STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255280	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELLIA ESTATES	1714 WHITE STREET , MCCOMB, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 02/17/26 through 2/19/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F677, F689, F761, and F880. The facility had a census of 22 and was licensed for 30 beds.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F0656		

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 reverse for further 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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F0656 SS = D	Continued from page 1 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to implement the resident's care plan relating to personal hygiene for one (1) of (13) sample residents. Resident #7. Findings include: A policy review of the facility policy, "The Care Plan Process" revised 12/24 reveals on page 4, "...The facility staff shall follow the care plan...A care plan that is based on a thorough assessment...can provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A well developed and executed assessment and care plan...provide for a resident's highest practical level of well-being... A record review of the “Care Plan Report” with a date initiated of 10/19/2025 revealed “Focus: Resident needs assistance with ADLs…Interventions… Personal Hygiene: The resident needs partial/moderate assistance with personal hygiene…” During an observation and interview on 2/17/26 at 8:38 AM, observed Resident# 7 with very visible long, gray hair on the upper lip, about a quarter to a half inch long, with chin hair of the same length. Resident #7 stated she would like the mustache on her upper lip and chin shaved.	F0656		

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F0656 SS = D	Continued from page 2 On 2/17/26 at 9:56 AM, Certified Nursing Assistant (CNA) #1 assigned to Resident #7, explained that removing the hair from the resident's face is a normal part of Activities of Daily Living (ADL) care of residents who are unable to do it themselves. She added that she had previously completed ADL care on Resident #7 and observed that she had long hair on her chin and upper lip but did not ask whether Resident #7 wanted it removed. She confirmed that the hair is long and appeaeds that it has not been cut in quite a few days. On 2/19/26 at 10:00 AM, in an interview the Director of Nursing (DON) revealed the general consensus is that they offer facial hair removal during ADL care. She indicates doing this is an intricate part of making sure that all the resident's needs are met. A record review of the "Face Sheet" revealed the facility admitted Resident #7 on 5/20/24 with diagnoses that included Hemiplegia and Hemiparesis following other Cerebrovascular Disease affecting the left non-dominant side.A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/25 revealed a Brief Interview for Mental Status (BIMS) score of (15) indicating the resident is cognitively intact.On 2/19/26 at 10:03 AM, in an interview with License Practical Nurse (LPN) #3, who works as the Care Plan nurse, explained that the care plan is designed to show the type of care residents need while they are in the facility. LPN #3 acknowledged that following the care plan is important because it enables staff to properly care for residents in a way that is individualized to their specific needs. She stated that if staff do not follow the care plan, they may not provide proper, individualized care.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to ensure a Resident who is unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming for one (1) of (13) sampled residents. Resident #7.	F0677		

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F0677 SS = D	Continued from page 3 Findings include: A review of the facility policy, "Activities for Daily Living" revised 9/25 revealed, "1. ADLs are to be resident specific...2. ADLs shall include, but are not limited to personal hygiene..." On 2/17/26 at 8:38 AM, during an observation and interview, observed Resident# 7 with very visible long, gray hair on the upper lip, about a quarter to a half inch long, with chin hair of the same length. Resident #7 stated she would like the mustache on her upper lip and chin shaved. During an interview and observation on 2/17/26 at 9:56 AM, Certified Nursing Assistant (CNA) #1 assigned to Resident #7, explained that removing the hair from the resident's face is a normal part of ADL care for residents who are not able to do it themselves. She further stated that she had previously completed ADL care on Resident #7 and observed that she had long hair on her upper lip and chin but did not ask whether Resident #7 wanted it removed. She confirmed that the hair is long and appeared that it has not been cut in quite a few days. In an interview on 2/19/26 10:00 AM, the Director of Nursing (DON) revealed the general consensus is that they offer facial hair removal during ADL care. She indicates doing this is an intricate part of making sure that all the resident's needs are met. A record review of the "Face Sheet" revealed the facility admitted Resident #7 on 5/20/24 with diagnoses that included Hemiplegia and Hemiparesis following other Cerebrovascular Disease affecting the left non-dominant side. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/25 revealed a Brief Interview for Mental Status (BIMS) score of (15) indicating the resident is cognitively intact.	F0677		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689		

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F0689 SS = D	Continued from page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure chemicals were stored properly and secured in accordance with facility policy and regulatory requirements for one (1) of four (4) survey days. Findings included: Record review of the facility policy “Storage of Chemicals” revised 05/18 revealed “…Chemicals are stored in a storage area, designated only for chemicals…” On 02/17/2026 at 6:21 AM, during an observation and interview observed an unattended spray bottle of Virex antiviral disinfectant that was openly accessible on top of a personal protective equipment (PPE) bin on Hall “A.” During an interview at this time, Licensed Practical Nurse (LPN) #1 confirmed the Virex solution was easily accessible to residents and stated it should not be left in the open because ingestion or exposure could result in chemical burns or other harm. She stated the disinfectant was being used due to a flu outbreak and was unsure of the facility’s storage policy for the chemical. On 02/17/2026 at 8:34 AM, during an interview, the Director of Nursing confirmed the Virex solution should have been secured and could have been stored in a drawer when not in use to prevent access by residents.	F0689		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761		

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F0761 SS = E	Continued from page 5 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure medications were stored securely and expired medications were removed in accordance with facility policy and regulatory requirements for one (1) of four (4) survey days. Findings include: A review of the facility policy “Medication Storage” revised 11/2017, revealed “… A lock and key system with suitable protection against theft or access by unauthorized personnel. The locked system shall be secured when not in use by authorized personnel...” A review of the facility’s “Destruction of Unused, Expired or Discontinued Medication” with a revision date of 10/19 revealed “…These will be removed during monthly inspections or any other time as such are found, and will be disposed of according to policy…” On 02/17/2026 at 6:10 AM, during an observation and interview revealed a wound care cart unattended and unlocked on Hall “A.” Licensed Practical Nurse (LPN) #1 confirmed the cart was a wound treatment cart and acknowledged it was unlocked and unattended. A review of the cart’s contents revealed in the top-drawer diclofenac gel, nystatin cream, gentamicin ointment, and moisturizing lotion. The second drawer contained three bottles of wound cleanser, two bottles of hydrogen peroxide, and one bottle of betadine. She stated it is the responsibility of all nurses and staff to ensure medication carts are locked and was unsure who last accessed the cart. On 02/17/2026 at 8:34 AM, during an interview, the	F0761		

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F0761 SS = E	Continued from page 6 Director of Nursing confirmed wound care carts should always be locked when not directly attended by a nurse. She stated failure to secure the cart could result in accidental ingestion, poisoning, or skin and eye irritation. On 02/17/2026 at 10:00 AM, during an observation of the medication storage room refrigerator with LPN #1, twenty-five prefilled influenza vaccine syringes were observed with an expiration date of 05/06/2025. On 02/17/2026 at 10:07 AM, during an interview, LPN #1 stated expired influenza vaccines should have been disposed of upon expiration and that administration of expired medication would not be effective. She stated all nurses are responsible for removing expired medications. On 02/17/2026 at 11:10 AM, during an interview, the Director of Nursing stated the pharmacy consultant informed her on 01/23/2026 to remove expired influenza vaccines. She acknowledged she checked some but not all vaccines in the refrigerator and that expired vaccines should have been disposed of. She confirmed that administration of an expired influenza vaccine may not be effective and could increase residents' risk of developing influenza and related complications, including pneumonia and other respiratory conditions.	F0761		
F0880 SS = E	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: §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	F0880		

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F0880 SS = E	Continued from page 7 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. §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	F0880		

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F0880 SS = E	Continued from page 8 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement infection prevention and control practices for three (3) of five (5) residents reviewed (Resident #2, Resident #6, and Resident #11). Findings include: A record review of the facility policy “Procedure for isolation Status “revised August 2021 revealed "… 2. In addition to Standard Precautions, use Droplet Precautions for a resident known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident sneezing, coughing, talking, etc. and drop from the air...” A record review of the facility policy “Hand Hygiene Policy” revised August 2021 revealed “…2. Hand hygiene should be performed between all contact with residents or when entering and exiting a resident's room...” A record review of the facility policy "Procedure for Isolation Status", revised August 2021, revealed, "...Check room for hygiene supplies, toiletries, handwashing soap, paper towels, and any other equipment that is to be dedicated to that resident’s care..." Resident #2 On 02/18/2026 at 12:10 PM, Licensed Practical Nurse (LPN) #2 was observed performing percutaneous endoscopic gastrostomy (PEG) tube site care for Resident #2, who was on droplet isolation precautions for influenza. After completing care, the nurse used a permanent marker with her bare hand to mark the dressing. While holding the marker, she removed the barrier from the bedside table with bare hands and placed it into a biohazard bag. She then carried the marker out of the room, placed it on the medication cart, and then into her scrub pocket without disinfecting it. On 02/18/2026 at 12:13 PM, during an interview, the Director of Nursing (DON) stated the marker should have been left in the room, discarded, or disinfected. She stated placing the marker on the cart and in a scrub pocket after contact with contaminated materials was not appropriate due to the risk of spreading influenza. On 02/19/2026 at 11:51 AM, during an interview, LPN #2	F0880		

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F0880 SS = E	Continued from page 9 confirmed she held the marker while discarding contaminated items and placed it on the cart and into her pocket before performing hand hygiene. She acknowledged the DON instructed her to discard it. A record review of Resident #2's "Face Sheet" revealed an admission date of 12/16/25 with diagnoses that included cerebral infarction. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) o12/22/25 a Brief Interview for Mental Status (BIMS) summary score of 12 indicating Resident #2 had moderate cognitive impairment. A record review of Resident #2's "Order Summary Report" with active orders as of 2/18/26 revealed an order dated12/17/25 "PEG tube site care: Remove dressing clean with normal saline dry with 4x4 gauze. Apply clean dry split gauze to abdomen, secure with tape. To be performed daily and prn if saturated. Monitor for s/s (signs/symptoms) of irritation or infection every day shift for peg tube related to gastrostomy status. Resident #6 On 02/18/2026 at 8:48 AM, LPN #2 was observed preparing and administering Empagliflozin 10 milligrams (mg) and Aspirin 81 mg to Resident #6. After determining the medications needed to be crushed, she removed the aspirin from the medication cup using her bare, ungloved hand. She crushed the Empagliflozin and administered it in yogurt. During medication administration, she used her bare hands to touch the resident's tray, glass, and patted the resident on the back. She returned to the medication cart and began charting on the laptop without performing hand hygiene between resident contact and touching the medication cart and computer. On 02/18/2026 at 8:52 AM, during an interview, LPN #2 acknowledged she should not have touched the medication with bare hands and should have performed hand hygiene after contact with resident items before returning to the medication cart to prevent spread of infection, particularly during a flu outbreak. On 02/18/2026 at 10:05 AM, during an interview, the DON confirmed staff should never touch medications with bare hands and must perform hand hygiene when exiting resident rooms to prevent infection transmission. A record review of Resident #6's "Face Sheet" revealed an admission date of 1/20/26 with diagnoses that	F0880		

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F0880 SS = E	Continued from page 10 included acute respiratory failure with hypoxia. A record review of Resident #6's MDS with an ARD of 1/26/26 revealed a BIMS score of 14 which indicated the resident was cognitively intact. A record review of Resident # 6's February 2026 Medication Administration Record (MAR) revealed Empagliflozin 10mg 1 tablet by mouth was initialed by staff as given on 2/18/26. A record review of Resident #6's "Order Summary Report" revealed an order dated 1/21/26 for Empagliflozin Oral Tablet 10 MG. Give 1 tablet by mouth one time a day for DMII (Type 2 diabetes mellitus without complications). Resident #11 On 02/17/2026 at 8:20 AM, the State Agency (SA) observed Certified Nursing Assistant (CNA) #2 enter Resident #11's room, which had a droplet precautions sign posted indicating influenza. CNA #2 entered wearing only a mask and did not don (put on) a gown or gloves. The door remained open throughout the care provided. CNA #2 carried a non-disposable breakfast tray into the room and used her bare hands to hand juice, milk, and food items to the resident. She also used her bare hands to adjust the resident's bed linens. After exiting the room, CNA #2 proceeded to another resident's room without performing hand hygiene. On 02/17/2026 at 8:25 AM, during an interview, CNA #2 confirmed the sign indicated the resident had the flu but stated she was new to the hall and unaware of the resident's diagnosis. When asked about infection control breaches, she was unable to initially identify them. Upon further questioning, she acknowledged she should have worn gown and gloves, closed the door, and performed hand hygiene after exiting the room to prevent the spread of infection. On 02/18/2026 at 10:00 AM, during an interview, the DON stated that droplet precaution signage must be followed. She confirmed gown and gloves should have been worn and hand hygiene performed after exiting the room to prevent spreading influenza. A record review of Resident #11's "Order Summary Report" with active orders as of 2/18/26 revealed an order dated 2/16/26 "Strict isolation for droplet precautions… mask… related to influenza…All services provided in room…related to Influenza virus…"	F0880		

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CAMELLIA ESTATES	**1714 WHITE STREET , MCCOMB, Mississippi, 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
F0880 SS = E	Continued from page 11 A record review of Resident #11's “Face Sheet” revealed the resident was admitted 1/15/26 with diagnoses that included fracture left femur neck. A record review of resident # 11's MDS with an ARD of 1/21/26 revealed a BIMS score that was unable to be determined mental status due to being unable to be understood by staff members.	F0880		