STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER: Camelot Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1555 Commerce St Logansport, IN 46947	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure staff followed the physician's order for medications given through a gastrostomy tube (a feeding tube inserted through the abdominal wall directly into the stomach) for 3 of 3 residents reviewed for medication administration. (Resident 46, 33 and 72) Findings include: 1. During an observation, on 6/26/25 at 10:57 a.m., Qualified Medication Aide (QMA) 2 indicated the resident received her medication through her gastrostomy tube (g-tube). QMA 2 poured 120 milliliters (ml) of water into a plastic cup and 130 ml into another plastic cup. She pulled Resident 46's medication out of the cart and crushed the pills. She put the crushed pills into the cup with 130 ml water. She took the two cups into the resident's room. The QMA checked the resident's residual and attached the piston to the g-tube. QMA 2 poured the medication into the piston and then poured 120 ml of water. QMA 2 did not flush before the medication was given and flushed the medication with 120 ml of water after the medication. The clinical record for Resident 46 was reviewed on 6/27/25 at 11:35 a.m. The diagnoses included, but were not limited to, gastrostomy tube (g-tube) and dysphagia (difficulty swallowing). A physician's order, dated 11/22/22, indicated to check placement of the g-tube prior to giving medications and to flush the gastrostomy tube with 30 ml of water before and after the medication was given. During an interview, on 6/26/25 at 11:10 a.m., QMA 2 indicated she was not aware of the resident's order for a water flush, and she used this amount most of the time. 2. During an observation, on 6/26/25 at 11:47 a.m., QMA 2 indicated Resident 33 received her pills through her gastrostomy tube (g-tube). QMA 2 poured 130 ml of water into a plastic cup and 120 ml into another plastic cup. She pulled Resident 46's pills out of the medication cart and placed them in a plastic sleeve. She crushed all the pills and poured the crushed pills into the cup with 130 ml water. She took the two cups into the resident's room. QMA 2 poured the medication into the piston and followed with 120 ml of water. The clinical record for Resident 33 was reviewed on 6/27/25 at 11:55 a.m. The diagnoses included, but were not limited to, gastrostomy tube (g-tube) and dysphagia (difficulty swallowing). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155385	A. Building B. Wing	07/02/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 8/6/22, indicated to administer 30 ml of water into the g-tube before and after medication was administered. During an interview, on 6/26/25 at 12:01 p.m., QMA 2 indicated she was not aware of the correct amount of water the resident had ordered for a flush. 3. During an observation, on 6/30/25 at 10:26 a.m., QMA 2 crushed all Resident 72's pills and put them in 120 ml of water. Then she poured another cup of 90 ml of water for the flush. She poured all 120 ml of water with the crushed pills and followed it with 90 ml of water for a flush. QMA 2 did not flush the g-tube with 30 ml of water before and after giving the medication. The clinical record for Resident 72 was reviewed on 6/30/25 at 11:35 a.m. The diagnoses included, but were not limited to, gastrostomy tube (g-tube) and dysphagia (difficulty swallowing), severe intellectual disabilities, feeding difficulties, neuromuscular scoliosis, and gastrostomy status. A physician's order, dated 10/12/23, indicated to administer 30 ml of water by g-tube before and after medication was given. During an interview, on 6/30/25 at 11:40 a.m., QMA 2 indicated she knew the order was to flush with water before and after the medication was given. A current facility policy, titled Physician Orders, revised 10/2017 and received from the Administrator on 6/30/25 at 9:30 a.m., indicated .Facility nursing personnel will ensure clear, accurate and complete physician's orders A current facility policy, titled Tube Feedings (Naso-gastric or Gastrostomy tube), revised 10/2014 and received from the Administrator on 6/30/25 at 9:30 a.m., indicated .Physician Orders .Flush with 5 cc water between each medication .Thirty (30) cc of water flush before and after medication administration 3.1-44(a)(2)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medication bottles were correctly labeled, refrigerated medications were safely stored, and medication carts were free of loose pills for 4 of 6 medication carts reviewed for medication storage. (vent-hall cart 1, vent-hall cart 2, boys-hall cart 2 and middle-hall cart 2) Findings include: 1. During a medication cart observation with Registered Nurse (RN) 4, on 6/27/25 at 9:30 a.m., the vent-hall cart 1 had one loose orange pill in the bottom of the second drawer and five sticky bottles for Resident 185 in the bottom drawer. The bottles contained the following medication: a. Two bottles of diazepam (for anxiety) 5 milligrams (mg)/milliliter (ml). b. One bottle of cetirizine (for allergy symptoms) 1 mg/ml. c. Two bottles of levetiracetam (for seizures) 100 mg/ml. During an interview, on 6/27/25 at 9:33 a.m., RN 4 indicated the pills should never be loose in the medication cart. The medication bottles for Resident 185 were brought in by the resident's mother. Resident 185's mother had filled the prescriptions and poured some of the medication into the bottles at their home. The resident's mother would bring in the leftover medication and the nurse would pour the new medication into the old bottles. The bottles needed directions and resident information on them. The medication bottles did not have the proper information. 2. During an observation with RN 4, on 6/27/25 at 9:40 a.m., the vent-hall cart 2 had eight bottles of liquid medication stored on the right side of the cart in a basket on the bottom drawer of the cart. The eight bottles needed to be refrigerated and were left out at room temperature. The mediations were as follows: a. erythromycin ethylsuccinate (an antibiotic) suspension for reconstitution 200 mg/5 ml. b. omeprazole (treats gastroesophageal reflux disease) solution 2 mg/ml. c. lansoprazole (treats gastroesophageal reflux disease) oral 2 mg/ml. d. amoxicillin-pot clavulanate (an antibiotic) suspension for reconstitution 400-57 mg/5 ml. e. gabapentin (treats seizures) solution 250 mg/5 ml. f. baclofen (treat muscle spasms) solution 10 mg/5 ml. g. acidophilus (promotes good bacteria in your body) capsule. h. Augmentin (an antibiotic) suspension for reconstitution 250-62.5 mg/5 ml. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 6/27/25 at 9:44 a.m., RN 4 indicated the bottles were taken from the refrigerator and put in the medication cart around 7:35 a.m. She would use the medication and put all the bottles back into the refrigerator after she was finished with her medication pass. 3. During an observation with RN 5, on 6/27/25 at 10:40 a.m., the boys-hall cart 2 had two brown, four white and one yellow loose pill in the bottom drawer of the cart. During an interview, on 6/27/25 at 10:45 a.m., RN 5 indicated loose pills should not be left in the bottom of the cart. The loose pills would need to be destroyed in the drug buster stored in the medication room. 4. During an observation with QMA 3, on 6/27/25 at 10:56 a.m., the middle-hall cart 2 had one large white, one-half white and two orange pills loose in the bottom of the second large drawer. During an interview, on 6/27/25 at 11:05 a.m., QMA 3 indicated there should not be any loose pills in the medication cart. During an interview, on 6/27/25 at 11:30 p.m., the Administrator indicated loose pills should not be in the bottom of the medication carts. A current facility policy, titled Storing Drugs, revised 12/2017 and received from the Administrator on 6/30/25 at 9:30 a.m., indicated .Drugs and biological's will be stored in a safe, secure, and orderly manner at appropriate temperatures .Each drug must be kept and stored in the labeled dispensing container. Drugs may not be transferred from one container to another. When a permitted person is not in a drug storage area, the drug storage area and devices must be kept locked .Refrigerated medications must be stored in a refrigerator designated for medication only at a temperature of 36-46 degrees A current facility policy, titled Drug Labels, revised 12/2017 and received from the Administrator on 6/30/25 at 9:30 a.m., indicated .The pharmacist will verify the information on all tables before medication is delivered. Only the pharmacist is permitted to make changes to the prescription label. The facility must never change, modify, or affix anything to the prescription label or medication A current facility policy, titled Physician Orders, revised 4/2017 and received from the Administrator on 6/30/25 at 9:30 a.m., indicated .Never pour medication back into the bottle .The individual medication administration records (MAR's) should be reviewed at the need of medication pass to ensure all ordered medications were administered and all administered doses were documented 3.1-25(j) 3.1-25(o)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide at least 80 square feet per resident in 1 of 33 resident rooms reviewed. (room [ROOM NUMBER]) Findings include: During the initial facility observation, on 6/26/25 at 1:12 p.m., room [ROOM NUMBER] was found to have three beds. room [ROOM NUMBER] had 3 beds and was 237.9 square feet. This was 79.3 square feet for each resident. During the entrance conference, the Regional Director provided a copy of the Indiana Department of Health recommendation, dated 11/7/24, to approve the room size waiver for room [ROOM NUMBER]. 3.1-19(l)(2)(A)