

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
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 02/19/2026
NAME OF PROVIDER OR SUPPLIER Camellia Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 1714 White Street McComb, MS 39648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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.		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 #2On 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 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) 012/22/25 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 dated 12/17/25 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 #6On 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 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 #11On 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.A record review of Resident #11's Face Sheet revealed the resident was admitted [DATE] 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.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 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. 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 appeared 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.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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. 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.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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.		