STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195516	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camelot Leisure Living	6818 Highway 84 West Ferriday, LA 71334

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review the facility failed to ensure prompt resolution of an allegation of not providing proper Ileostomy care for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents by failing to initiate a grievance for Resident #1.Findings: Review of the Facility's Policy titled Filing/Grievances/Complaints with a revision date of 01/22/2025 revealed in part.Policy Statement: Our facility will assist residents or his/her responsible party in filing grievances or complaints when such requests are made.Policy Interpretation and Implementation:3. Grievances and/or complaints may be submitted orally or in writing.5. Upon receipt of written grievance and/or complaint, the social services director will investigate the allegation and submit a written report of such findings to the administrator within 24 hours of receiving the grievance and/or complaint.7. The resident, or person filing the grievance and/or complaint in behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee, within 3 working days of the filing of the grievance or complaint with the facility.Review of Resident #1's medical record revealed an admit date of 04/20/2022 with diagnoses which included in part.Type 2 Diabetes Mellitus, Moderate Protein-Calorie Malnutrition, Gastrostomy Status, Ileostomy Status, Pain Unspecified, and Unspecified Dementia.Review of Resident #1's Quarterly MDS with ARD of 05/27/2025 revealed Resident #1 had a BIMS score of 99 indicating the resident was unable to complete the interview. Resident #1's MDS revealed she required partial to moderate assistance with toileting, bathing, eating, and personal hygiene.Review of Resident #1's Care Plan with a Target date of 07/22/2025 revealed in part.Alteration in Gastrointestinal Status related to Ileostomy with interventions that included provide treatment as ordered, change Ileostomy appliance (wafer and bag) every Tuesday and Thursday and PRN dislodgement.Telephone interview on 07/14/2025 at 7:57 a.m. with Resident #1's daughter revealed she had complained to the DON on three separate occasions (unable to remember dates) of her mother's (Resident#1) Ileostomy bag leaking and her mother having feces on her. Responsible Party revealed she visited her mother daily and on several visits her mother would have feces on her and a towel would be stuffed around the Ileostomy bag to catch the feces. Responsible Party stated the DON had assured her the matter would be taken care of, but it had not been.Review of the facility's Grievance Log revealed no grievances for Resident #1.Review of the facility's form titled Hand in Hand Program read in part.Date: 04/02/2025Any concerns or issues to be addressed: RP has a concern: says that the Nurse isn't changing Resident #1's Colostomy bag in a timely manner.Action taken to resolve the issue: I will notify the ADON and DON.Person contacted about what was done to resolve: BlankHand in Hand Rep signature: BlankAdministrator signature issue resolved: Signed by AdministratorInterview on 07/15/2025 at 9:16 a.m. with S7 [NAME] Clerk revealed Hands in Hands was a weekly call that she made to all resident's family members to help identify any concerns or complaints. S7 [NAME] Clerk (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #1's RP had voiced many complaints mostly about nursing and those complaints had been given to S1 ADON and S8 DON.Interview on 07/15/2025 at 2:00 p.m. with S3 Administrator and S1 ADON stated department heads decide what is considered a grievance. S3 Administrator and S1 ADON confirmed the Hand in Hand tool did not replace a grievance. S3 Administrator and S1 ADON confirmed the facility had no grievances/investigations or resolutions to any grievances on Resident #1.

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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. Based on interview and record review, the facility failed to develop a person-centered care plan for 1 (Resident #2) of 3 (Residents #1, #2, and #3) sampled residents. The facility failed to develop a care plan related to feeding assistance for Resident #2.On 07/16/2025 at 10:39 a.m., review of facility policy titled, Care Plans, Comprehensive Person- Centered, with revision date of 01/15/25, revealed in part. A Comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. A comprehensive, person-centered care plan will. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.On 07/16/2025 at 10:40 a.m., review of facility policy titled, Activities of Daily Living (ADLs), Supporting, with revision date of 01/15/25, revealed in part. Appropriate care and services will be provided to 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. dining (meals and snacks).A review of Resident # 2's medical record revealed an admission date of 05/28/2025, with diagnoses that included in part. Dysphagia following Unspecified Cerebrovascular Disease, Senile Degeneration of Brain Not elsewhere Specified, Anorexia, Moderate Protein Calorie Malnutrition, and Other Sequelae of Non-traumatic Intracerebral Hemorrhage. Review of Resident #2's admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 06/09/2025, revealed Resident #2 was rarely/never understood with an altered level of consciousness that was continuously present. Resident #2 required moderate assistance with eating and was dependent for personal hygiene, mobility, and transfers. On 07/14/2025 at 12:00 p.m., review of grievance filed by Resident #2's family member on 06/23/2025 revealed in part. Date Incident Occurred: 06/20/2025Description: Family member reported that the resident's lunch tray was on the bedside table, left over her mom in bed. Family member reported the tray had tumbled over in her bed next to residents head and no aide was in the room.Findings of Investigation: Findings were that the tray was left in the room over the resident.On 07/14/2025 at 12:30 p.m., review of Resident #2's care plan revealed that the comprehensive care plan did not reflect the level of feeding assistance Resident #2 required. During an interview on 07/15/2025 at 10:00 a.m., S2 MDS Nurse confirmed Resident #2 required staff assistance to be fed. Resident #2's care plan was reviewed with S2 MDS Nurse and S1 ADON at this time. S2 MDS Nurse confirmed Resident #2's level of assistance required for feeding was not care planned and should have been.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on Observation, interview and record review the facility failed to ensure that a resident who required Ileostomy services received such care consistent with professional standards of practice for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents by failing to change Resident #1's ileostomy bag as needed.Findings: Review of the Facility's Policy titled Colostomy/Ileostomy Care with a review date of 01/25/2025 revealed in part.Purpose: The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter.Documentation: The following information should be recorded in the resident's medical record:1. The date and time the colostomy/ileostomy care was provided.2. The name and title of the individual (s) who provided the colostomy/ileostomy care.6. The signature and title of the person recording the data.Reporting: Report other information in accordance with facility's policy and professional standards of practice.Review of Resident #1's medical record revealed an admit date of 04/20/2022 with diagnoses which included in part.Type 2 Diabetes Mellitus, Moderate Protein-Calorie Malnutrition, Gastrostomy Status, Ileostomy Status, Pain Unspecified, and Unspecified Dementia.Review of Resident #1's Quarterly MDS with ARD of 05/27/2025 revealed Resident #1 had a BIMS score of 99 indicating the resident was unable to complete the interview. Resident #1's MDS revealed she required partial to moderate assistance with toileting, bathing, eating, and personal hygiene.Review of Resident #1's Care Plan with a Target date of 07/22/2025 revealed in part.Alteration in Gastrointestinal Status related to Ileostomy with interventions that included provide treatment as ordered, change Ileostomy appliance (wafer and bag) every Tuesday and Thursday and PRN dislodgement. Review of Resident #1's July 2025 Medication Administration Record revealed in part. Burp/Empty Colostomy-change as needed six times a day related to encounter for attention to Ileostomy.Telephone interview on 07/14/2025 at 7:57 a.m. with Resident #1's daughter revealed she had complained to the DON on three separate occasions (unable to remember dates) of her mother's (Resident#1) Ileostomy bag leaking and her mother having feces on her. Resident #1's Responsible Party stated she visited her mother daily and on several visits her mother would have feces on her and a towel would be stuffed around the Ileostomy bag to catch the feces. Resident #1's Responsible Party revealed her mother had to wait for long periods of time before a nurse could provide Ileostomy care for her.Observation on 07/14/2025 at 11:30 a.m. with S4 CNA in attendance revealed Resident #1 lying in bed. Resident #1 had loose feces on her skin which had leaked from her Ileostomy bag. S4 CNA stated the towel had been placed around the Ileostomy bag to catch the feces. S4 CNA stated that she had informed S5 RN/ADON Treatment Nurse a little after 10:00 a.m. that Resident #1's Ileostomy bag needed to be changed and that S5 RN/ADON Treatment Nurse replied it would be a minute (a while) before she would be able to change Resident #1's Ileostomy bag.Interview on 07/15/2025 at 8:20 a.m. with S1 ADON confirmed the following orders for Resident #1: Burp/Empty Colostomy-change as needed six times a day related to encounter for attention to Ileostomy. S1 ADON revealed it was the treatment nurse's and floor nurse's responsibility to provide Ileostomy care for Resident #1. S1 ADON revealed if the treatment nurse or floor nurse is busy they should notify another nurse to provide ileostomy care for Resident #1. S1 ADON revealed Resident #1's RP had complained of certain staff not changing Resident #1's Ileostomy bag.Interview on 07/15/2025 at 9:48 a.m. with S5 RN/ADON Treatment Nurse revealed she did not provide Ileostomy care to Resident #1 on 07/14/2025. S5 RN/ADON Treatment Nurse stated S6 LPN provided Ileostomy care for Resident #1 on 07/14/2025.Interview on 07/15/2025 at 11:10 a.m. with S9 Bookkeeper revealed S6 LPN clocked in to work at 11:16 a.m.Telephone Interview on 07/16/2025 at 8:09 a.m. with S6 LPN revealed it was after 2:00 p.m. on 07/14/2025 when she provided Ileostomy care for Resident #1. S6 CNA (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she had not been informed that Resident #1 needed Ileostomy care prior to that.Interview on 07/16/2025 at 9:38 a.m. with S5 RN/ADON Treatment Nurse confirmed she had not reported to S6 CNA on 07/14/2025 that Resident #1 needed Ileostomy care.