MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey from 11/25/19 to 11/27/19. The SA determined the facility was not in compliance with the State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M500 and M615. The census at the time of the survey was 78. The facility had a license for 99 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		12/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 500	Continued From page 1 participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 500	Continued From page 2	M 500		

responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 500	Continued From page 3 documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on resident and staff interviews, record review, and policy review, the facility failed to assist three (3) of six (6) residents in Resident Council Group Meeting, who wanted to vote in the General election on 11/6/2019; Resident #20, #44	M 500	1. Resident #20,#44 and #54 were made aware of their right to vote and the facilities plan to ensure they can exercise their right to vote on 12/3/2019 by the Social Services Director. 2.All residents who wish to vote have the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 500	Continued From page 4 and #54. The facility also failed to honor the resident's wishes and physician's orders regarding code status for one (1) of 20 resident records reviewed, Resident #74. Findings include: Review of the facility's "Residents Right to Vote" policy, dated 9/18, revealed: Prior to an election, the Social Worker, Social Service designee, or assigned staff member should identify the residents who choose to vote, and identify the residents who need to register. During an interview, with the residents at a group meeting, on 11/25/19 at 3:00 PM, Resident #20, #44 and #54, stated they did not get to vote in the general election, and expressed the desire to vote. Review of the most recent Minimum Data Set (MDS) assessments, revealed, Resident # 20, Resident #44 and Resident #54 had Brief Mental Status (BIMS) scores of 15, which indicated no cognitive impairment. During an interview, on 11/25/19 at 3:25 PM, the Social Worker stated Resident #20, #44 and #54 did not indicate to her they wanted to vote. Resident #74 Review of the facility's "Advance Directives Policy", dated 11/18, revealed: The advance directives will be respected in accordance with state law and facility policy. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. A resident will not be treated against his or her own wishes. The facility's Do Not Resuscitate (DNR) definition	M 500	potential to be affected. 3. A resident council meeting was held with the Social Services Director on 12/3/2019 to discuss the facilities policy and procedure to accommodate residents who wish to exercise their right to vote during an election. The following policies and procedures were discussed by the Social Services Director during the resident council meeting on 12/3/2019. The Social Services Director will establish and maintain a list of all residents who have expressed the desire to vote in upcoming elections. Each resident will be approached prior to the election and it will be documented in the medical record if they wish to exercise their right to vote in any upcoming elections. The Social Services Director will post in writing a notice of upcoming elections in a highly visible area. The Social Services Director will also post upcoming elections on the information monitors. All policies and procedures discussed during the resident council meeting held on 12/3/2019 are effective as of 12/3/2019. 4.The Social Services Director will report monthly to the Quality Assurance committee and Quality Assurance Performance Improvement program committee on the residents right to vote and any updates to the list of residents that wish to exercise their right to vote. This will be monitored and reported to each committee until 12/01/2020 for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 500	Continued From page 5 indicated in case of respiratory or cardiac failure, the resident, legal guardian. health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life sustaining treatments or methods are to be used. Review of the physicians orders and "Advance Care Planning" document, dated 5/9/18, revealed the resident/representative chose a DNR code status. Review of Nurses Notes, dated 10/6/19 at 9:18 PM, revealed Resident #74 was found unresponsive and without a pulse. Resident #74 was assisted to the floor, and CPR was initiated per nurse. The nurses notes documented 911 was called at 7:30 PM. The fire department arrived at 7:35 PM, and CPR ceased at that time. Resident #74 was pronounced at 7:42 PM. The nurses notes revealed the resident was resuscitated for five (5) minutes, prior to the fire department's arrival. During an interview, on 11/26/19 at 4:44 PM, Firefighter #1 stated he responded to the call the night Resident #74 died. Firefighter #1 said the Chief got the medical records and confirmed Resident #74 was a DNR code status and CPR was discontinued. During an interview, on 11/26/19 at 5:52 PM, the Director of Nursing (DON) confirmed the Charge Nurse found Resident #74 unresponsive, without a pulse, and initiated CPR. The DON said CPR ceased after they found out Resident #74 was a DNR code status.	M 500		
M 615	45.21.3 Pressure sores	M 615		12/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 615	Continued From page 6 Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level III Based on observation, staff interview, record review, and facility policy review, the facility failed to assist the resident for pain at time of treatment for one (1) of three (3) pressure ulcers observed, Resident #22. Resident #22 cried out in pain during wound care treatment, without the nurse assessing and/or providing pain management prior to continuing the wound care. Findings include: Review of the facility's "Wound Treatment Management Policy", dated 11/18, revealed: the policy is to promote wound healing of various types of wound, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Characteristics of the wound, includes the pressure ulcer stage, size, and presence of pain. During an observation of Resident #22's wound care, and interview with Registered Nurse (RN) #1, on 11/26/2019 at 9:00 AM, revealed the resident lying in bed on her right side, with no obvious signs of pain or distress. Resident #22 cried out "OWWW", and drawed her left leg up towards her chest, during the wound care performed by RN #1. RN #1 stated she had not	M 615	1. On 11/26/2019 at 9:00 am resident #22 received wound care treatment. During observation of Resident #22's wound care treatment the wound care nurse failed to assist the resident for pain at the time of treatment. Resident #22 was assessed for pain during wound care on 11/26/2019 at 9:00 am by registered nurse. Physician was notified of pain and discomfort during wound care treatment and an order was given by the physician to medicate resident thirty minutes to one hour prior to wound care. Registered nurse was in-serviced regarding pain management before and during wound care on 11/26/2019 by director nursing. All residents with wound treatments were evaluated for potential pain associated with wound care on 11/27/2019 by registered nurse. 2.All residents have the potential to be effected. 3.All nurses were in-serviced on pain management related to wound care and treatments on 11/27/2019 by the director of nursing. All residents with wound treatments were evaluated for potential pain associated with wound care on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 615	Continued From page 7 given Resident #22 pain medication prior to wound care. RN #1 continued to clean Resident #22's wound with normal saline, measured the wound, washed her hands, applied gloves, and cleaned the wound again. Resident #22 cried out "OWWW" a second time. RN #1 applied Sure Prep to the wound edges, Santyl to the wound bed, covered the wound with foam dressing, and wrapped it with Kerlix. At no time during the wound care process, was Resident #22 offered pain medication, nor did the nurse discontinue treatment when the resident cried out. Review of Resident #22's physicians orders, dated 9/16/19, revealed an order for Ultram 50 milligrams (mg) one (1) every six (6) hours as needed for pain. During an interview, on 11/26/19 at 10:00 AM, Certified Nursing Assistant (CNA) #1 confirmed Resident #22 only complains of pain when the nurses do her wound care. During an interview, on 11/26/19 at 11:00 AM, RN #1 confirmed Resident #22 did not receive pain medication, prior to wound care to the left heel. RN #1 stated Resident #22 normally does not complain of pain. RN #1 confirmed she should have stopped the treatment when the resident complained of pain. RN #1 stated she thought the State Agency (SA) would have a problem with her stopping the treatment. During an interview, on 11/26/19 at 5:58 PM, the Director of Nursing (DON) stated residents are assessed prior to wound care treatments. The DON stated, "I would have stopped as soon as the resident cried out in pain during the wound treatment and got her some pain medication."	M 615	11/27/2019 by a registered nurse. An assessment tab has been added to the treatment log on 12/24/2019 to document potential pain prior to and during wound treatment by the assistant director of nursing. All nurses were in-serviced by the assistant director of nursing completed on 12/24/2019 implementing the pain assessment tab. 4. Wound care observations will be conducted weekly by the director of nursing to ensure potential pain during wound treatment is being properly assessed. The director of nursing will randomly select and monitor wound treatments effective 11/27/2019 weekly for six weeks and as needed. Resident wound care and treatment plan will be discussed weekly during the interdisciplinary team care plan meeting. Results will be reported monthly to the Quality Assurance and Quality Performance Improvement Program committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66AG	A. BUILDING: _____ B. WING _____	11/27/2019

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) COMPLETE DATE
M 615	Continued From page 8 A review of Resident #22's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/19, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident is cognitively impaired.	M 615		