STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255233	A. BUILDING _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA GARDENS NURSING CENTER	530 HALL ST WIGGINS, MS 39577

(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 3/03/2025 through 03/06/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F732 , F812, and F880. The facility had a census of 63 and was licensed for 99 beds.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		4/10/25

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

Electronically Signed | 03/19/2025

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F 732	Continued From page 1 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to post the daily nursing staffing hours in a location readily accessible to residents and visitors and failed to update the posted staffing for three (3) of four (4) days of survey. This deficient practice had the potential to affect all 63 residents residing in the facility. Findings included: A review of the facility's "Nurse Staffing Posting Information Policy," dated 10/2023, revealed, " ...It is the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines 1. The nurse staffing information will be posted on a daily basis ...2. The facility will post the nurse staffing data at the beginning of each shift. 3. The information posted will be presented a. Presented in a clear and readable format. B. In a prominent place readily accessible to residents and visitors ..." A record review of the facility's posted staffing	F 732	1.On 3/5/2025 the daily staffing information was updated to reflect current nurse staffing information and moved to a more central, prominent location close to the front entrance assessable to residents and visitors. 2.All residents have the potential to be affected. 3.The Director of Nursing (DON) was in-serviced by the Administrator on the Nurse Staffing Posting Information Policy, on 3/5/2025, to include maintaining staffing sheets with the following information: facility name, date, census, the total number of actual hours worked by licensed nursing staff directly responsible for resident care. 4.Beginning 3/10/2025 the Administrator began daily auditing the accuracy and location of daily staffing information for a minimum of five, (5) days a week for four, (4) weeks then will audit two, (2) times a week for four, (4) weeks. The audit results	

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F 732	Continued From page 2 information revealed that the last update was on 03/03/2025. On 03/03/2025 at 10:00 AM, during an observation, the staffing information was located at the back of the facility near the vending machines. No residents or family members were observed near the area. This location was identified as the staff entryway, not a central location accessible to residents or visitors. On 03/04/2025 at 9:55 AM, during an observation, the staffing information posted was dated 03/03/2025 and was not updated with current information. The posted form remained near the back door of the facility where there were no residents or family members observed. On 03/04/2025 at 1:00 PM, during an interview with a family member of Resident #11, she stated that she had not seen the staffing information posted and did not know where it was located. On 03/05/2025 at 3:15 PM, during an observation conducted with Licensed Practical Nurse (LPN) #1, the staffing information remained posted at the back door near the vending machines and was still dated 03/03/2025. No residents or family members were observed in the area. On 03/05/2025 at 3:45 PM, during an interview, the Director of Nursing (DON) and Administrator confirmed that the staffing information had not been updated since Monday, 03/03/2025. The DON acknowledged that she had gotten sidetracked and forgot to update the staffing information. The Administrator stated that she believed family members and residents frequently visited the back area to get drinks and snacks	F 732	will be brought to the monthly Quality Assessment and Assurance (QAA) Committee meeting on 4/10/2025 for review and recommendations and will be taken to the QAA Committee for two (2) months.	

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F 732	Continued From page 3 from the vending machines. However, both the Administrator and the DON later confirmed that the staffing information was not centrally located, and that residents and family members typically did not enter through this door, as it was primarily used as a staff entrance.	F 732		
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, staff interview, and facility policy review, the facility failed to use hand hygiene, discard overly ripe produce, and failed to calibrate a food thermometer prior to checking food temperatures, for two (2) of two (2) kitchen observations. Findings included:	F 812	1.On 3/3/2025 the Certified Dietary Manager (CDM) completed inspection of all food items in the pantry and discarded 7 sweet potatoes, 1 onion, and an opened bag of raisins. No other potentially compromised food items were identified. The CDM was in serviced by the Registered Dietician (RD) on the Food	4/10/25

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F 812	Continued From page 4 A review of the facility's "Food Safety Policy," dated November 2023, revealed, "Food will... be stored, prepared... with professional standards for food service safety. Policy Guidelines 1. Food safety practices shall be followed throughout the facility's entire food handing process ...Elements of the process include the following ...b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from the growth of microorganisms... 3. Facility shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage ...7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. a. Staff shall wash hands according to facility procedures ..." A review of the facility's "Record of Food Temperatures Policy," dated November 2023, revealed, " ...It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled ...Policy Guidelines ...14. Food temperatures will be verified using a thermometer which is... calibrated to ensure accuracy..." On 03/03/2025 at 10:17 AM, during an observation of the kitchen and an interview with the Certified Dietary Manager (CDM), seven (7) sweet potatoes and one (1) onion with soft spots and white biological growth were observed in the pantry. Additionally, a bag of raisins was found open and exposed. Dietary Aide (DA) #2 was observed placing cartons of juice in the refrigerator and retrieved a plastic drink lid from the floor, discarded it, and continued placing five (5) juice cartons into the refrigerator without	F 812	Safety Policy on 3/3/2025. On 3/3/2025, dietary aide #2 was in serviced on Handwashing Guidelines for Dietary Employees Policy by the CDM. On 3/4/2025, the Cook was in serviced, by the CDM on how to calibrate a thermometer to ensure the Record of Food Temperature Policy is being followed correctly. All thermometers were calibrated at this time by CDM. 2.All residents who receive food from dietary department have the potential to be affected. 3.On 3/3/2025 the CDM in serviced all dietary staff on the Food Safety Policy. On 3/3/2025 the CDM in serviced all dietary staff on the Handwashing Guidelines for Dietary Employees. A demonstration was performed by the Infection Prevention (IP) and return demonstrations of all dietary staff was conducted at this time. The CDM and Assistant Dietary Manager (ADM) in serviced all dietary staff on how to calibrate a thermometer with a visual demonstration and staff return demonstrations on 3/4/2025. The facility keeps a food temperature log each shift and checks the thermometer is at 32 degrees before each temperature check. The staff will recalibrate the thermometer as needed. 4.3/10/2025 the CDM or ADM began inspecting all received pantry goods, pantry temperatures and the pantry for properly stored foods and fresh produce	

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F 812	Continued From page 5 washing her hands. The CDM acknowledged that the staff member should have performed hand hygiene after retrieving the plastic drink lid from the floor and confirmed the presence of overly ripe produce and opened and exposed food items in the pantry. The CDM further stated that she and the Assistant Dietary Manager (ADM) were the only staff responsible for selecting produce from storage for the food preparation area, ensuring that no staff member would have mistakenly used the overly ripe produce. On 03/03/2025 at 10:30 AM, during an interview, DA #2 confirmed that she retrieved the plastic drink lid from the floor and continued handling food items without performing hand hygiene. She acknowledged that she should have stopped and washed her hands before continuing food preparation. The Dietary Aide stated that staff receive monthly in-service training on infection control. On 03/04/2025 at 11:00 AM, during an observation of the meal tray line and an interview the Cook was unable to explain how to properly calibrate a food thermometer before checking and recording food temperatures. The Cook stated that the thermometer should be calibrated to 22 degrees but did not use ice to calibrate the thermometer, despite the ADM providing ice for the process. The Cook acknowledged that she failed to properly calibrate the thermometer and stated that she was nervous. The Cook further stated that she normally would have calibrated the food thermometer using ice. On 03/04/2025 at 11:20 AM, during an interview with the ADM, she confirmed that the Cook should have properly calibrated the food	F 812	that may need discarded three, (3) days a week for four, (4) weeks. Beginning on April 7, 2025 the RD or Administrator will perform audits of the food storage areas one time a week for four, (4) weeks. The audit results will be brought to the monthly Quality Assessment and Assurance (QAA) Committee meeting on 4/10/2025 for review and recommendations and will be taken to the QAA Committee for two (2) months. Beginning on 3/10/2025 the IP observed dietary staff handwashing and return demonstrations as needed for two, (2) times a week for four, (4) weeks then will audit one (1) time a week for four (4) weeks. The audit results will be brought to the monthly QAA Committee meeting on 4/10/25 for review and recommendations and will be taken to the QAA Committee for two (2) months. On 3/10/2025 the CDM and or the ADM began performing checks of food temperatures and thermometer calibration as needed by dietary staff two, (2) times a week for four, (4) weeks then will audit one (1) time a week for four (4) weeks. The audit results will be brought to the monthly QAA Committee meeting on 4/10/25 for review and recommendations and will be taken to QAA Committee for two (2) months.	

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F 812	Continued From page 6 thermometer before use, which was why she had placed ice near her. The ADM emphasized the importance of ensuring thermometer accuracy to obtain correct food temperature readings. The ADM stated that her expectation was that all staff would correctly calibrate thermometers before use. The ADM also stated that staff receive monthly in-service training on infection control. On 03/06/2025 at 10:24 AM, during an interview, the Administrator acknowledged that she was aware of the presence of overly ripe and opened and exposed food items in the pantry, the Dietary Aide's failure to use hand hygiene after retrieving an item from the floor, and the Cook's failure to calibrate the food thermometer. The Administrator stated that she expected staff to correctly monitor food temperatures for safety reasons and to ensure that food items were not stored in a deteriorated state. The Administrator confirmed that staff were expected to follow appropriate handwashing procedures to maintain food safety.	F 812		
F 880 SS=D	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		4/10/25

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F 880	Continued From page 7 §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 8 §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 observation, staff interview, record review, and facility policy review, the facility failed to ensure a nurse performed hand hygiene, changed gloves, and discarded a feeding tube syringe after it was dropped onto the floor during a medication administration observation for one (1) of three (3) residents reviewed for medication administration. (Resident #31) Findings included: A review of the facility's "Infection Prevention and Control Program Policy," dated February 2024, revealed, " ...The facility has established and maintains 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 as per accepted national standards and guidelines. Policy Guidelines ...d. Standard Precautions ...b. Hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures ...d. Licensed staff shall adhere to safe injection and medication administration practices, as described	F 880	1.On 3/4/2025, Licensed Practical Nurse,(LPN)#2 was in serviced on the Infection Prevention and Control Program and Policy by Infection Preventionist, IP. 2.All residents with a feeding tube has the potential to be affected. 3.The IP in serviced all nurses, on 3/4/2025, on the Infection Prevention and Control Program and Policy to ensure accuracy with hand hygiene, handling of clean and dirty materials and disposal of contaminated gloves that are outlined in the Infection Prevention and Control Program and Policy. 4.On 3/10/2025 the IP began observing hand hygiene and infection control measures used when handling clean and dirty supplies and return staff demonstrations for hand hygiene two, (2) times a week for a period of four, (4) weeks then will audit one (1) time a week for four (4) weeks. The audit results will	

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F 880	Continued From page 9 in relevant facility policies ...p. Staff Education ...a. Facility staff receive training relevant to their specific roles and responsibilities regarding the facility's infection prevention and control program, including policies and procedures related to their job function ..." A record review of the facility's "In-Service Attendance Record," dated 01/13/2025, 01/14/2025, and 01/17/2025, revealed that staff receiving training related to "Infection Control Principles", including "importance of hand hygiene ..." On 03/04/2025 at 8:16 AM, during a medication administration observation for Resident #31, Licensed Practical Nurse (LPN) #2, while wearing gloves, retrieved the Percutaneous Endoscopic Gastrostomy (peg) tube syringe, which fell to the floor. LPN #2 picked up the syringe and proceeded to administer medications via the resident's peg tube without discarding the contaminated syringe, performing hand hygiene, or changing her gloves. On 03/05/2025 at 8:20 AM, during an interview, LPN #2 confirmed she failed to change gloves, wash hands, or use a new syringe. LPN #2 stated the resident could develop an infection from using contaminated gloves and syringe. She explained that she should have removed the gloves, sanitized her hands, and used a new syringe. LPN #2 stated she was nervous and was not thinking clearly. On 03/05/2025 at 1:00 PM, during an interview, the Director of Nursing (DON) stated that LPN #2 should have changed her gloves, sanitized her hands, and used a new syringe to prevent the	F 880	be brought to the monthly Quality Assessment and Assurance (QAA) Committee meeting on 4/10/2025 for review and recommendations and will be taken to the QAA Committee for two (2) months.	

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F 880	Continued From page 10	F 880		

resident from developing an infection.

On 03/06/2025 at 1:41 PM, during an interview, Registered Nurse (RN)#2/Infection Preventionist stated that the nurse should have changed her gloves, sanitized her hands, and used a new syringe. RN #2 also confirmed that LPN #2 had been trained regarding infection control practices.

On 03/06/2025 at 1:43 PM, during an interview, the Administrator stated that she expects staff to follow infection control policies to prevent residents from acquiring infections.

A record review of Resident #31's "Admission Record" revealed the facility admitted the resident on 01/10/2024 with diagnoses including Unspecified Dementia.

A record review of Resident #31's Significant Change In Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/2024 revealed he had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired.