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	11/06/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record reviews, observations, interviews, and review of facility policy and procedure the facility failed to ensure a resident was provided privacy during personal care for 1 (#2) out of 3 (#1, #2, and #3) sampled residents reviewed for resident rights. Findings: On 11/06/2024, a review of the facility's policy titled, Quality of Life - Dignity with a last reviewed date of 12/27/2023, read in part, . Policy Statement: Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Policy Interpretation and Implementation . 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care . Review of Resident #2's record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Disease of Basal Ganglia, Muscle Weakness, Parkinson's Disease, and Tremor. Review of Resident #2's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 12, indicating her cognition was moderately impaired. Section GG: Functional Status read in part, Toilet use was coded as Extensive assistance/2. One person physical assist. Section H- Bladder and Bowel read in part, urinary continence was coded as occasionally incontinent Review of Resident #2's comprehensive plan of care, read in part, The resident has an ADL self-care performance deficit r/t (related to) . Muscle Weakness with interventions . dated 11/02/2023; Personal Hygiene: Resident requires assistance with personal hygiene Review of video surveillance in Resident #2's room revealed: 1. On 08/31/2024 at 9:52 p.m. S7CNA (Certified Nursing Assistant) was changing resident's brief with the door open. Resident #2's lower half of her body was uncovered and exposed from the hallway during personal care. 2. On 10/16/24 at 11:11 p.m. S7CNA was checking resident's brief to see if she was soiled. Resident #2's lower half of her body was uncovered and exposed from the hallway during personal care. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 4:41 p.m. a review of video surveillance from 08/31/2024 and 10/16/2024 and interview was conducted with S2DON (Director of Nursing) who confirmed Resident #2's door should have been closed during personal care.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record reviews, observations, interviews, and facility policy and procedure review, the facility failed to protect the residents' right to be free from abuse. The facility failed to protect: 1. Resident #2 from verbal abuse and mental abuse by S6CNA (Certified Nursing Assistant), and 2. Resident #1 from physical abuse by Resident #3. Findings: On 11/06/2024, a review of the facility's policy titled, Abuse and Neglect - Clinical Protocol with a last reviewed date of 12/27/2023, read in part, . Policy Statement: The facility will ensure that each resident had the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility will provide a safe resident environment and protect residents from abuse. Policy interpretation and Implementation: . Staff to Resident Abuse of any Types: . The facility assumes the responsibility upon admission of ensuring safety and well-being of the resident . Staff are expected to be in control of their behavior and behave professionally . Definitions: Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . Verbal Abuse - the use of oral, written or gesture language that willfully include disparaging and derogatory terms to residents . regardless of their age, ability to comprehend . Physical Abuse - this includes but not limited to hitting, slapping, pinching, and kicking . Mental Abuse - this includes but is not limited to humiliation, harassment, and threats of punishment or deprivation . 1. Resident #2: Review of Resident #2's record revealed she was admitted to the facility on [DATE] with diagnoses that included in part Disease of Basal Ganglia, Muscle Weakness, Cognitive Communication Deficit, and Depression. Review of Resident #2's most recent Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 12, indicating her cognition was moderately impaired. Section GG: Functional Status read in part, Transfers, toileting and bed mobility was coded as Extensive assistance/2. One person physical assist. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's comprehensive plan of care, read in part, the resident has impaired cognitive function/dementia or impaired thought process r/t (related to) degenerative diseases of Basal Ganglia with interventions that read in part, ask yes/no questions in order to determine the resident's needs, . communication: use the resident preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact, reduce any distractions ., the resident understands consistent, simple, directive sentences, provide the resident with necessary cues- stop and return if agitated. The resident has an ADL self-care performance deficit r/t . Muscle Weakness with interventions . Bed Mobility: Resident requires assistance with bed mobility . Transferring: Resident requires assistance with transferring. Review of video surveillance in Resident #2's room revealed: On 09/04/2024 at 10:25 p.m.: S6CNA was observed walking with Resident #2 and assisting her back to her bed after using the restroom. S6CNA stated, Go all the way to the top of the bed, all the way .Don't you sit down until I tell you, walk, walk all the way to the top grab that rail . all the way to the top grab that rail . don't you lay your big butt down . go up some more cause ain't nobody got time pulling up on you, you're too heavy . Resident #2 stated, Are you mad at me? CNA stated, I ain't never mad I'm just not going to let you waste my time cause I don't play that .I got things to do . On 9/27/2024 at 11:28 p.m.: Resident #2 set off bed alarm by sitting up in bed. S6CNA came into the room and stated, Where you going? Resident #2 stated, I'm going walk for a little bit. S6CNA stated, No you're not get back in the bed .not playing with you and I already told you that .get yourself back in that bed get back in the bed. Resident #2 is seen attempting to lay down by herself without assistance from S6CNA was seen hovering over the resident. She displayed signs of struggling to lay back down without assistance and can be heard grunting. S6CNA stated, You're going to figure it out. S6CNA walked away from resident and leaned against the wall and put her hands in her pockets and stated, Next time you're going to know how hard it is to get back in the bed .go to sleep, go to bed .don't get out that bed . cause you going put yourself right back in. On 10/16/2024 at 9:46 p.m.: Resident #2 was seen sitting up in the bed. S6CNA walked in and stated, Why are you getting up? . No, you're not you just went to the bathroom .I don't care what your daughter got going on I just took you to the bathroom and I am not going to be in this room all night with you I came in here at 10:00 (p.m.), 10:15 (p.m.), and its 10:49 (p.m). S6CNA then pointed at to resident and then pointed to the bed and said Lay down. I'm not straining on you all night and I can go home .I can find me another job .I'm not dealing with you all night every night .get back in the bed, get yourself back in the bed how you got up . they got other patients around here not just you. S6CNA then exits Resident #2's room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/2024 at 2:12 p.m. a phone interview with Resident #2's RP (Responsible Party) who stated that Resident #2 is her mom. She stated her mom has Fahr's Disease or Basal Ganglia Disease which affected her memory at times. She stated Resident #2 had a history of being verbally abused in her marriage of [AGE] years. She stated when her mother experienced this verbal abuse she would have nervous tics in her face caused by her increased anxiety. She stated she noticed her mom started having nervous tics which alerted her to start reviewing the video surveillance camera footage of Resident #2's room in October 2024. She stated Resident #2 would feel terrible about being spoken to in that manner by S6CNA if her cognition was not impaired. She stated on occasion she would hear her mom say, I'm not being bad am I? She stated she was scared for her mom and that is why she was transferred out of the facility. On 11/06/2024 at 2:46 p.m. a phone interview was conducted with Resident #2. She stated she does remember living at the previous facility. She stated the CNA's would talk to her very ugly but she does not remember their names. She reported after they spoke to her in an ugly way she was a little scared of them. She stated she left the facility because of the way they were treating her. On 11/06/2024 at 4:34 p.m. a review of video surveillance from the dates listed above and joint interview was conducted with S1ADM (Administrator), S2DON (Director of Nursing), and S3QI (Quality Insurance Nurse). They confirmed S6CNA was unprofessional, had communication problems, and a gruffness to her voice towards Resident #2. S2DON confirmed when S6CNA stated things such as you're too heavy was insulting to Resident #2. 2. Resident #3: Review of Resident #3's record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Anxiety Disorder, Major Depressive Disorder, and Alzheimer's Disease. Review of Resident #3's most recent Annual Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 00, indicating her cognition was severely impaired. Section GG: Functional Status read in part, coded yes for wheelchair use, and coded as no impairment to her upper and lower extremity. Review of Resident #3's comprehensive plan of care, read in part, The resident is/has potential to be physically aggressive r/t (related to) Resident hit another resident. Date Initiated: 10/18/2024 . Review of Resident #3's nurse's note dated 10/16/2024 at 12:15 p.m. by S8LPN (Licensed Practical Nurse) read in part, Summoned to dining room by CNA (Certified Nursing Assistant) . states that resident noted on front of Hall W way where she was witnessed hitting another resident repeatedly .resident unable to say what happened but verbalized that she knew hitting people is wrong . On 11/04/2024 at 3:17 p.m. an interview was conducted with Resident #3. She was unable to recall an incident with Resident #1. 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, Cognitive Communication Deficit, and Muscle Weakness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's most recent Admission Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 3, indicating her cognition was severely impaired. Section GG: Functional Status read in part, coded yes for wheelchair use. Review of Resident #1's nurse's note dated 10/16/2024 at 12:15 p.m. by S7LPN (Licensed Practical Nurse) read in part, noted by staff that resident was in an altercation with another resident, ask resident what transpired, resident denied any incident. No bruises to the upper/lower extremities. No complaints of pain. On 11/04/2024 at 3:32 p.m. an interview was conducted with Resident #1. She was unable to recall the incident in which she was struck by Resident #3. On 11/04/2024 at 2:36 p.m., a joint interview with S1ADM (Administrator) and S9AsstADM (Assistant Administrator) was conducted. They stated that they reviewed the video surveillance after the incident and Resident #1's back was towards the camera Resident #3 wheeled by Resident #1 and slapped her on the arm. S1ADM stated based off of the video surveillance Resident #3 was the aggressor and it looked like Resident #3 was meaning to strike at Resident #1. On 11/04/2024 at 2:39 p.m., review of video surveillance with no time stamps on S9AsstADM phone with permission. Resident #1's back was faced towards the camera, she was sitting on her wheelchair. Resident #3 passed by Resident #1 in her wheelchair and slapped Resident #1 on her arm. On 11/04/2024 at 2:44 p.m., an interview with S2DON (Director of Nursing) was conducted. She stated she reviewed video surveillance and Resident #1 and Resident #3 were on Hall W where the incident took place. S2DON stated that based off the video surveillance Resident #3 was wheeling towards Resident #1 and started hitting her. Regarding Resident #3's willful action, S2DON stated that's hard to say but yes, we didn't know if she wanted to hurt her but she did want to hit her. S2DON stated Resident #3 does have a history of aggressive behavior.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record reviews, observations, interviews, and review of facility's manual the facility failed to report to the administrator of the facility an event involving verbal abuse for 1 (#2) out of 3 (#1, #2, and #3) sampled resident reviewed for reporting alleged violations. Findings: On 11/06/2024, a review of the facility's manual titled, Abuse Neglect Reporting with a last revision date of 09/01/2016, read in part, Verbal Abuse - the use of oral, written or gesture language that willfully include disparaging and derogatory terms to residents . regardless of their age, ability to comprehend . Mental Abuse - this includes but is not limited to humiliation, harassment, and threats of punishment or deprivation . additional definitions: mistreatment: means to inappropriately treat or exploit a resident.In the event of any evidence involving mistreatment, exploitation, neglect or abuse, or other crime, including injuries of an unknown source, and an occurrence will be reported to the administrator of the facility . Findings: Review of Resident #2's record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Disease of Basal Ganglia, Muscle Weakness, Parkinson's Disease, and Tremor. Review of Resident #2's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 12, indicating her cognition was moderately impaired. Review of video surveillance in Resident #2's room revealed: On 10/16/2024 at 9:51 p.m. S4RN (Registered Nurse), S5LPN (Licensed Practical Nurse) and S6CNA (Certified Nursing Assistant) walk into Resident #2's room and Resident #2 is sitting on the floor. S6CNA stated this is what happens when they don't put their foot down with family members, and they play too many games they can find them another CNA tonight, and that's on my momma cause they will never work me like this S5LPN stated What's going on Resident #2? S6CNA stated to Resident #2 not listening for no reason she had just got up and 10 (p.m.), 10:15 (p.m.) you didn't have no reason to get up, you didn't have to use the bathroom and I'm not even with all of this, Resident #2 can beg me picking up on her like this . On 11/06/2024 at 9:34 a.m., an interview with S4RN. Reviewed video surveillance from 10/16/2024 involving what was said by S6CNA and how she spoke to Resident #2 and she confirmed that is a not a way to talk to a resident. She confirmed that speaking to a resident in that manner is not acceptable and she did not report it to her ADON (Assistant Director of Nursing), DON (Director of Nursing), or administrator. She confirmed that the S6CNA speaking to the resident in this manner in front of others could have caused the resident to feel humiliated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 10:06 a.m. an interview was conducted with S5LPN. Reviewed video surveillance on 10/16/2024 involving what was said by S6CNA and how she spoke to Resident #2. He confirmed S6CNA mistreated the resident. He confirmed that he did not report this to the ADON, DON, or administrator and should have. On 11/06/2024 at 4:34 p.m. a review of video surveillance from 10/16/2024 and joint interview was conducted with S1ADM (Administrator), S2DON (Director of Nursing), and S3QI (Quality Insurance Nurse). They confirmed S6CNA was unprofessional with Resident #2 and this was not reported to them by S4RN and/or S5LPN.