

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

PRINTED: 07/27/2021
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 C 07/01/2021
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 a complaint survey, CI MS #17364, CI MS #16993, CI MS #16942, and CI MS#16726 at the facility from 6/28/21 to 7/1/21. During the survey, the SA determined that the facility was in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate MS #17364 complaint of responsible party not notified and neglect and abuse, The SA unsubstantiated MS #16993, complaint on neglect and quality of care. The SA unsubstantiated MS #16942 responsible party not notified, and pressure precautions not taken. The SA did not substantiate MS #16726, responsible party not being notified, pressure sore prevention not taken by the facility and resident not being turned. The census at the time of the survey was 20 and the facility held a license for 30 beds.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.