

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER CAMELLIA ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 at the facility from 11/12/24 through 11/14/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F800, F812, and F880.	F 000			
F 800 SS=D	The facility had a census of 23 and had a license for 30 beds. Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that dietary staff supported the nutritional well-being of residents while respecting an individual's right to make choices about their diet for one (1) of thirteen (13) sampled residents reviewed for food preferences. (Resident #169) Findings included: On 11/12/2024 at 10:50 AM, during an interview, Resident #169 stated his primary concern about the facility was the type of food he was being served. He reported that his doctor instructed him to follow a high-protein and low-carbohydrate diet. However, he stated that since being in the facility, he was served more carbohydrates than protein.	F 800	On 11/13/2024, Resident #169's tray card was updated and Resident #169 was served the requested diet. Resident #169 was assessed by the Director of Nurses and found to not have any adverse effects from this practice. All residents who receive meals from the dietary department have the potential to be affected by this practice. On 11/13/2024, the Dietary Manager reviewed and updated all tray cards to reflect residents' food preferences. Beginning 11/14/2024, all current and any newly hired staff will receive in-service training on the facility's responsibility to	12/20/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/25/2024

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.

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F 800	Continued From page 1 He indicated that he had complained to the Dietary Manager, leading to a temporary change, but the facility reverted to serving high-carbohydrate meals. He expressed concern that this could negatively impact his health. On 11/13/2024 at 12:10 PM, during a follow-up interview and an observation, Resident #169 described his meals for the day. He reported having pancakes, eggs, and grits for breakfast and stated that he would not eat both buns of the hamburgers served for lunch and did not want the banana pudding because he is diabetic, and it would raise his blood sugar levels. An observation of the lunch meal on 11/13/2024 revealed that Resident #169 was served two hamburgers, French fries, and banana pudding. On 11/13/2024 at 1:11 PM, during an interview, the Dietary Manager confirmed that Resident #169 had expressed his preference for high-protein and low-carbohydrate meals, which she understood to be part of the doctor's orders due to surgical incisions. She admitted that the resident's breakfast and lunch meals did not align with his meal ticket and acknowledged that her staff did not consistently follow the preferences listed for Resident #169. She attributed this inconsistency to staff not understanding high-protein diets. On 11/14/2024 at 8:20 AM, during an interview, the Administrator confirmed the facility had failed to honor Resident #169's food preferences but stated it was the facility's goal to meet his and all residents' preferences. A record review of the "Admission Record" revealed that the facility admitted Resident #169	F 800	provide the diet of the resident's choice to honor food preferences. In-service training will be completed on the facility's responsibility to provide the diet of the resident's choice to honor food preferences by the Dietary Manager and the Director of Nurses by 12/01/2024. A Quality Assessment and Assurance Committee Meeting was held on 11/25/2024, to review the plan of correction and finalize the performance improvement plans. Beginning 12/1/2024, the Dietary Manager will observe food service 3 times a week for 4 weeks then monthly for 3 months to ensure the facility is honoring the food preferences of residents. Beginning 12/20/2024, any observed issues will be corrected and then forwarded to the Quality Assurance and Improvement Committee for review and follow up including any needed corrective actions, additional in-service training or change to current plan for three months then quarterly as needed.		

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F 800	Continued From page 2 on 10/31/2024 with diagnoses that included Fusion of Cervical Spine, Essential Hypertension, and Type 2 Diabetes Mellitus. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/6/24 revealed Resident #169 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. A record review of the Registered Dietitian (RD) Assessment dated 11/13/2024 for Resident #169 revealed, "Nutrition Diagnosis: 1.) Increased energy needs R/T (related to) surgical wounds ...2.) Inadequate energy/protein intake...Interventions: Recommend 1.) Increase protein portions to large at meals TID (three times a day). 2.) 30 mL (milliliters) Liquid protein daily for 30 days." Record review of Resident #169's tray card dated 11/13/24 revealed "Diet Order: CCD/NAS (Consistent Carbohydrate Diet/No Added Salt) High Protein ..."	F 800			
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		12/20/24	

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F 812	Continued From page 3 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility policy reviews, the facility failed to ensure food items were stored in accordance with professional standards for food safety, as related to food items not being labeled and dated for one (1) of two (2) kitchen observations. Findings included: A review of the facility's policy titled, "Food Storage Labeling" with a revision date of 5/18, revealed "The facility will ensure the safety and quality of food by following good storage and labeling procedures. Procedure: 1. Labeling a. All temperature controlled foods and ready to eat foods that are prepared in the facility and held for longer than twenty-four hours will be labeled. Information included on the label: Name of the Food ...Date of storage ... 3. Rotation a. First In, First Out method is used to rotate food in all storage areas ...Identify the food item's use by date or expiration date. Store items with the earliest use-by or expiration date in front of items with later dates ... " On 11/12/2024 at 10:10 AM, during an observation of the initial tour of the kitchen with	F 812	On 11/12/2024, items identified have been removed from service by the Dietary Manager. All residents who receive meals from the dietary department have the potential to be affected by this practice. On 11/14/2024, the Dietary Manager checked all items in the dietary department to ensure all items are labeled and dated. Beginning 11/13/2024, all current and any newly hired dietary staff will receive in-service training on labeling and dating food items by the Dietary Manager to be completed by 12/01/2024. A Quality Assessment and Assurance Committee Meeting was held on 11/25/2024, to review the plan of correction and finalize performance improvement plans. Beginning 12/1/2024, the Dietary Manager will audit food items for proper labeling and dates 3 times a week for 4 weeks then monthly for 3 months to ensure the facility's policy on labeling and dating food items is in place. Any observed issues will be corrected and then forwarded to the		

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F 812	Continued From page 4 the Dietary Manager, several items in the stockroom and kitchen were noted to lack open dates. These items included a six (6) pound container of rainbow sprinkles, a 16-ounce container of red shade pure food color, a 48-ounce container of Real Lemon 100% juice, a one-half (1/2) gallon of buttermilk labeled "Wholesome," a clear container of seasoning salt without a date or item description, and a 32-ounce container of imitation vanilla flavor. All items were open with no open dates on the packages or containers. On 11/13/2024 at 11:47 AM, during an interview, the Dietary Manager explained that staff are required to date all open items in the kitchen. She stated that dating items indicates their shelf life and helps prevent potential outbreaks. She further stated that it is her responsibility to ensure staff adhere to this practice and that she has conducted in-service training on the importance of dating open items.	F 812	Quality Assurance and Improvement Committee for review and follow up beginning 12/20/2024, including any needed corrective actions, continued in-service education or change to current plan for 3 months then quarterly as needed.		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		12/20/24	

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F 880	Continued From page 5 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880			

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F 880	Continued From page 6 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility policy reviews, the facility failed to follow infection control practices by not implementing Enhanced Barrier Precautions (EBP) for a resident at high risk for multidrug-resistant organisms (MDRO) (Resident #3) and failed to practice hand hygiene during care for five (5) of thirteen (13) sampled residents (Residents #3, #11, #68, #70 and #216). Findings included: A review of the facility's policy titled, "Suprapubic Catheter Site Care," revised 01/2024, revealed, "Purpose * To maintain catheter patency. * To keep area clean and prevent infection ... Procedure ... 4. Perform hand hygiene and apply clean gloves ..." A review of the facility's policy titled, "Hand Hygiene," dated 08/21, revealed, "Purpose *To cleanse hands to prevent transmission of infection or other conditions. *To provide clean, health environment for residents, staff and visitors ... Procedure ... Indications for Hand	F 880	On 11/13/2024, an order was received to place Resident #3 on Enhanced Barrier Precautions (EBP). Residents #3, #11, #68, #70 and #216 have been assessed by the Director of Nurses and found to not have any adverse effects from this practice. All residents have the potential to be affected by this practice. On 11/13/2024, an audit was completed by the Assessment Nurse to identify all residents who needed to be placed on Enhanced Barrier Precautions. Four residents were identified and placed on Enhanced Barrier Precautions on 11/13/2024. Beginning 11/14/2024, all current and newly hired staff will be in-serviced on the facility's policy on Enhanced Barrier Precautions and hand hygiene by the Director of Nurses to be completed by 12/1/2024. A Quality Assessment and Assurance Committee Meeting was held on 11/25/2024, to review the plan of		

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F 880	Continued From page 7 Washing ... 3. Before and after procedures. 4. Before and after applying gloves ..." A review of the facility's titled, "Enhanced Barrier Precautions," revised 03/24, revealed, "Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions may involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices) ..." Resident #3 An observation of sacral wound care on 11/13/2024 at 10:31 AM, revealed that during care by Registered Nurse (RN) #1 and the Physical Therapist Assistant (PTA), neither RN #1 nor the PTA donned (put on) a gown prior to providing care. On 11/13/24 at 10:41 AM, during an interview, Registered Nurse (RN) #1 confirmed that neither she nor her assistant wore gowns while providing care. When asked if Resident #3 required EBP, RN #1 stated, "No, we don't have anyone in the facility on that." On 11/13/2024 at 11:20 AM, during an interview, Licensed Practical Nurse (LPN) #2, the Infection Prevention (IP), explained residents are usually placed on contact or isolation precautions for infections, but she had just been informed by RN #1 that EBP included residents with catheters, Percutaneous Endoscopic Gastrostomy (PEG)	F 880	correction and finalize performance improvement plans. Beginning 12/1/2024, the Director of Nurses will audit resident conditions and diagnosis to identify residents who will need to be placed on Enhanced Barrier Precautions and observe hand hygiene 3 times a week for 4 weeks then monthly for 3 months to ensure the facility's policy for Enhanced Barrier Precautions and hand hygiene is being followed. Any observed issues will be corrected and then forwarded to the Quality Assurance and Improvement Committee for review and follow up beginning 12/20/2024, including any needed corrective actions or change to current plan for 3 months then quarterly as needed.		

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F 880	Continued From page 8 tubes, and chronic wounds. She was unable to recall if staff had received training regarding EBPs. On 11/13/2024 at 12:15 PM, during an interview, the Director of Nursing (DON) stated that Resident #3 required the use of EBP, which the facility had not instituted. She explained that anyone performing close contact care with Resident #3 should wear a gown and gloves in accordance with EBP guidelines. She stated that an in-service was conducted by the facility in March when the Centers for Medicare and Medicaid Services (CMS) recommended the use of EBP, and it was her expectation that staff would follow these guidelines. She emphasized that not following them placed residents at increased risk for MDROs. A record review of the "Admission Record" for Resident #3 revealed that the facility admitted the resident on 09/19/24. The resident had admission diagnoses that included Pressure Ulcer of Sacral Region, Stage 2 and Pressure Ulcer of Other Site, Unstageable. Resident #11: On 11/13/24 at 2:48 PM, during an observation of PEG tube site care provided by LPN #1, revealed LPN #1 removed the soiled dressing and proceeded to clean the site. LPN#1 did not remove her soiled gloves, perform hand hygiene, and apply clean gloves before cleaning the site. During an interview on 11/13/24 at 2:55 PM, LPN #1 confirmed that she did not remove her gloves, wash her hands, or apply clean gloves before cleaning the site. She acknowledged her actions	F 880			

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F 880	Continued From page 9 could potentially cause the resident to develop an infection. A record review of Resident #11's "Admission Record" revealed the facility admitted the resident on 09/23/24. The resident had diagnoses that included Parkinsonism, Dementia, and Dysphagia. Resident #68: During an observation of perineal care on 11/12/24 at 11:12 AM, with Certified Nursing Assistant (CNA) #1 revealed CNA #1 entered the room holding one pair of gloves. She did not perform hand hygiene before donning gloves, closing the privacy curtain, adjusting the bed with the remote control, and retrieving a pack of wipes from the dresser. She then proceeded with care without washing her hands. During an interview on 11/12/24 at 11:18 AM, CNA #1 admitted she did not think about washing her hands upon entering the room. She stated she performed hand hygiene in the hallway before entering but confirmed that she did not perform hand hygiene after touching the door, privacy curtains, and bed remote. CNA #1 acknowledged that her actions could result in cross-contamination, potentially causing an infection. A record review of Resident #68's "Admission Record" revealed an admission date of 11/07/24 with diagnoses that included a Urinary Tract Infection (UTI), Nausea and Vomiting, and Encounter for Palliative Care. Resident #70:	F 880			

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F 880	Continued From page 10 During an observation of perineal care on 11/13/24 at 11:03 AM, with CNA #1 revealed CNA #1 entered the room, washed her hands, and donned a pair of gloves. During the care, she retrieved pre-moistened wipes from a container four times, touching the container with soiled gloves. She then placed the container on the resident's bedside table. After cleaning the resident, CNA #1 applied barrier cream to the resident's perineal area and buttocks while wearing the same soiled gloves. She later changed her gloves but did not perform hand hygiene before applying clean gloves. During an interview on 11/13/24 at 11:15 AM, CNA #1 confirmed she had received training and understood that she should not touch objects with dirty gloves and should wash her hands before applying clean gloves. Record review of the "Admission Record" revealed Resident #70 was admitted to the facility on 11/6/24 with diagnoses that included Urinary tract infection and Type 2 Diabetes Mellitus. Resident #216 On 11/13/2024 at 1:21 PM, during an observation, LPN #3 was observed providing suprapubic catheter care for Resident #216. LPN #3 failed to remove or change her gloves during the entire procedure. She removed the soiled dressing, placed it in the biohazard container, cleaned the site, and applied a new dressing while wearing the same gloves. On 11/13/2024 at 1:25 PM, during an interview, LPN #3 confirmed that she did not remove or	F 880			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER CAMELLIA ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 11 change her gloves during the procedure. She acknowledged placing the soiled dressing in the biohazard trashcan in Resident #216's room and then touching the suprapubic catheter site with the same gloves. She agreed this was a break in infection prevention protocol. A record review of the "Admission Record," revealed the facility admitted Resident #216 on 10/30/24. The resident had diagnoses that included Sepsis due to Methicillin-Resistant Staphylococcus Aureus (MRSA). with diagnoses including Sepsis due to methicillin-resistant Staphylococcus aureus (MRSA). On 11/13/2024 at 2:10 PM, during an interview LPN #2/Infection Preventionist (IP) verified staff are expected to follow infection prevention guidelines by changing gloves each time they are soiled and performing hand hygiene before applying new gloves. She stated that failing to do so could increase infection rates in the facility. On 11/13/2024 at 2:21 PM during an interview, the Director of Nursing (DON) stated that her expectation was for staff to clean their hands and change gloves after removing soiled dressings. She further explained that not doing so could increase the risk of infections such as UTIs and other complications due to cross-contamination.	F 880			