral medications, in the form of tablets, on the resident's bedside table. Resident #120 picked up the plastic cup and began to take one loose tablet out of the cup. Resident #120 stated S13LPN left her oral medications in her room earlier this morning. On 04/13/2026 at 10:02 a.m., an interview and observation was conducted with S13LPN in Resident #120's room with the resident present. S13LPN confirmed she placed morning medications in a cup for the resident at 9:30 a.m., placed the cup on the bedside table, and left the room. S13LPN confirmed she did not observe Resident #120 swallow the tablets. S13LPN also confirmed the medications should not have been left unattended in Resident #120's room. On 04/14/2026 at 2:30 p.m., an interview was conducted with S9DON. S9DON confirmed that a nurse should not have left the resident's medications unattended at the bedside. S9DON also confirmed all medications should be administered to the resident before the nurse leaves the resident's room. S9DON stated this service provided by the nurse did not meet professional standards of quality. On 04/15/2026 at 9:31 a.m., an interview was conducted with S12NA. She confirmed that Resident #120 had not been assessed for self-administration of medications and she was not considered safe to self-administer medications.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy and procedures review, the facility failed to ensure a resident who required assistance, received assistance with activities of daily living (ADLs) to maintain good grooming and personal hygiene for 1 (#76) of 38 sampled residents.Findings:On 04/15/2026, a review of the facility's policy titled Activities of Daily Living (ADL), Supporting with a last reviewed date of 01/21/2026, read in part: Policy Statement .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy Interpretation and Implementation .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care).Review of Resident #76's records revealed he was admitted to the facility on [DATE], with diagnoses that included, but were not limited to unspecified urethral stricture, muscle weakness, fatigue, malaise and unspecified abnormalities of gait and mobility. The resident was diagnosed with malignant neoplasm of esophagus on 02/20/2026 and received hospice services.Review of Resident #76's Modification of Significant Change Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/25/2026, revealed in Section C that he had a Brief Interview for Mental Status (BIMS) of 12, indicating moderate cognitive impairment. Further review revealed in Section GG that the resident required partial/moderate assistance to shower/bathe, indicating he needed help to lift, hold, or support his trunk or limbs, but the helper provides less than half the effort. Further review revealed the resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity.) for personal hygiene and upper body dressing. Review of Resident #76's current plan of care revealed the following:The resident has an ADL self-care performance deficit R/T (related to) muscle weakness, fatigue, abnormalities of gait and mobility, malaise, Date Initiated: 12/30/2024.Interventions in part:Resident required assistance with dressing.Resident required assistance with bathing. Resident required assistance with personal hygiene.Resident required assistance with transferring.Resident required assistance with walking. The resident has risk for nausea and vomiting Date Initiated: 02/23/2026Interventions in part:Keep resident clean, dry and comfortable with bathing, linen and gown changes as needed. The resident has a terminal prognosis r/t esophageal cancer. Date Initiated: 02/23/2026Interventions in part:Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate.On 04/13/2026 at 9:44 a.m., Resident #76 was observed sitting on the side of his bed with a garbage can on his lap throwing up blood tinged fluid. The resident was wearing a gray jacket with splatters of vomit observed on his jacket. The resident stated he was not feeling well and had been coughing and vomiting. S5LPN came into the resident's room and observed him. He stated he had given the resident some medication for nausea and was waiting for it to work. He did not offer to change the resident's jacket.On 04/14/2026 at 8:48 a.m., Resident #76 was observed sitting on the side of his bed attempting to eat breakfast. The resident was wearing the same gray jacket which was now stained with what looks like large amounts of vomit. The resident stated no one offered to give him a bath or changed his jacket. The resident was asked if staff knew his jacket was dirty and he needed help and he stated his nurse knew. On 04/14/2026 at 10:29 a.m., a third observation was made of Resident #76 in his room. The resident was still wearing his stained gray jacket. The resident stated he had been wearing the jacket since yesterday (04/13/2026). He was asked if he had other jackets and he stated he had clean jackets in his closet but needed help to get one. The resident stated his nurse had been in his room and knew he was not feeling well On 04/14/2026 at 11:53 a.m., a fourth observation was made of the resident in his room. The resident was sitting on the side of his bed with his upper body (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bare. The resident's gray jacket was beside him on his bed and a pink vomit stain observed on the resident's blanket. He stated that he took the jacket off but was not feeling well to get up and get cleaned up and get clean clothes. The resident stated that no staff had offered him a bath or changed him. On 04/14/2026 at 11:55 a.m., S7CNAMR was observed walking outside the resident's room. S7CNAMR stated she was not caring for the resident today. She observed Resident #76 and stated the resident should not have been left in that dirty jacket. She asked the resident if he wanted her to give him a shower and he stated yes. S7CNAMR placed the resident's stained gray jacket in a plastic bag and told the resident she would get it washed for him. On 04/14/2026 at 11:57 a.m., S5LPN and S6CNA who were caring for the resident, both went to the resident's room and confirmed his jacket was soiled and stained. S6CNA stated she thought the resident could care for himself, and did not offer him a bath or changed his jacket. S5LPN confirmed he had been in the resident's room to give him medications and did not offer to change his jacket. On 04/14/2026 at 3:01 p.m., an interview was conducted with S6CNA. She stated that she became a certified nurse assistant (CNA) in February 2026 and had been working at the facility for only a week. She stated last week she worked with the resident and he was doing for himself at that time and wasn't vomiting. S6CNA stated when she returned to work on Monday, no one informed her the resident was not feeling well and was vomiting. She stated the nurse did not tell her the resident needed a bath or his jacket changed.On 04/15/2026 at 8:15 a.m., an interview was conducted with S8CNASup. She stated she was informed of the incident yesterday (04/14/2026) when S6CNA did not change the resident and offered care. She stated that S6CNA should have checked on the resident, bathe him and changed his soiled jacket. She stated staff should not have left the resident like that.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to provide oxygen therapy as ordered for 1 (#34) of 38 residents sampled.Findings:Review of Resident #34's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 11, which indicated resident #34 had moderate cognitive impairment. Resident #34's MDS section O was coded as oxygen therapy, non-invasive mechanical ventilator, and respiratory therapy. Review of Resident #34's EHR (Electronic Health Record) revealed she was admitted on [DATE] and had diagnoses including, but not limited to, insomnia, anxiety disorder, unspecified atrial fibrillation, and heart failure. Review of Resident #34's April 2026 physician's orders revealed an order for Oxygen: CPAP (Continuous Positive Airway Pressure) 5/2L (Liters) at bedtime related to heart failure, with an order date of 06/27/2025. Review of Resident #34's MAR (Medication Administration Record) revealed Oxygen: CPAP 5/2L at bedtime related to heart failure was documented as not administered on the following dates April 1st through April 8th, 2026 and April 11th through April 13th 2026. On 04/13/2026 at 10:35 a.m., an interview was conducted with Resident #34. Resident #34 reported her CPAP machine was broken and she had not been using the machine for a while now; she was unable to recall a specific timeframe. Resident #34 stated the nurse broke her CPAP machine but she could not recall who the nurse was or when it happened. On 04/14/2026 at 8:40 a.m., an interview was conducted with S9DON in Resident #34's room. S9DON stated she was not aware that Resident #34's CPAP was broken. S9DON brought a concentrator and oxygen tubing into Resident #34's room. S9DON attempted to connect the tubing to the CPAP machine and stated she could not connect the oxygen tubing because the CPAP adaptor was broken. S9DON confirmed the oxygen therapy as ordered via CPAP was not able to be delivered to Resident #34 as ordered by physician. On 04/15/2026 at 4:45 p.m., a second interview was conducted with S9DON. S9DON provided MAR documentation to the surveyor. S9DON confirmed that the MAR documentation which read N indicated the physician's order for Oxygen: CPAP 5/2L at bedtime for Resident #34 was not administered on the following dates: April 1st through April 8th 2026, and April 11th through April 13th 2026. S9DON confirmed the nursing staff did not provide oxygen therapy for Resident #34 as ordered by the physician.

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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 observations and interview, the facility failed to maintain professional standards for food service safety by failing to wear appropriate hair restraints. The facility had a census of 125 residents.Findings:A review of the facility's policy titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, with a last review date of 01/21/2026, read in part.Policy Statement: Food Service employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy Interpretation and Implementation.12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens.On 04/13/2026 at 8:42 a.m., initial tour of kitchen was conducted with S1DM. Throughout the tour, S1DM was observed with his facial hair exposed and was not wearing a beard restraint.On 04/13/2026 at 9:13 a.m., at conclusion of initial tour, S1DM confirmed that his facial hair should be covered and was not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record and policy review, the facility failed to maintain an effective infection prevention and control program by failing to ensure:1. Clean, laundered mop heads and blankets were stored away from soiled linens; and2. Resident #81's urinary catheter drainage bag avoided contact with the floor. The facility had a census of 125 residents.Findings:1.Review of a facility policy titled Laundry and Bedding, Soiled, with a last reviewed date of 01/21/2026, revealed in part, 1. Clean linen is stored separately, away from soiled linens, at all times.3. Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination.On 04/14/2026 at 2:58 p.m., an observation was made of the soiled linen room of the laundry department with S3HLS. There were 3 covered plastic bins stored on the soiled side of the laundry room. S3HLS stated two of the bins contained clean mop heads and one bin contained clean blankets. S3HLS removed the covers of the plastic bins, an observation was made and revealed clean mop heads in two bins and clean blankets in one bin. S3HLS confirmed that clean laundered items were being stored on the soiled side of the laundry room and should not have been.On 04/14/2026 at 3:59 p.m., an interview was conducted with S2IC. S2IC confirmed that clean laundered items should not have been stored on the soiled side of the laundry room. 2.Resident #81Review of Resident #81's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included, in part, retention of urine, chronic kidney disease stage 4, and other obstructive and reflux uropathy.On 04/13/2026 at 12:45 p.m., an observation was made of Resident #81 in his room. The bottom of Resident #81's urinary catheter drainage bag was touching the fall mat which was on the floor next to his bed. On 04/14/2026 at 5:26 p.m., a second observation was made of Resident #81 in his room. The bottom of Resident #81's urinary catheter drainage bag was touching the fall mat which was on the floor next to his bed.On 04/15/2026 at 8:20 a.m., a third observation was made of Resident #81 in his room. The bottom of Resident #81's urinary catheter drainage bag was noted laying on the floor in his room.On 04/15/2026 at 8:29 a.m., a concurrent observation and interview was conducted with S4CNA. S4CNA confirmed that Resident #81's urinary catheter drainage bag was laying on the floor and it should not have been.On 04/15/2026 at 8:48 a.m., an interview was conducted with S2IC. S2IC confirmed that Resident #81's urinary catheter drainage bag should not have been touching the fall mat or laying on the floor in his room.