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 _____	01/30/2020

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 re-certification survey at the facility from 01/28/2020 to 01/30/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited deficiencies at F657, F761 and F812. The census at time of survey was 24, and the facility was certified for 30 beds.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		3/13/20

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

Electronically Signed | 03/13/2020

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.

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 _____	01/30/2020

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 657	Continued From page 1 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed to revise a care plan related to hospice for one (1) of 13 resident care plans reviewed, Resident #5. Findings include: A review of the facility's "Care Plan Process" policy, revised 08/2017, revealed, the care plan must be reviewed and revised on an ongoing basis to reflect the services provided or arranged. A review of Resident #5's comprehensive care plan, revealed a problem that addressed hospice services, with an onset date 06/03/2016, and a goal/target date of 03/05/2020. Review of Resident #5's electronic record, revealed the physician's order for hospice services was discontinued on 01/22/2020. During an interview, on 01/28/2020 at 2:16 PM, Resident # 5 stated she was no longer on hospice services. An interview on 1/28/2020 at 3:05 PM, with the Administrator, revealed Resident #5 had to be discharged from hospice related to long term admission, and she was no longer a candidate for hospice services. An interview on 01/30/2020 at 11:13 AM, with	F 657	The care plan for Resident #5 has been updated to address hospice services ending 1/28/2020, by our Licensed Practical Nurse Medicare Case Manager on 1/30/2020. Residents receiving hospice services has the potential to be affected. Staff completing care plans have been in-serviced on 2/1/2020, by the Director of Nurses, on the care plan process policy including updating comprehensive care plans. The Director of Nurses will audit weekly beginning 2/3/2020, to ensure that residents with hospice care plans are up to date 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 for review any needed corrective actions or change to the current plan at least quarterly.	

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 _____	01/30/2020

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 657	Continued From page 2 Licensed Practical Nurse (LPN) #1/Minimum Data Nurse (MDS)/Care Plan Nurse, revealed, she was aware of Resident # 5's discharge from hospice because she had consulted with the Hospice Nurse on the day of discharge. LPN #1 confirmed Resident #5's care plan had not been updated or removed related to hospice services, but she was "working on that today." LPN #1 stated the policy of the facility was to update the care plan as soon as possible by entering the changes in the computer and printing out a copy for the chart. LPN #1 also stated it was important to keep the care plans updated because that was what the staff used to care for the residents.	F 657		
F 761 SS=D	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 §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	F 761		3/13/20

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 _____	01/30/2020

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 761	Continued From page 3 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, staff interview, record review, and facility policy review, the failed to ensure an expired medication was removed from the medication stock, for one (1) of three (3) medication storage areas observed. Findings include: Review of the facility's "Destruction of Unused, Expired or Discontinued Medications" policy, dated 10/2019, revealed: "All outdated, discontinued and/or recalled drugs, and all containers with illegible or no labels will be given to the Director of Nursing (DON) for proper disposition. These will be removed during monthly inspections or any other time as such are found, and will be disposed of according to policy, at least quarterly." On 01/29/2020 at 10:00 AM, during an interview and observation of the medication storage room, Licensed Practical Nurse (LPN) #3 revealed a bottle of Calcium 600 milligrams (mg)/Vitamin D, 400 tablets, with an expiration date of 07/2019. LPN #3 stated the medication should have been pulled and destroyed. The LPN #3 revealed the expired medication could cause harm to the resident, if it was given. During an interview, on 01/30/2020 at 12:58 PM, the Director of Nursing (DON) revealed the expired medications should have been pulled,	F 761	The bottle of Calcium + Vitamin D was removed ay the Director of Nurses on 1/30/2020. Residents with a physician's order for Calcium + Vitamin D has the potential to be affected. The nursing staff have been in-serviced on 2/1/2020 thru 2/11/2020, by the Director of Nurses on our policy for Medication Storage including storage of expired medications. The Director of Nurses will round weekly beginning 2/3/2020, for expired medications in the medication storage room for four weeks then monthly for two months. Any observed issues will be corrected and then forwarded to the Quality Assurance and Improvement Committee for review any needed corrective actions or change to the current plan at least quarterly.	

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 _____	01/30/2020

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 761	Continued From page 4 destroyed, and reordered. The DON stated the expired medication may not work effectively if it is out of date. The DON revealed she checks the medication stock rooms monthly or bi-monthly. The DON stated, "I missed it."	F 761		
F 812 SS=F	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 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 observation, record review, staff interview and facility policy review the facility failed to ensure the milk and ice cream cooler were kept in a clean and sanitary condition, for two (2) of four (4) kitchen observations. Findings include: A review of the facility's "Sanitation Check List"	F 812	The thermostat on the milk cooler was adjusted by the maintenance supervisor on 1/29/2020. The ice cream freezer was cleaned on 1/29/2020, and later replaced with a new unit on 2/11/2020. All residents who receive ice cream or milk has the potential to be affected.	3/13/20

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 _____	01/30/2020

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 812	Continued From page 5 policy, dated 09/2004, revealed: "The sanitation checklist shall be used as a part of an ongoing program designed to ensure sanitary conditions and to correct an sanitation deficiencies found in the food service department." The sanitation check of the food service department of the storage areas would be done at least monthly by the Dietary Manager or Dietician which would included the refrigerators and freezers. Review of the facility's "Cleaning Instructions Milk Cooler" policy, dated 09/2004, revealed: "POLICY: Equipment shall be maintained in a clean and sanitary condition." A review of the facility's "Sanitary Conditions of the Food Service Department" policy, dated 09/2004, revealed, the dietary manager would develop a master cleaning schedule to include what, when, who, and how the equipment in the kitchen would be cleaned. An observation, on 01/28/2020 at 10:30 AM, during the initial tour of the kitchen, revealed,. the ice cream freezer had frost and ice inside on all four (4) walls with a temperature of 32 degrees Fahrenheit (F). The ice cream freezer also had water accumulated on the plexi-glass doors. The milk cooler's thermometer was at a temperature 32 degrees (F), with several of the milk cartons frozen. The milk cooler had accumulated ice and frost on all four (4) walls inside the cooler. The top inside of the cooler had clear water droplets that had frozen. During an observation of the kitchen, on 01/29/2020 at 11:31 AM, the milk cooler temperature measured at 28 degrees (F). The milk cooler still had ice and frost accumulation on	F 812	Employees responsible for cleaning the milk cooler and ice cream freezer have been in-serviced by the Dietary Manager on 1/29/2020, on our policy for cleaning and sanitizing the ice cream freezer and milk cooler. The Dietary Manager will round weekly beginning 1/31/2020, to ensure that there is not any ice build up on the milk cooler and no condensation on the ice cream freezer 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 for review any needed corrective actions or change to the current plan at least quarterly.	

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 _____	01/30/2020

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 812	Continued From page 6 all four sides, and the top noted with frozen water droplets hanging down. Ice and frost accumulation was also still present in the ice cream freezer, and present on several ice cream cartons. The ice cream freezer temperature measured at 28 degrees (F). During an interview with the Dietary Manager (DM), on 01/29/2020 at 11:25 AM, DM revealed there were schedules in place for monthly defrosting of ice and frost build up in coolers/freezers. The DM revealed there was the ice and frost build up in the ice cream and milk coolers, and frozen water droplets hanging in the milk cooler. The DM could not produce any documentation to indicate when the milk cooler and ice cream freezer had been defrosted or cleaned.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255280	A. BUILDING **01 - "A" & "F" WINGS** B. WING _____	**02/05/2020**

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
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		

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

Electronically Signed | 03/04/2020

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.

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 _____	02/05/2020

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
E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/5/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 03/04/2020

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.