STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255280	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELLIA ESTATES	1714 WHITE STREET MCCOMB, MS 39648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 10/31/18 to 11/02/18. The SA determined the facility was not in compliance with the requirements for the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, and cited the deficiency F656. The facility had a census of 23 at the time of entrance, and held a license for 30 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		11/23/18

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

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to develop a comprehensive care plan to address Depression for one (1) of 15 records reviewed; Resident #122. Findings Include: Review of the facility's policy titled, "Care Plan Process", revised 08/17, revealed the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs. "The comprehensive care plan is an interdisciplinary communication tool. The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged." A review of the Baseline Care Plan, dated	F 656	- The care plan for Resident #122 has been updated to address Depression on 11/2/2018, by the LPN MDS Nurse. - All residents with a diagnosis of Depression have the potential to be affected. - Staff completing care plans has been in-serviced by the Director of Nurses on developing a comprehensive care plan including Depression on 11/7/2018. - The Director of Nurses will audit weekly to ensure that residents with a diagnosis of Depression has a care plan for four weeks and then monthly for two months. Any observed issues will be corrected and then forwarded to the Quality Assurance and Improvement Committee monthly for three months and then quarterly until	

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F 656	Continued From page 2 10/22/18, for Resident # 122 revealed there was not a care plan initiated to address Depression, or to indicate Fluoxetine, an antidepressant, had been started. Review of the Face Sheet revealed Resident #122 was admitted by the facility, on 10/22/18, with diagnoses which included Depressive Disorder, Cerebral Infarction and Aphasia. Review of the Physician Orders for Resident #122, revealed an order was written, on 10/26/18, for Fluoxetine 20 milligrams (mg) per 5 milliliters (ml), give 10 ml per tube daily for Depressive Disorder. An observation, on 11/01/18 at 2:21 PM, revealed Resident #122 lying in bed awake, but appeared sad. An interview, on 11/02/18 at 3:30 PM, with Licensed Practical Nurse (LPN) #1, who serves as the Minimum Data Set (MDS) Nurse, revealed she is responsible for updating the care plan when an order is written. LPN #1 revealed the nurse noting the order puts it in the computer, and then she gets the pink copy of the order to update the care plan. LPN #1 stated, they use the Baseline Care Plan until the final comprehensive care plan is completed. Upon reviewing the Baseline Care Plan for Resident #122 as well as looking at the computerized care plans, LPN #1 confirmed she could not locate where the order for Fluoxetine was updated to the care plan, or where there was a care plan to address Depression. LPN #1 stated, "It's not there." An interview, on 11/02/18 at 5:15 PM, with the Director of Nursing (DON), revealed the MDS	F 656	resolved.	

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F 656	Continued From page 3 Nurse is suppose to update the care plan when new orders are written. The DON revealed orders are suppose to be done on a daily basis, but they make sure all orders are reviewed, and put on the care plan on Wednesday. Review of the five (5) day Admission MDS assessment, with an Assessment Reference Date (ARD) of 10/29/18, revealed this resident was unable to complete the Brief Interview for Mental Status (BIMS). Section I (Active Diagnoses) revealed Resident #122 was coded for Depression.	F 656		

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	255280	A. BUILDING **01 - "A" & "F" WINGS** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELLIA ESTATES	**1714 WHITE STREET MCCOMB, MS 39648**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 11/5/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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