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 _____	C 09/06/2020

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	F 000		

The State Agency (SA) conducted a COVID-19 Focus Infection Control Survey, along with Complaint Investigation (CI) MS #16992 on 09/01/2020 through 09/06/2020. The COVID-19 survey was found to be in compliance with 42 CFR: 483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices; however, the facility was not in substantial compliance related to CI MS #16992, which involved a choking incident which resulted in the death of Resident #1.

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), that began on 09/02/2020, when the facility failed to provide Resident #1, who was a known choking risk, supervision during food consumption which resulted in Resident #1 choking, aspirating, and expiring.

The failure to supervise Resident #1 during food consumption, caused the death of Resident #1 and placed other residents, who are at risk for choking, in a situation which could potentially cause serious injury, harm, impairment, and death.

On 09/02/2020 at 12:30 PM, the SA notified the facility's Administrator of the IJ and SQC.

The IJ and SQC existed at:

42 CFR(s): 483.12(a)(1) - Freedom from Abuse, Neglect (F600)

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

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 _____	C 09/06/2020

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	Continued From page 1 42 CFR(s): 483.21(b)(1) - Care Plan Timing and Revision (F657) 42 CFR(s): 483.25(d)(1)(2) - Free of Accidents/Hazards/Supervision/Devices (F689) 42 CFR(s): 483.35(a)(1)(2) - Sufficient Nursing Staffing (F725) 42 CFR(s): 483.75 (g)(2) - QAPI/QAA Improvement Activities (F867) The facility submitted an Acceptable Removal Plan on 09/05/2020, in which the facility alleged all corrective actions were completed on 09/04/2020, and the IJ removed on 09/05/2020. The SA validated the facility's Removal Plan on 09/06/2020 and determined the IJ was removed on 09/05/2020, prior to exit. Therefore, the scope and severity for 42 CFR(s): 483.12(a)(1) - Freedom from Abuse, Neglect (F600); 42 CFR(s): 483.21(b)(1) - Care Plan Timing and Revision (F657); 42 CFR(s): 483.25(d)(1)(2) - Free of Accidents/Hazards/Supervision/Devices (F689);42 CFR(s): 483.35(a)(1)(2) - Sufficient Nursing Staffing (F725); and 42 CFR(s): 483.75 (g)(2) - QAPI/QAA Improvement Activities (F867) were lowered from a "J" to a scope and severity of a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The SA also cited deficiencies at F609 at the scope and severity of a "D." At the time of the survey, the facility had a census of 64, and held a license for 100 beds.	F 000		

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 _____	C 09/06/2020

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 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, facility investigation, record review, staff interview, and facility policy review, the facility failed to ensure a resident was free of neglect and provide the necessary care and services to avoid physical harm, as evidenced by, Resident #1, who had behaviors of shoveling food in his mouth and was a known choking risk, was left unattended in the dining room with food, for one (1) of four (4) residents reviewed for behaviors/choking risk. On 06/01/2020, the State Agency (SA) received a complaint from the local Ombudsman, which revealed, the facility failed to provide one on one supervision with Resident #1 to prevent choking and aspiration. On 05/15/2020 at 6:44 AM, Resident #1 was left unattended with food at the dining room table. Resident #1 shoveled his food, along with another resident's food, in his mouth, which caused Resident #1 to aspirate and die at	F 600		

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 _____	C 09/06/2020

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 600	Continued From page 3	F 600		

the facility.

The facility's failure to ensure a resident's right to be free from neglect, placed Resident #1 and other residents with behaviors and choking risks, in a situation that would likely cause serious harm, injury, impairment, or death.

This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 05/15/2020, when the facility left Resident #1 unsupervised with food, in the dining room. Resident #1 was known by staff for shoveling food in his mouth and was a choking risk. There was no licensed personnel in the dining room at the time of the incident.

The facility's Administrator was notified of the IJ and SQC on 09/02/2020. The facility submitted an acceptable Removal Plan on 09/05/2020, in which the facility alleged all corrective actions were completed as of 09/04/2020, and the Immediate Jeopardy was removed on 09/05/2020.

The SA validated the Removal Plan and determined the IJ and SQC was removed as of 09/05/2020, prior to exit. Therefore, the scope and severity for the IJ and SQC at 42 CFR(s): 483.12(a)(1) - Freedom from Abuse/Neglect, (F600), was lowered to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

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 _____	C 09/06/2020

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 600	Continued From page 4	F 600		

Review of the facility's "Abuse, Neglect and Exploitation Policy", dated 11/2018, revealed: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of residential property. "The policy also revealed the definition of neglect as: "Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

Record review of the facility's Speech Therapy Plan of Care, dated 11/08/2019, revealed, Resident #1 was referred to Speech Therapy because he exhibited new onsets of decreased safety during oral intake, coughing, choking during oral intake, risk for aspiration, decreased safety awareness, increased behaviors, decreased verbal communication, increased need for assistance from others, decreased ability to use compensatory strategies and cognitive-communicative deficits placing patient at risk for aspiration, weight loss and further decline in functions and falls. The Speech Therapist also indicated Resident #1 was at risk for aspiration, had impulsive tendencies, to restrict the resident's performance in unsupervised tasks, reduce background noise, stand directly in front of the resident and speak in a deep voice when communicating. The Speech Therapist recommended a Mechanical Soft Diet with supervision, and assistance required being determined by the resident's mood and impulsive tendencies at that moment dated 01/02/2020.

A review of Resident #1's Nurses' Notes dated

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 _____	C 09/06/2020

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 600	Continued From page 5	F 600		

11/05/2019, revealed, a nurse was called to the Memory Care Unit. The Certified Nursing Assistant (CNA) reported Resident #1 shoved a roll into his mouth and choked. The CNA also stated she had to dig the roll out of his mouth. The CNA revealed, the resident choked yesterday on green beans because he eats so fast.

Review of the facility's Nurses' Notes for Resident #1, dated 12/31/2019, revealed, Resident #1 feeds self with cueing and supervision. Resident #1 gulps food unless monitored.

Record review of the Speech Therapy's Plan of Care, dated 05/01/2020, revealed, Resident #1 was referred to Speech Therapy after a new onset of decreased safety during a meal, which was evidenced by Resident #1 severely choking during a meal when food was stuck in the resident's throat. As a result, nursing monitored Resident #1 and took Pneumonia precautions with X-ray, after the resident's temperature spiked. The Therapist standardized test, dated 05/01/2020, revealed, Resident #1 was given the bedside dysphagia evaluation, in which Resident #1 was found to have both Oral and Pharyngeal Dysphagia, which put him at risk for aspiration. The test indicated Resident #1 was impulsive and put large spoons/bites in his mouth and sometimes two (2) or more spoons/bites in his mouth causing severe choking episodes. Resident #1 was found to be a candidate for skilled dysphagia therapy to implement training strategies for both Resident and caregivers to decrease choking risk.

A record review of the Speech Therapist's in-service instructions for Resident #1, dated 05/01/2020, revealed, Certified Nursing Assistant

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 _____	C 09/06/2020

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 600	Continued From page 6	F 600		

(CNA) #1 and CNA #2 was in-serviced on: Purpose of a small spoon, to encourage liquids between swallows during meal time, strategies to recognize impulsive behavior during meal time also have the ability to recognize mood of patient and determine level of assistance needed that day. Implement use of compensatory strategies (i.e. Hand over Hand, diet modifications "not giving roll", removing tray from patient and calming patient down, giving meal tray last, and being one-on-one, handing patient something to drink in between bites and ultimately removing tray from patient and feeding patient) to decrease impulsive behavior and to ensure meal time safety.

Record review of Resident #1's Nurses' Notes, dated 03/18/2020, revealed, Resident #1 was noted to be coughing and choked on some food during lunch. Resident #1 was trying to put too much food in his mouth at one time, swallowed it whole, and choked on it. On 04/06/2020, Registered Nurse (RN) #1 documented, "Resident #1 feeds self with tray set up help. Resident #1 over stuffs mouth with food. Resident #1 is encouraged to slow down and take his time eating. Resident #1 is offered fluids with meals." On 04/29/2020, Resident #1 choked on food due to him shoveling food in his mouth.

A record review of the facility's nurses' note for Resident #1, dated 05/15/20, revealed, RN #1 was called to the Memory Care Unit where she observed Resident #1 standing up with a bluish-gray pale tint to his face and around his lips. Resident #1 appeared to be choking. The resident was unable to cough to clear his airway. The Heimlich maneuver was performed. Resident #1 became weak and collapsed to the floor.

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 _____	C 09/06/2020

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 600	Continued From page 7	F 600		

Mouth sweeps were performed with food particles removed. Resident #1 was placed in a wheelchair and taken to his room. The Medical Doctor (MD) was at bedside. Oxygen was administered, as well as suctioning. Food particles were removed from Resident #1's airway. The staff was unable to clear airway. The MD pronounced Resident #1 at 7:28 AM.

Record review of the Physicians Notes for Resident #1, dated 05/15/2020 at 7:45 AM, revealed, Resident #1 was eating breakfast without swallowing, and aspirated with collapse. The Heimlich and mouth sweeps were performed by the nursing code team. Large chunks of scrambled eggs were removed from Resident #1's airway before he arrived from down the hall. Resident #1 was awake, eyes opened, sitting up, no coughing, but spontaneous respirations. Within a minute, Resident #1 collapsed again, was transferred to the bed, and suctioned with more food debris. Resident #1 noted to be a Do Not Resuscitate (DNR), no spontaneous respiration effort, no gag reflex, oxygen added, ambulance in route, agonal heartbeat but no pulse, no heartbeat, eyes fixed and dilated. Ambulance canceled. Resident #1 pronounced at 7:28 AM.

A review of Resident #1's Death Certificate, dated 05/27/2020, revealed the cause of death was hypoxia due to airway obstruction and aspiration of food.

Record review of the Physician Orders for Resident #1, dated 09/01/2020, revealed, Resident #1 was ordered a Mechanical Soft Diet with chopped meat texture consistency. Chopped meats in gravy. Resident #1 would receive a

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 _____	C 09/06/2020

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 600	Continued From page 8	F 600		

small spoon with all meals to lower risk of choking due to impulsive and big spoons of food during oral consumption.

On 06/01/2020, the State Agency (SA) received a complaint from the local Ombudsmen stating the facility failed to provide one on one care with Resident #1, causing him to choke, aspiration and die.

During an interview with the local Ombudsman on 08/31/2020, she revealed, Resident #1's family called and stated the facility gave Resident #1 the wrong diet, which caused him to aspirate and die. The family said this incident happened on 05/15/2020.

An interview via phone, on 09/03/2020 at 9:30 AM, with Resident #1's daughter, revealed, she called the local Ombudsman and stated Resident #1 had behaviors and was in the Memory Care Unit at the facility. Resident #1's daughter stated the facility gave Resident #1 the wrong diet which caused him to aspirate and die. The daughter also stated two (2) weeks prior to Resident #1's death, the facility called her mother and said Resident #1 had choked on a roll and aspirated. Resident #1 was placed on an antibiotic for aspiration and bronchitis. Resident #1's daughter stated two (2) weeks later, the facility called and stated Resident #1 had choked and died. The family asked for a copy of Resident #1's medical records. She stated the facility did not return their calls.

During an interview, on 09/03/2020 at 10:15 AM, Certified Nursing Assistant (CNA) #2 revealed, she worked the Memory Care Unit on 05/15/2020. CNA #2 stated Resident #1 came out

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 _____	C 09/06/2020

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 600	Continued From page 9	F 600		

of the dining room, with CNA #1 patting him on his back, because he had stuffed food in his mouth. She stated Resident #1 fell to the floor. CNA #1 was trying to get food out of his mouth. She revealed the nurse was not in the dining room. CNA #2 stated the nurse made rounds on the unit periodically. CNA #2 stated she called for help and Registered Nurse (RN) #1 came on the unit and pulled eggs out of Resident #1's mouth. CNA #2 stated Resident #1 would hoard food and pocket food in his mouth. CNA #2 stated the Speech Therapist in-serviced all the CNAs on the Memory Care Unit indicating Resident #1 should eat last, should drink in between bites and should be supervised during meals because he has a history of choking by shoveling large amounts of food down his throat. CNA #2 stated Resident #1 had several behaviors that required one on one supervision.

An observation of the lunch meal, on the Memory Care Unit, on 09/03/2020 at 11:45 AM, revealed, two (2) CNAs assisting residents with lunch. The residents were spread out around the dining room. There were no licensed nurses in the dining room during the meal. The CNAs uncovered the residents' lunch trays, and they fed themselves without difficulty.

During an interview, on 09/03/2020 at 12:30 PM, CNA #1 stated she was assisting Resident #1 with his breakfast on 05/15/2020, when another resident came into the dining room. CNA #1 confirmed she left Resident #1 at the table to assist the other resident with unwrapping her food and setting up her tray. CNA #1 stated when she turned around to check on Resident #1, she noticed Resident #1 stuffing food in his mouth from his tray and another resident's tray. She

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 _____	C 09/06/2020

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 600	Continued From page 10	F 600		

stated Resident #1 was turning gray and that she tried to get him to open his mouth. She stated Resident #1 clenched his teeth together. CNA #1 revealed she tried to assist Resident #1 to the bathroom to clean his mouth, but he started turning blue and fell to the ground in the day area by the nurses' station. CNA #2 stated she tried to take the food out of Resident #1 mouth. She revealed that CNA #2 called for a nurse, because there were no nurses on the unit. CNA #1 stated the nurses were not on the unit during meals. CNA #1 stated she was in-serviced by the Speech Therapist to give Resident #1 his meals last and to assist him with his meals, because he stuffed food in his mouth that would choke him. CNA #1 stated she should have asked CNA #2 to assist with the other resident's breakfast. CNA #1 confirmed Resident #1 should not have been left unattended because he was impulsive and had a history of shoving food in his mouth.

During an interview, on 09/03/2020 at 1:00 PM, RN #1 revealed, she was called into the Memory Care Unit by CNA #1. RN #1 stated she was the supervisor on the day of the choking incident. RN #1 stated Resident #1 was blue when she entered the unit and was laying on the floor. RN #1 stated she performed the Heimlich maneuver, but was not successful. RN #1 revealed Resident #1 was taken to his room and suction was initiated. She stated a large amount of scrambled eggs was removed from Resident #1's mouth. RN #1 also stated Resident #1 had a history of choking on his food because he puts large amounts of food in his mouth at one time. RN #1 confirmed Resident #1 needed one on one supervision with meals.

During an interview, on 09/03/2020 at 1:30 PM,

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 _____	C 09/06/2020

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 600	Continued From page 11	F 600		

the Speech Therapist (ST) revealed, Resident #1 had a history of choking and aspirating. She stated Resident #1 was impulsive and shoveled food into his mouth. The ST stated she had put several things in place for Resident #1's behavior medication and safety, such as: Resident #1 should receive his tray last, one on one supervision with meals, ordered a small spoon and receive sips of water between each bite. The ST said she in-serviced the CNAs on May 1, 2020 on Resident #1's feeding instructions. The ST also stated she talked to the Director of Nursing (DON) about Resident #1's behavior modification and safety. The Speech Therapist revealed, she recommended the facility have a nurse in all the dining rooms to promote patient safety. The ST further stated, the Assistant Director of Nursing (ADON) told her that Resident #1 swallowed a whole roll and coughed the roll up. The Speech Therapist stated Resident #1 was re-evaluated on 05/01/2020. The Speech Therapist revealed, she in-serviced the CNAs with instructions on how to provide behavior modifications to keep the resident from choking. The ST stated she in-serviced the CNAs because they were the ones taking care of the resident. The Speech Therapist stated she placed instructions in her notes. The ST stated the facility had a communication issue between Nursing and Therapy.

During an interview, on 09/04/2020 at 9:30 AM, RN #3/Nursing Supervisor, revealed, she observed Resident #1 lying on his right side on the floor. She stated Resident #1 was gray in color. Scrambled eggs were noted on Resident #1's shirt sleeves. RN #3 stated that RN #1 was pulling eggs out of Resident #1's mouth using finger sweeps. She stated Resident #1 slumped

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 _____	C 09/06/2020

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 600	Continued From page 12	F 600		

over and became unresponsive. Suction was set up and RN #1 suctioned pieces of food out of his mouth, mainly eggs. She stated Resident #1 remained unresponsive. RN #3 revealed the MD pronounced Resident #1 at that time. RN #3 also confirmed Resident #1 had a history of choking during mealtime. RN #3 stated Resident #1 should have always been supervised during meals because he shoved large amounts of food into his mouth. She revealed Resident #1 had an incident on 04/29/2020 where a roll was stuck in his throat. RN #3 stated Resident #1 was able to cough up the roll with assistance. RN #3 further stated the doctor ordered an x-ray, Speech Therapy was consulted, and antibiotics ordered.

An interview, on 09/04/2020 at 10:00 AM, with the Medical Director (MD), revealed, Resident #1 had a history of choking. The MD stated Resident #1 was impulsive and had several other behaviors. He stated Resident #1 should have had one on one supervision, 24 hours a day due to his behaviors. The MD further stated he was called to the Memory Care Unit on 05/15/2020 and was at the bedside while the staff suctioned the food particles from the resident's mouth. The MD said Resident #1 became unresponsive, stopped breathing, and was pronounced at 7:28 AM. The MD confirmed the cause of death was Hypoxia due to choking and aspirating his breakfast. The MS further stated he was involved in the Quality Assurance (QA) meetings after the incident in which everything was discussed, and he approved the facility's plan of action.

During an interview, on 09/04/2020 at 5:00 PM, the Director of Nursing (DON) confirmed, Resident #1 had a history of choking as well as other behaviors. The DON stated she did not

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 _____	C 09/06/2020

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 600	Continued From page 13	F 600		

know the Speech Therapist had requested a special spoon to prevent choking until 05/01/2020, when it was discussed in a meeting. The DON stated the staff informed her the resident was not getting the spoon with all meals because the facility only had one. The DON revealed she told the Dietary Manager to order more spoons. The DON stated she was not aware the Speech Therapist recommended one on one supervision, serving Resident #1 last, and to offer sips of water in between bites until after the resident's death. The DON stated she did not know the Speech Therapist had in-serviced the CNAs on 05/01/2020 with behavior modifications to Resident #1. The DON said she discussed with the Administrator and the Owner of the facility, that the Memory Care Unit should have a nurse during meals. She stated the Administrator and Owner refused.

Review of the facility's Removal Plan, revealed, the facility took the following actions to remove the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC):

1. Sixty-three (63) residents were assessed by the Licensed Social Worker and the Social Services Director for behaviors that may lead to self-injury or harm on September 4, 2020 completed at 12:30 PM. Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at

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 _____	C 09/06/2020

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 600	Continued From page 14	F 600		

12:30 PM.

2. Sixty-three (63) residents were assessed by the Speech Therapist for swallowing difficulties and choking. Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 2:30 PM.

3. Eight (8) of eight (8) Registered Nurses(RN), seven (7) of 13 Licensed Practical Nurses(LPN), 30 of 38 Certified Nursing Assistants (CNA), four (4) of 12 Dietary Aides, five (5) of seven (7) Housekeepers, five (5) of seven (7) Activity Personnel, two (2) of three (3) Laundry Personnel, one (1) of three (3) Therapist, four (4) of four (4) Administrative Staff were in-serviced on September 2, 2020 by the Assistant Director of Nursing (ADON) from 2:30 PM until 3:00 PM on supervising and monitoring risk for aspiration and choking hazards.

4. A total of 64 residents' charts were reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/ Quality Assurance Nurse. All 64 residents' charts were reviewed and assessed based on their prescribed diets and diagnosis related to those diets were found to be 100% accurate. A total of 64 residents care plans were reviewed at this time with 100% accuracy. The chart reviews were completed on September 2, 2020 at 5:30 PM.

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 _____	C 09/06/2020

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 600	Continued From page 15	F 600		

5. Eight (8) of eight (8) RN's, 22 of 38 CNA's, eight (8) of 13 LPN's, two (2) of seven (7) Housekeeper's, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on September 2-3, 2020 by the Social Services Director and the ADON from 6:00 PM until 10:00 AM on Meal Supervision and Assistance Policy.

6. Eight (8) of eight (8) RN's, 22 of 38 CNA's, eight (8) of 13 LPNs, two (2) of seven (7) Housekeeper's, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in- serviced on September 2, 2020 by the Owner of the facility from 2:30 PM until 3:00 PM on the accessibility of care plans and nutritional systems location.

7. Eight (8) of eight (8) RN's, 22 of 38 CNA's, eight (8) of 13 LPN's, two (2) of seven (7) Housekeeper's, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when, and how to report to the State Agency.

8. The Quality Assurance Committee (QA) comprised of the Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, Quality Assurance, Owner of facility, Certified Recreational Therapist, Certified Dietary Manager, Assistant Director of Nursing, Licensed Social Worker, Social Services Director, Admissions Nurse, Minimum Data Set Nurse, Medical Records Nurse and Care Plan Nurse met

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 _____	C 09/06/2020

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 600	Continued From page 16	F 600		

on September 2, 2020 at 1:00 PM. A plan of action was implemented at this time to ensure that all staff is in-serviced on supervising and monitoring risk for aspiration and choking hazards, Meal Supervision and Assistance Policy, systematic communication within the facility related to residents that are deemed to be at risk for aspiration or a choking hazard, implementation of the nursing/therapy communication form, accessibility of care plans and nutritional systems location. If a resident is identified as being a choking or aspiration risk, the resident will be assessed by a Speech Therapist to determine the adequate level of supervision needed. This determination will be based on the individual needs of the resident and identified hazards. A nursing/therapy communication form was implemented at this time to ensure all residents that are deemed at risk for aspiration or choking will be reviewed and discussed by the Interdisciplinary Team (IDT) and reviewed by the Quality Assurance Committee. The Care Plan Nurse will review all charts and diet orders of the resident who is at risk for aspiration or choking and refer to the Quality Assurance Committee for review and implementation of any negative outcomes. All residents' charts that were identified according to their prescribed diet and aspiration risk have been reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/Quality Assurance Nurse. A total of 64 residents care plans were updated on September 2, 2020 at 5:30 PM by the Care Plan Nurse. The IDT reviewed all policy and procedures related to the adverse event and deemed all policies and procedures do not require any revision at this time. QA reviewed the state and federal regulation and facility guideline

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 _____	C 09/06/2020

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 600	Continued From page 17	F 600		

requirements for reporting incidents to the State Agency and the Attorney General's office. All reported incidents will be reviewed in the monthly QA meeting.

9. The QA Committee met on September 4, 2020 at 8:00 AM for review and implementation to have all 63 residents assessed for behaviors that may lead to self-injury or harm, to identify anyone who is at risk and implement person centered interventions, and to in-service all staff members on recognizing behaviors and potential for self-harm and injury and whom to report to. The findings were as followed: Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. The QA Committee determined all 63 residents will be assessed by the Speech Therapist for difficulty swallowing and choking and to review and implement a plan of care to prevent any adverse reactions related to findings by the Speech Therapist. The findings were as followed Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. All residents that have a diet order or diet changes will be reviewed during the weekly care plan meeting by the IDT to

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 _____	C 09/06/2020

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 600	Continued From page 18	F 600		

prevent any further adverse events. All residents that are reported on the Nurse/Therapy documentation form will be immediately reviewed by the IDT, recommendations discussed, and a plan of care will be put into effect. The Nurse/Therapy documentation forms will be reviewed weekly during the care plan meeting with the IDT to prevent any further adverse events.

No staff will be allowed to work until they are in-serviced.

The facility alleges the IJ and SQC was removed on September 5, 2020.

The State Agency (SA) validated the facility's Corrective Actions through observation, interview, record review, and review of sign-in sheets.

1. The SA validated through interviews and record review of all residents were assessed by the licensed Social Worker and the director of Social Services for behaviors that may lead to self-injury or harm.

2. The SA validated through interviews and record review of all residents were assessed by the speech therapist for swallowing difficulties and choking aspiration.

3. The SA validated through interviews and were in-serviced on supervising and monitoring risk for aspiration and choking hazards.

4. The SA validated through record review that all residents in the facility charts were reviewed by the care plan nurse for accuracy of all Residents diets.

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 _____	C 09/06/2020

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 600	Continued From page 19 5. The SA validated through interviews and in-services by the Social Worker on meal Supervision. 6. The SA validated through interview and in-services on the accessibility of care plans and nutritional systems location. 7. The SA validated through interview and in-services on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when and how to report to the state agency. 8. The SA validated a Quality Assessment and Assurance Committee meeting was held on September 2, 2020 and September 4, 2020 by interview and review of the sign-in sheet. 9. The SA validated that all corrective actions listed were accomplished by 09/05/2020. 10. The SA validated through interviews and record review that staff were not allowed to work until in-serviced. 11. The SA validated that all corrective actions were completed as of 09/05/2020, and the IJ was removed prior to exit on 09/05/2020.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		

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 _____	C 09/06/2020

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 609	Continued From page 20	F 609		

involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review and facility policy review, the facility failed to report an allegation of Quality of Care/Supervision, related to an incident which resulted in Resident #1 choking/aspirating and death, within the two (2) hour required timeframe for one (1) of six (6) residents reviewed, Resident #1.

Review of the facility's, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Policy", dated May 2020, revealed: It is the policy of this facility to report all allegations of abuse, neglecr, exploitation or mistreatment, including injuries of

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 _____	C 09/06/2020

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 609	Continued From page 21	F 609		

unknown sources and misappropriation of resident property, are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. All alleged violation involving abuse, neglect, exploitation or mistreatment must be reported immediately. This includes injury of unknown source and misappropriation of resident property. "If the alleged violation involves abuse/neglect or results serious bodily injury it must be reported immediately but no later than two (2) hours after allegation is made." If the alleged violation does not involve abuse or does not involve serious bodily injury it must be reported no later than 24 hours after allegation is made. The definition of neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Injuries of unknown source includes circumstances when the injury is suspicious because of the extent of injury as soon as possible, but not to exceed 24 hours after discovery of the incident.

Record review of the facility's Nurses' Notes, dated 5/15/20, by RN #1, revealed she was called to the Memory Care Unit where she observed Resident #1 standing up with a bluish gray pale tint to his face and around his lips. Resident #1 appeared to be choking. Resident #1 was unable to cough to clear his airway. The Heimlich maneuver was performed twice. Resident #1 became weak and collapsed to the floor. Mouth sweeps were performed with food particles removed. Resident #1 was placed in a wheelchair and taken to his room. The Medical Doctor was at bedside, Oxygen administered as well as suctioning. Food particles were removed from

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 _____	C 09/06/2020

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 609	Continued From page 22	F 609		

Resident #1's airway. The staff was unable to clear airway. The Medical Doctor pronounced Resident #1 dead at 7:28 AM.

An interview, on 09/04/2020 at 10:00 AM, with the Medical Director (MD), revealed, Resident #1 had a history of choking. The MD said Resident #1 was impulsive and had several other behaviors. He stated Resident #1 should have had one on one supervision 24 hours a day due to his behaviors. The MD also stated he was called to the Memory Care Unit on 05/15/2020, and was at Resident #1's bedside while the staff attempted to suction the food particles from the resident's mouth. The MD stated Resident #1 became unresponsive and stopped breathing. He revealed that he pronounced the resident at 7:28 AM. The MD said the cause of death was Hypoxia due to choking and aspirating his breakfast. The MD also stated he was involved in the Quality Assurance (QA) meetings after the incident, in which everything was discussed, and he approved the facility's plan of action.

A review of Resident #'s1 Death Certificate, dated 05/27/2020, revealed, the cause of death was Hypoxia due to airway obstruction and aspiration of food.

During an interview, on 09/04/2020 at 9:15 AM, with the Administrator, she confirmed the facility had communication problems between Therapy and Nursing. The Administrator stated she was aware of Resident #1's death. The Administrator stated she did not report the incident to the State Agency because the facility knew what happened to the resident. She stated Resident #1 aspirated and died. The Administrator stated that she did not feel the resident was neglected. The

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 _____	C 09/06/2020

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 609	Continued From page 23 Administrator said she did not know Resident #1 had a choking history and was not aware of the Speech Therapist recommendation. The Administrator stated the facility did everything to care for Resident #1.	F 609		
F 657 SS=J	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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility	F 657		

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 _____	C 09/06/2020

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 657	Continued From page 24	F 657		

policy review, the facility failed to revise the Comprehensive Care Plan to include recommendations made by the Speech Therapist, related to safe food consumption, for one (1) of four (4) residents reviewed, Resident #1.

The facility's failure to revise the care plan for Resident #1 caused serious harm, injury, and death. This situation was determined to be an Immediate Jeopardy (IJ), which began on 05/15/2020, when the facility left Resident #1, who was known for choking and aspirating, unattended with food in the dining room. The facility's Administrator was notified of the IJ on 09/02/2020. The State Agency (SA) received an acceptable, credible Removal Plan on 09/05/2020, in which the facility alleged that all corrective actions were completed as of 09/04/2020, and the IJ was removed on 09/05/2020.

The SA determined the IJ to be removed as of 09/05/2020, prior to exit. Therefore, the scope and severity for IJ at 42 CFR (s): 483.21(b) (1) - Comprehensive Care Plan, (F657) was lowered to a "D", while the facility revised a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

A review of the facility's, "Care Plan Policy", dated January 2020, revealed, the Comprehensive Care Plan will be reviewed and revised as necessary, when a resident experience a status change. The nurse will notify the Minimum Data Set (MDS) Coordinator, the Physician, and the

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 _____	C 09/06/2020

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 657	Continued From page 25	F 657		

Resident's Representative. The MDS Coordinator and Interdisciplinary Team will discuss the resident's condition and collaborate on intervention options. The team meeting discussion will be documented in the nursing progress notes. The care plan will be updated with the new or modified interventions. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. The Unit manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident's needs.

A review of Resident #1's Comprehensive Care Plan , dated 04/17/2020, revealed, it was not revised to include the Speech Therapist recommendations dated 05/01/2020, for one on one supervision due to impulsive behavior, hand over hand intervention to prevent resident from shoveling large amounts of food in his mouth, and sips of water in between each bite.

A review of the facility's Nurses Notes for Resident #1, dated 11/05/2019, revealed a nurse was called to the Memory Care Unit. The Certified Nursing Assistant (CNA) reported Resident #1 shoved a roll into his mouth and choked. The Nurses' Notes revealed, the CNA further stated she had to dig the roll out of his mouth. The Nurses' Notes also revealed, the CNA stated the resident choked yesterday on green beans because eats so fast.

Review of the facility's Nurses' Notes for Resident

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 _____	C 09/06/2020

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 657	Continued From page 26	F 657		

#1, dated 12/31/2019, revealed, the resident feeds self with cueing and supervision. Resident #1 gulps food unless monitored. A review of Resident #1's Nurses' Notes, dated 05/15/2020, documented by Registered Nurse (RN) #1, revealed, she entered the Memory Care Unit and observed Resident #1 standing up with a bluish-gray, pale tint to his face and around his lips. Resident #1 appeared to be choking. Resident #1 was unable to cough to clear his airway. The Heimlich maneuver was performed two times. Resident #1 became weak and collapsed to the floor. Mouth sweeps were performed with food particles removed. Resident #1 was transferred to his room. The Medical Doctor (MD) was at bedside, oxygen administered as well as suctioning. Food particles were removed from Resident #1's airway. The staff was unable to clear airway. The Medical Doctor pronounced Resident #1 at 7:28 AM.

Record review of the facility's "Physicians Notes", dated 05/15/2020 at 7:45 AM, revealed, Resident #1 was eating breakfast without swallowing, aspirated with collapse. The Heimlich and mouth sweeps performed by the nursing code team. Large chunks of scrambled eggs removed from air way before he arrived from down the hall. Resident #1 was awake, eyes open sitting up, no coughing but spontaneous respirations. Within a minute Resident #1 collapsed again, transferred to bed the staff yanker suctioned more food debris. Resident #1 noted to be DNR, no spontaneous respiration effort, no gag reflex, oxygen added, ambulance in route, agonal heartbeat but no pulse, no heartbeat, eyes fixed and dilated. Ambulance canceled. Resident #1 pronounced at 7:28 AM.

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 _____	C 09/06/2020

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 657	Continued From page 27	F 657		

During an interview, on 09/03/2020 at 1:30 PM, with the Speech Therapist (ST), she revealed, Resident #1 had a history of choking and aspirating. The ST stated Resident #1 was impulsive and shoveled food in his mouth. The ST stated she had put several things in place for Resident #1 behavior medication and safety. She stated the facility had a Utilization Review (UR) Meeting every Friday, where the MD, Administrator (ADM), Director of Nursing (DON), Minimum Data Set (MDS), Care Plan Nurse, Assistant Director of Nursing (ADON), Therapy, and Quality Assurance (QA) Nurse to discuss the care of all the residents receiving skilled care. She revealed the Therapist gives a copy of all their notes to the UR team. She stated the Therapy notes has all the goals, recommendations, and updates for each resident.

An interview, on 09/04/2020 at 9:00 AM, with RN #2, revealed, he stated that he wasn't aware of the Speech Therapist recommendation for Resident #1 to have one on one supervision during meals. RN #2 further stated he did not know about the recommendations for sips of water after each bite. RN #2 revealed he receives the therapy updates during stand up and at the care plan meetings. RN #2 stated he did not have access to the therapy notes. He stated that he was just given the therapy tab on his computer. RN #2 also said he only looked at the seven (7) day look back of nurses notes when he updates the care plan.

During an interview, on 09/04/2020 at 9:15 AM, the Administrator confirmed, the facility had communication problems between Therapy and Nursing. The Administrator stated the facility had created a communication form to start using as of

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 _____	C 09/06/2020

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 657	Continued From page 28	F 657		

today to communicate between nursing and therapy.

Review of the facility's Removal Plan, revealed, the facility took the following actions to remove the Immediate Jeopardy:

1. Sixty-three (63) residents were assessed by the Licensed Social Worker and the Social Services Director for behaviors that may lead to self-injury or harm on September 4, 2020 completed at 12:30 PM. Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM.

2. Sixty-three (63) residents were assessed by the Speech Therapist for swallowing difficulties and choking. Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 2:30 PM.

3. Eight (8) of eight (8) Registered Nurses (RN), seven (7) of 13 Licensed Practical Nurses(LPN), 30 of 38 Certified Nursing Assistants (CNA), four

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 _____	C 09/06/2020

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 657	Continued From page 29	F 657		

(4) of 12 Dietary Aides, five (5) of seven (7) Housekeepers, five (5) of seven (7) Activity Personnel, two (2) of three (3) Laundry Personnel, one (1) of three (3) Therapist, four (4) of four (4) Administrative Staff were in-serviced on September 2, 2020 by the Assistant Director of Nursing (ADON) from 2:30 PM until 3:00 PM on supervising and monitoring risk for aspiration and choking hazards.

4. A total of 64 residents' charts were reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/ Quality Assurance Nurse. All 64 residents' charts were reviewed and assessed based on their prescribed diets and diagnosis related to those diets were found to be 100% accurate. A total of 64 residents care plans were reviewed at this time with 100% accuracy. The chart reviews were completed on September 2, 2020 at 5:30 PM.

5. Eight (8) of eight (8) RN's, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeeper's, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on September 2-3, 2020 by the Social Services Director and the ADON from 6:00 PM until 10:00 AM on Meal Supervision and Assistance Policy.

6. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in- serviced on September 2, 2020 by the Owner of the facility from 2:30 PM until 3:00 PM on the accessibility of care plans and nutritional

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 _____	C 09/06/2020

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 657	Continued From page 30	F 657		

systems location.

7. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when, and how to report to the State Agency.

8. The Quality Assurance Committee (QA) comprised of the Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, Quality Assurance, Owner of facility, Certified Recreational Therapist, Certified Dietary Manager, Assistant Director of Nursing, Licensed Social Worker, Social Services Director, Admissions Nurse, Minimum Data Set Nurse, Medical Records Nurse and Care Plan Nurse met on September 2, 2020 at 1:00 PM. A plan of action was implemented at this time to ensure that all staff is in-serviced on supervising and monitoring risk for aspiration and choking hazards, Meal Supervision and Assistance Policy, systematic communication within the facility related to residents that are deemed to be at risk for aspiration or a choking hazard, implementation of the nursing/therapy communication form, accessibility of care plans and nutritional systems location. If a resident is identified as being a choking or aspiration risk, the resident will be assessed by a Speech Therapist to determine the adequate level of supervision needed. This determination will be based on the individual needs of the resident and identified hazards. A nursing/therapy communication form was implemented at this

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 _____	C 09/06/2020

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 657	Continued From page 31	F 657		

time to ensure all residents that are deemed at risk for aspiration or choking will be reviewed and discussed by the Interdisciplinary Team (IDT) and reviewed by the Quality Assurance Committee. The Care Plan Nurse will review all charts and diet orders of the resident who is at risk for aspiration or choking and refer to the Quality Assurance Committee for review and implementation of any negative outcomes. All residents' charts that were identified according to their prescribed diet and aspiration risk have been reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/Quality Assurance Nurse. A total of 64 residents care plans were updated on September 2, 2020 at 5:30 PM by the Care Plan Nurse. The IDT reviewed all policy and procedures related to the adverse event and deemed all policies and procedures do not require any revision at this time. QA reviewed the state and federal regulation and facility guideline requirements for reporting incidents to the State Agency and the Attorney General's office. All reported incidents will be reviewed in the monthly QA meeting.

9. The QA Committee met on September 4, 2020 at 8:00 AM for review and implementation to have all 63 residents assessed for behaviors that may lead to self-injury or harm, to identify anyone who is at risk and implement person centered interventions, and to in-service all staff members on recognizing behaviors and potential for self-harm and injury and whom to report to. The findings were as followed: Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical

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 _____	C 09/06/2020

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 657	Continued From page 32	F 657		

Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. The QA Committee determined all 63 residents will be assessed by the Speech Therapist for difficulty swallowing and choking and to review and implement a plan of care to prevent any adverse reactions related to findings by the Speech Therapist. The findings were as followed Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. All residents that have a diet order or diet changes will be reviewed during the weekly care plan meeting by the IDT to prevent any further adverse events. All residents that are reported on the Nurse/Therapy documentation form will be immediately reviewed by the IDT, recommendations discussed, and a plan of care will be put into effect. The Nurse/Therapy documentation forms will be reviewed weekly during the care plan meeting with the IDT to prevent any further adverse events.

No staff will be allowed to work until they are in-serviced.

The facility alleges the immediate jeopardy be removed on September 5, 2020.

The State Agency (SA) validated the facility's Corrective Actions through observation, interview,

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 _____	C 09/06/2020

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 657	Continued From page 33	F 657		

record review, and review of sign-in sheets.

1. The SA validated through interviews and record review of all residents were assessed by the licensed Social Worker and the director of Social Services for behaviors that may lead to self-injury or harm.

2. The SA validated through interviews and record review of all residents were assessed by the speech therapist for swallowing difficulties and choking aspiration.

3. The SA validated through interviews and were in-serviced on supervising and monitoring risk for aspiration and choking hazards.

4. The SA validated through record review that all residents in the facility charts were reviewed by the care plan nurse for accuracy of all Residents diets.

5. The SA validated through interviews and in-services by the Social Worker on meal Supervision.

6. The SA validated through interview and in-services on the accessibility of care plans and nutritional systems location.

7. The SA validated through interview and in-services on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when and how to report to the State Agency.

8. The SA validated a Quality Assessment and Assurance Committee meeting was held on September 2, 2020 and September 4, 2020 by

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 _____	C 09/06/2020

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 657	Continued From page 34 interview and review of the sign-in sheet. 9. The SA validated that all corrective actions listed were accomplished by 09/05/2020. 10. The SA validated through interviews and record review that staff were not allowed to work until in-serviced. 11. The SA validated that all corrective actions were completed as of 09/05/2020, and the IJ was removed prior to exit on 09/05/2020.	F 657		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to provide a resident with supervision required and needed to prevent accidents and hazards, choking injury and death during meal consumption for one (1) of four (4) residents reviewed for choking, Resident #1. Resident #1 was left unattended in the Memory Care Dining Room. Resident #1 choked and aspirated on breakfast meal which caused him to die in the facility. The facility's failure to provide supervision and	F 689		

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 _____	C 09/06/2020

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 689	Continued From page 35	F 689		

leaving Resident #1 unattended placed other residents in a situation caused harm, injury, impairment and death.

This situation was determined to be an Immediate Jeopardy (IJ), which began on 05/15/2020, when the facility left Resident #1 unsupervised with food in the dining room. Resident #1 had was known for shoveling food in his mouth and a choking risk. There were no licensed personnel in the dining room.

The facility ' s Administrator was notified of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 09/02/2020. The facility submitted an acceptable credible Removal Plan on 09/05/2020, in which the facility alleged all corrective actions were completed as of 09/04/2020, and the IJ and SQC was removed on 09/05/2020.

The SA validated the Removal Plan and determined the IJ to be removed as of 09/02/2020, prior to exit. Therefore, the scope and severity for the IJ at CFR(s): 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices (F-689), was lowered to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

A review of the facility's "Accident and Supervision Policy", dated November 2018, revealed, the facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood

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 _____	C 09/06/2020

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 689	Continued From page 36	F 689		

of accidents. Using specific interventions to try to reduce a resident's risk from hazards in the environment by communicating interventions with staff, assigning responsibility, providing training, ensuring that the interventions are put into action. The facility's definition of supervision is an intervention and a means of mitigating accident risk. He facility will provide adequate supervision to prevent accident. Adequacy of supervision.

A review of the facility's "Meal Supervision and Assistance Policy", dated November 2018, revealed, the resident will be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event this includes identifying hazards and risk, evaluating and analyzing hazards and risk, implementing interventions to reduce hazards and risks, monitoring for effectiveness and modifying interventions when necessary. He facility will utilize a systemic approach to ensure safety throughout the resident's environment and among all staff. Do not serve the meal until attendant is ready to assist the resident. Supervision/adequate supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and frequency of supervision needed. This determination is based on individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.

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 _____	C 09/06/2020

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 689	Continued From page 37	F 689		

A review of the facility's Nurses' Notes for Resident #1, dated 11/05/2019, documented, a nurse was called to the Memory Care Unit. The notes revealed, a Certified Nursing Assistant (CNA) reported Resident #1 shoved a roll into his mouth and choked. The CNA also reported she had to dig the roll out of his mouth. The CNA further revealed the resident choked yesterday on green beans because eats so fast.

Review of the facility's Nurses' Notes for Resident #1, dated 12/31/2019, revealed, Resident #1 fed himself with cueing and supervision. Resident #1 gulps food unless monitored. A review of Resident #1's Nurses' Notes, dated 05/15/2020, documented by Registered Nurse (RN) #1, revealed she entered the Memory Care Unit and observed Resident #1 standing up with a bluish-gray, pale tint to his face and around his lips. Resident #1 appeared to be choking. Resident #1 was unable to cough to clear his airway. The Heimlich maneuver performed times two (2). Resident #1 became weak and collapsed to the floor. Mouth sweeps were performed with food particles removed. Resident #1 was transferred to his room. The Medical Doctor was at bedside, Oxygen administer as well as suctioning. Food particles were removed from Resident #1's airway. The staff was unable to clear airway. The Medical Doctor pronounced Resident #1 at 7:28 AM.

Record review of the facility's Physicians Notes, dated 05/15/2020 at 7:45 AM, revealed, Resident #1 was eating breakfast without swallowing, and aspirated with collapse. The Heimlich and mouth sweeps performed by the nursing code team. Large chunks of scrambled eggs removed from

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 _____	C 09/06/2020

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 689	Continued From page 38	F 689		

air way before he arrived from down the hall. Resident #1 was awake, eyes open sitting up, no coughing but spontaneous respirations. Within a minute Resident #1 collapsed again, transferred to bed the staff yanker suctioned more food debris. Resident #1 noted to be a Do Not Resuscitate (DNR), no spontaneous respiration effort, no gag reflex, oxygen added, ambulance in route, agonal heartbeat but no pulse, no heartbeat, eyes fixed and dilated. Ambulance canceled. Resident #1 pronounced at 7:28 AM.

A review of the facility's Speech Therapy Plan of Care, dated 11/08/2019, revealed, Resident #1 was referred to Speech Therapy because he exhibit new onsets of decreased safety during oral intake, coughing, choking during oral intake, risk for aspiration, decreased safety awareness, increased behaviors, decreased verbal communication, increased need for assistance from others, decreased ability to use compensatory strategies and cognitive-communicative deficits placing patient at risk for aspiration, weight loss and further decline in functions and falls. The Speech Therapist revealed, Resident #1 was at risk for aspiration, had impulsive tendencies, to restrict the resident's performance in unsupervised tasks, reduce background noise, stand directly in front of the resident and speak in a deep voice when communicating. The Speech Therapist recommended a Mechanical Soft Diet with supervision and assistance required being determined by the resident's mood and impulsive tendencies at that moment dated 01/02/2020.

Record review of the Speech Therapy Plan of Care, dated 05/01/2020, revealed, Resident #1 was referred to Speech after a new onset of

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 _____	C 09/06/2020

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 689	Continued From page 39	F 689		

decreased safety during a meal which was evidenced by Resident #1 severely choking during a meal when food was stuck in the resident's throat. As a result, nursing monitored Resident #1 and took Pneumonia precautions with X-ray, after the resident's temperature spiked. ATherapist standardized test dated 05/01/2020, revealed, Resident #1 was given the bedside Dysphagia evaluation, which Resident #1 was found to have both oral and pharyngeal dysphagia which put him at risk for aspiration. Resident #1 was impulsive and put large spoon/bites in mouth and sometimes two (2) or more spoon/bites in his mouth causing severe choking episodes. Resident #1 was found to be a candidate for skilled dysphagia therapy to implement training strategies for both resident and caregivers to decrease choking risk.

A record review of in-service instructions related to Resident #1, dated 05/01/2020, by the Speech Therapist, revealed, Certified Nursing Assistant (CNA) #1 and CNA #2 was in-serviced on: purpose of a small spoon, to encourage liquids between swallows during meal time, strategies to recognize impulsive behavior during meal time also have the ability to recognize mood of patient and determine level of assistance needed that day. Then, implement use of compensatory strategies (i.e. Hand over Hand, diet modifications "not giving roll", removing tray from patient and calming patient down, giving meal tray last, and being one-on-one, handing patient something to drink in between bites and ultimately removing tray from patient and feeding patient) to decrease impulsive behavior and to ensure meal time safety.

An interview, on 09/03/2020 at 10:15 AM, with

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 _____	C 09/06/2020

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 689	Continued From page 40	F 689		

CNA #2, revealed, she was assisting another resident in the dining room. CNA #2 stated Resident #1 came out of the dining room with CNA #1 patting him on his back, because he had stuffed food in his mouth. CNA #2 stated Resident #1 fell to the floor, and CNA #1 was trying to get food out of his mouth. She revealed there was not a nurse in the dining room at that time. CNA #2 stated the nurse made rounds on the unit periodically. CNA #2 stated she called for help, and Registered Nurse (RN) #1 came on the unit and pulled eggs out of Resident #1 mouth. CNA #2 revealed Resident #1 would hoard food and pocket food in his mouth. CNA #2 stated the Speech Therapist in-serviced all the CNAs on the Memory Care unit instructing that Resident #1 should eat last, should drink in between bites, and should be supervised during meals because he had a history of choking by shoveling large amounts of food down his throat. CNA #2 stated Resident #1 had several behaviors that required one on one supervision.

Observation of the lunch meal, on the Memory Care Unit, on 09/03/2020 at 11:45 AM, revealed, two (2) CNAs assisting eight (8) residents with lunch. The residents were spread out around the dining room. There were no licensed nurses noted in the dining room during the meal. The CNAs uncovered the lunch trays and the residents fed themselves without difficulty.

During an interview, on 09/03/2020 at 12:30 PM, with CNA #1, she stated that she was assisting Resident #1 with his breakfast on 05/15/2020 (day of incident). CNA #1 stated another resident came into the dining room. CNA #1 confirmed she left Resident #1 at the table unattended. CNA #1 revealed she assisted another resident by

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 _____	C 09/06/2020

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 689	Continued From page 41	F 689		

unwrapping her food and setting up her tray, and CNA #2 was assisting another resident at that time. CNA #1 stated when she turned around to check on Resident #1, she noticed Resident #1 stuffing food from his tray and another resident's tray, into his mouth. She revealed Resident #1 was turning gray. CNA #1 stated she tried to get Resident #1 to open his mouth, but he clenched his teeth together. CNA #1 stated she tried to assist Resident #1 to the bathroom to clean his mouth, and he started turning blue, and fell to the ground in the day area by the nurse's station. She stated that CNA #2 called for a nurse. There were no nurses on the unit at that time. CNA #1 stated the nurses are not on the unit during meals. CNA #1 stated she was in-serviced by the Speech Therapist to give Resident #1 meals last and to assist him with his meals, because he stuffed food in his mouth that would choke him. CNA #1 further stated she should have asked CNA #2 to assist with the other resident's breakfast. CNA #1 confirmed Resident #1 should not have been left unattended because he was impulsive and had a history of shoving food in his mouth.

During an interview, on 09/03/2020 at 1:00 PM, with Registered Nurse (RN) #1, revealed, she was called into the Memory Care Unit by CNA #1. RN #1 stated she was the Supervisor for the day. RN #1 revealed Resident #1 was blue when she entered the unit and lying on the floor. RN #1 revealed she performed the Heimlich maneuver and was not successful. RN #1 said Resident #1 was taken to his room and suction was initiated. She stated large amounts of scrambled eggs were removed from Resident #1's mouth. RN #1 also stated, Resident #1 had a history of choking on his food because he puts large amounts of food in his mouth at one time. RN #1 confirmed

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 _____	C 09/06/2020

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 689	Continued From page 42	F 689		

Resident #1 needed one on one supervision with meals.

During an interview, on 09/03/2020 at 1:30 PM, the Speech Therapist (ST) revealed, Resident #1 had a history of choking and aspirating. She stated Resident #1 was impulsive and shoveled food in his mouth. The ST stated there were several things put in place for Resident #1's behavior medication and safety, such as: Resident #1 should receive his tray last, one on one supervision with meals, ordered a small spoon and receive sips of water between each bite. The ST stated she in-serviced the CNAs on May 1, 2020 of Resident #1's feeding instructions. She also stated that she talked to the Director of Nursing (DON) about Resident #1's behavior modification and safety. The Speech Therapist stated the facility refused to follow her recommendations. She stated, on 04/31/2020, the Assistant Director of Nursing (ADON) told her that Resident #1 had swallowed a roll whole. She stated Resident #1 was able to cough up the roll with her (ADON) and RN #3 patting him on his back. She stated RN #3 received an order to consult Speech Therapy on 04/31/2020. The ST stated Resident #1 was re-evaluated on 05/01/2020. The Speech Therapist stated she also in-serviced the CNAs with instructions on how to provide behavior modifications to keep Resident #1 from choking. The ST stated she in-serviced the CNAs because they were the ones taking care of Resident #1. She stated she place instructions for Resident #1 in her notes. The ST said the facility had a communication issue between Nursing and Therapy. She stated that she monitored the CNAs for several days to make sure they followed the protocol. The ST stated the CNAs demonstrated passing out the

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 _____	C 09/06/2020

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 689	Continued From page 43	F 689		

other resident's trays first, and Resident #1 received his tray last. She revealed Resident #1 had one on one supervision, sips of water in between each bite, and a small spoon used with no difficulty. The ST revealed, the facility had a Utilization Review (UR) Meeting on Fridays, which included the Medical Doctor (MD), Director of Nursing (DON), Care Plan Nurse, Minimum Data Set (MDS), Therapy, and Quality Assurance.

During an interview, on 09/04/2020 at 9:30 AM, RN #3/Nursing Supervisor stated she observed Resident #1 laying on his right side, on the floor. She stated Resident #1 was gray in color, and had scrambled eggs noted on his shirt sleeves. RN #3 stated that RN #1 was pulling eggs out of Resident #1's mouth with finger sweeps. She stated Resident #1 was slumped over and unresponsive. She stated suction was set up and RN #1 suctioned pieces of food out of his mouth, mainly eggs. She revealed Resident #1 remained unresponsive. RN #3 stated the MD pronounced Resident #1 at that time. RN #3 confirmed Resident #1 had a history of choking during meal time. RN #3 stated Resident #1 should have always been supervised during meals because he shoved large amounts of food in his mouth. She revealed Resident #1 had an incident on 04/29/2020, when a roll was stuck in his throat. RN #3 stated Resident #1 was able to cough up the roll with assistance. RN #3 also stated the doctor ordered an X-ray, speech was consulted, and antibiotics ordered.

An interview, on 09/04/2020 at 10:00 AM, with the Medical Director (MD) revealed, he stated that Resident #1 had a history of choking. The MD stated Resident #1 was impulsive and had several other behaviors. He revealed Resident

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 _____	C 09/06/2020

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 689	Continued From page 44	F 689		

#1 should have had one on one supervision 24 hours a day due to all of his behaviors. The MD revealed he was called to the Memory Care Unit, on 05/15/2020 (day of incident), and was at the bedside while the staff suctioned the food particles from Resident #1's mouth. The MD said Resident #1 became unresponsive, stopped breathing, and was pronounced at 7:28 AM. The MD confirmed the cause of death was Hypoxia due to Resident #1 choking and aspirating his breakfast.

During an interview, on 09/04/2020 at 5:00 PM, the Director of Nursing (DON) confirmed Resident #1 had a history of choking as well as other behaviors. The DON stated she did not know the Speech Therapist had requested a special spoon to prevent choking until 05/01/2020 during a meeting. The DON stated the staff informed her that Resident #1 was not getting the spoon with all meals because the facility only had one. The DON stated she told the Dietary Manager to order more spoons. The DON further stated she was not aware that the Speech Therapist had recommended one on one supervision for Resident #1, to serve Resident #1 last, and to offer him sips of water in between bites, until after the resident's death. The DON stated she did not know the Speech Therapist had in-serviced the CNAs on 05/01/2020 with behavior modifications for Resident #1. The DON revealed she discussed with the Administrator and the Owner of the facility, that the Memory Care Unit should have a nurse during meals, but the Administrator and Owner refused.

Review of the facility's Removal Plan revealed the facility took the following actions to remove the Immediate Jeopardy:

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 _____	C 09/06/2020

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 689	Continued From page 45	F 689		

1. Sixty-three (63) residents were assessed by the Licensed Social Worker and the Social Services Director for behaviors that may lead to self-injury or harm on September 4, 2020 completed at 12:30 PM. Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM.

2. Sixty-three (63) residents were assessed by the Speech Therapist for swallowing difficulties and choking. Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 2:30 PM.

3. Eight (8) of eight (8) Registered Nurses(RN), seven (7) of 13 Licensed Practical Nurses(LPN), 30 of 38 Certified Nursing Assistants (CNA), four (4) of 12 Dietary Aides, five (5) of seven (7) Housekeepers, five (5) of seven (7) Activity Personnel, two (2) of three (3) Laundry Personnel, one (1) of three (3) Therapist, four (4) of four (4) Administrative Staff were in-serviced on September 2, 2020 by the Assistant Director of

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 _____	C 09/06/2020

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 689	Continued From page 46	F 689		

Nursing (ADON) from 2:30 PM until 3:00 PM on supervising and monitoring risk for aspiration and choking hazards.

4. A total of 64 residents' charts were reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/ Quality Assurance Nurse. All 64 residents' charts were reviewed and assessed based on their prescribed diets and diagnosis related to those diets were found to be 100% accurate. A total of 64 residents care plans were reviewed at this time with 100% accuracy. The chart reviews were completed on September 2, 2020 at 5:30 PM.

5. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on September 2-3, 2020 by the Social Services Director and the ADON from 6:00 PM until 10:00 AM on Meal Supervision and Assistance Policy.

6. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in- serviced on September 2, 2020 by the Owner of the facility from 2:30 PM until 3:00 PM on the accessibility of care plans and nutritional systems location.

7. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity

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 _____	C 09/06/2020

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 689	Continued From page 47	F 689		

Personnel, four (4) of four (4) Administrative Staff were in-serviced on the facility's Abuse, Neglect, and exploitation policy to include information regarding who, when, and how to report to the State Agency.

8. The Quality Assurance Committee (QA) comprised of the Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, Quality Assurance, Owner of facility, Certified Recreational Therapist, Certified Dietary Manager, Assistant Director of Nursing, Licensed Social Worker, Social Services Director, Admissions Nurse, Minimum Data Set Nurse, Medical Records Nurse and Care Plan Nurse met on September 2, 2020 at 1:00 PM. A plan of action was implemented at this time to ensure that all staff is in-serviced on supervising and monitoring risk for aspiration and choking hazards, Meal Supervision and Assistance Policy, systematic communication within the facility related to residents that are deemed to be at risk for aspiration or a choking hazard, implementation of the nursing/therapy communication form, accessibility of care plans and nutritional systems location. If a resident is identified as being a choking or aspiration risk, the resident will be assessed by a Speech Therapist to determine the adequate level of supervision needed. This determination will be based on the individual needs of the resident and identified hazards. A nursing/therapy communication form was implemented at this time to ensure all residents that are deemed at risk for aspiration or choking will be reviewed and discussed by the Interdisciplinary Team (IDT) and reviewed by the Quality Assurance Committee. The Care Plan Nurse will review all charts and diet orders of the resident who is at risk for

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 _____	C 09/06/2020

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 689	Continued From page 48	F 689		

aspiration or choking and refer to the Quality Assurance Committee for review and implementation of any negative outcomes. All residents' charts that were identified according to their prescribed diet and aspiration risk have been reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/Quality Assurance Nurse. A total of 64 residents care plans were updated on September 2, 2020 at 5:30 PM by the Care Plan Nurse. The IDT reviewed all policy and procedures related to the adverse event and deemed all policies and procedures do not require any revision at this time. QA reviewed the state and federal regulation and facility guideline requirements for reporting incidents to the State Agency and the Attorney General's office. All reported incidents will be reviewed in the monthly QA meeting.

9. The QA Committee met on September 4, 2020 at 8:00 AM for review and implementation to have all 63 residents assessed for behaviors that may lead to self-injury or harm, to identify anyone who is at risk and implement person centered interventions, and to in-service all staff members on recognizing behaviors and potential for self-harm and injury and whom to report to. The findings were as followed: Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. The QA Committee determined all 63

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 _____	C 09/06/2020

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 689	Continued From page 49	F 689		

residents will be assessed by the Speech Therapist for difficulty swallowing and choking and to review and implement a plan of care to prevent any adverse reactions related to findings by the Speech Therapist. The findings were as followed Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time.
Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. All residents that have a diet order or diet changes will be reviewed during the weekly care plan meeting by the IDT to prevent any further adverse events. All residents that are reported on the Nurse/Therapy documentation form will be immediately reviewed by the IDT, recommendations discussed, and a plan of care will be put into effect. The Nurse/Therapy documentation forms will be reviewed weekly during the care plan meeting with the IDT to prevent any further adverse events.

No staff will be allowed to work until they are in-serviced.

The facility alleges the Immediate Jeopardy and SQC removed on September 5, 2020.

The State Agency (SA) validated the facility's Corrective Actions through observation, interview, record review, and review of sign-in sheets.

1. The SA validated through interviews and record review of all residents were assessed by the licensed Social Worker and the director of Social Services for behaviors that may lead to

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 _____	C 09/06/2020

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 689	Continued From page 50	F 689		

self-injury or harm.

2. The SA validated through interviews and record review of all residents were assessed by the Speech Therapist for swallowing difficulties and choking aspiration.

3. The SA validated through interviews and were in-serviced on supervising and monitoring risk for aspiration and choking hazards.

4. The SA validated through record review that all residents in the facility charts were reviewed by the care plan nurse for accuracy of all Residents diets.

5. The SA validated through interviews and in-services by the Social Worker on meal Supervision.

6. The SA validated through interview and in-services on the accessibility of care plans and nutritional systems location.

7. The SA validated through interview and in-services on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when and how to report to the State Agency.

8. The SA validated a Quality Assessment and Assurance Committee meeting was held on September 2, 2020 and September 4, 2020 by interview and review of the sign-in sheet.

9. The SA validated that all corrective actions listed were accomplished by 09/05/2020.

10. The SA validated through interviews and

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 _____	C 09/06/2020

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 689	Continued From page 51 record review that staff were not allowed to work until in-serviced. 11. The SA validated that all corrective actions were completed as of 09/05/2020, and the IJ was removed prior to exit on 09/5/2020.	F 689		
F 725 SS=J	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		

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 _____	C 09/06/2020

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 725	Continued From page 52	F 725		

Based on observation, interviews, record review, and facility policy review, the facility failed to have a sufficient number of staff to provide a resident with supervision required and needed to prevent choking, injury and death during meal consumption for one (1) of four (4) residents reviewed for choking, Resident #1.

On 05/15/2020, Resident #1 was left unattended, with food, in the Memory Care Dining Room. Resident #1 choked and aspirated on his breakfast meal, which caused him to die in the facility. There were no licensed personnel in the dining room at this time.

The facility's failure to provide supervision and leaving Resident #1 unattended, placed other residents in a situation that could potentially cause harm, injury, impairment and or death.

This situation was determined to be an Immediate Jeopardy (IJ), which began on 05/15/2020, when the facility left Resident #1 unsupervised, with food in the dining room. Resident #1 was known for shoveling food in his mouth and was a choking risk. There were no licensed personnel in the dining room during mealtime.

The facility's Administrator was notified of the IJ on 09/02/2020. The facility submitted an acceptable credible Removal Plan on 09/05/2020, in which the facility alleged all corrective actions were completed as of 09/04/2020, and the IJ was removed on 09/05/2020.

The State Agency (SA) validated the Removal Plan and determined the IJ to be removed as of 09/05/2020, prior to exit. Therefore, the scope

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 _____	C 09/06/2020

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 725	Continued From page 53	F 725		

and severity for the IJ at CFR(s): 483.35(a)(1)(2) Sufficient Staffing, (F725), was lowered to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

A review of the facility's, "Nursing Services and Sufficient Staff Policy", dated November 2018, revealed, it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnosis of the resident population will be considered based on the facility assessment. The facility will supply services by enough numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.

Review of the facility's Nurses Notes for Resident #1, dated 11/05/2019, documented, a nurse was called to the Memory Care Unit. The Certified Nursing Assistant (CNA) reported Resident #1 shoved a roll into his mouth and choked. The CNA also reported she had to dig the roll out of Resident #1's mouth. The CNA revealed Resident #1 choked yesterday on green beans because eats so fast. A review of the Nurses' Notes, dated 12/31/2019, revealed, the resident fed himself with cueing and supervision. Resident #1 would gulp food unless monitored.

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 _____	C 09/06/2020

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 725	Continued From page 54	F 725		

Record review of the Physicians Notes for Resident #1, dated 05/15/2020 at 7:45 AM, revealed, Resident #1 was eating breakfast without swallowing, and aspirated with collapse. The Heimlich and mouth sweeps were performed by the nursing code team. Large chunks of scrambled eggs were removed from Resident #1's airway before he arrived from down the hall. Resident #1 was awake, eyes opened, sitting up, no coughing, but spontaneous respirations. Within a minute, Resident #1 collapsed again, was transferred to bed. The staff yanker suctioned more food debris. Resident #1 was noted to be a Do Not Resuscitate (DNR). No spontaneous respiration effort, no gag reflex, oxygen added, ambulance in route, agonal heartbeat but no pulse, no heartbeat, eyes fixed and dilated. Ambulance canceled. Resident #1 pronounced at 7:28 AM.

A review of Resident #1's Death Certificate, dated 05/27/2020, revealed, the cause of death was Hypoxia due to airway obstruction and aspiration of food.

During an interview, on 09/03/2020 at 10:15 AM, Certified Nursing Assistant (CNA) #2 revealed she worked the Memory Care Unit on 05/15/2020 (day of incident). CNA #2 stated Resident #1 came out of the dining room, and CNA #1 was patting Resident #1 on his back because he had stuffed food in his mouth. She stated Resident #1 fell to the floor, and CNA #1 was trying to get food out of his mouth. There was not a nurse in the dining room at that time. CNA #2 stated the nurse made rounds on the unit periodically. CNA #2

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 _____	C 09/06/2020

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 725	Continued From page 55	F 725		

stated she called for help and the Nurses came on the unit and pulled eggs out of Resident #1's mouth. CNA #2 revealed Resident #1 would hoard food and pocket food in his mouth. CNA #2 said she was in-serviced by the Speech Therapist to make sure Resident #1 ate last and to monitor his eating because he had a history of choking by shoveling food down his throat. CNA #2 stated Resident #1 also wandered, was an elopement risk and had inappropriate sexual behaviors. There were 10 residents on the memory care unit on 05/15/2020.

An observation on, 09/03/2020 at 11:45 AM, of the lunch meal on the Memory Care Unit, revealed, two (2) CNAs assisting residents with lunch. The residents were spread out around the dining room. There were no nurses in the dining room during the meal.

During an interview, on 09/03/2020 at 12:30 PM, CNA #1 stated she was assisting Resident #1 with his breakfast on 05/15/2020. CNA #1 stated another resident came into the dining room. CNA #1 revealed there were 10 residents on the unit at that time. CNA #1 stated she left Resident #1 at the table to assist the other resident, by unwrapping her food and setting up her tray. She stated CNA #2 was assisting another resident at that time. CNA #1 stated when she turned around to check on Resident #1, she noticed him shoveling food into his mouth from his tray and another resident's tray. She stated Resident #1 was turning gray. CNA #1 revealed she tried to get Resident #1 to open his mouth, but he clenched his teeth together. CNA #1 said she tried to assist Resident #1 to the bathroom to

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 _____	C 09/06/2020

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 725	Continued From page 56	F 725		

clean his mouth. She stated Resident #1 started turning blue and fell to the ground in the day area by the nurse's station. CNA #2 stated CNA #1 tried to take the food out of Resident #1's mouth. She stated that CNA #2 called for a nurse, but there were no nurses on the unit. CNA #1 stated the nurses are not on the unit during meals. CNA #1 stated she was in-serviced by the Speech Therapist to give Resident #1 his meals last, and to assist him with meals because he stuffed food in his mouth that would choke him. CNA #1 stated that she should have asked CNA #2 to assist with the other resident's breakfast. She stated that she should not have left Resident #1 unattended, because Resident #1 was impulsive and had shoved food in his mouth in the past.

During an interview, on 09/03/2020 at 1:00 PM, Registered Nurse (RN) #1 revealed, she was called into the Memory Care Unit by CNA #1 on 05/15/2020 (day of the incident). RN #1 stated she was the Supervisor for the day. RN #1 stated Resident #1 was blue and laying on the floor when she entered the unit. RN #1 stated she performed the Heimlich maneuver and was not successful. RN #1 stated Resident #1 was taken to his room, suctioning was started, and a large amount of scrambled eggs was removed from his mouth. RN #1 stated Resident #1 had a history of choking on his food, because he puts large amounts of food in his mouth at one time. She stated Resident #1 needed one on one supervision with meals.

An interview, on 09/04/2020 at 5:00 PM, the Director of Nursing (DON) confirmed, the facility does not have a licensed nurse in the dining room

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 _____	C 09/06/2020

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 725	Continued From page 57	F 725		

during meals in the Memory Care dining room. The DON stated she discussed this with the Administrator and the Owner of the facility, and they decided to only have two (2) CNAs in this dining room at the time. She stated the nurses would come in and out during meals to make sure the residents have the correct diets.

Review of the facility's Removal Plan, revealed, the facility took the following actions to remove the Immediate Jeopardy:

1. Sixty-three (63) residents were assessed by the Licensed Social Worker and the Social Services Director for behaviors that may lead to self-injury or harm on September 4, 2020 completed at 12:30 PM. Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM.

2. Sixty-three (63) residents were assessed by the Speech Therapist for swallowing difficulties and choking. Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT),

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 _____	C 09/06/2020

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 725	Continued From page 58	F 725		

and the Dietician. No further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 2:30 PM.

3. Eight (8) of eight (8) Registered Nurses (RN), seven (7) of 13 Licensed Practical Nurses(LPN), 30 of 38 Certified Nursing Assistants (CNA), four (4) of 12 Dietary Aides, five (5) of seven (7) Housekeepers, five (5) of seven (7) Activity Personnel, two (2) of three (3) Laundry Personnel, one (1) of three (3) Therapist, four (4) of four (4) Administrative Staff were in-serviced on September 2, 2020 by the Assistant Director of Nursing (ADON) from 2:30 PM until 3:00 PM on supervising and monitoring risk for aspiration and choking hazards.

4. A total of 64 residents' charts were reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/ Quality Assurance Nurse. All 64 residents' charts were reviewed and assessed based on their prescribed diets and diagnosis related to those diets were found to be 100% accurate. A total of 64 residents care plans were reviewed at this time with 100% accuracy. The chart reviews were completed on September 2, 2020 at 5:30 PM.

5. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on September 2-3, 2020 by the Social Services Director and the ADON from 6:00

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 _____	C 09/06/2020

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 725	Continued From page 59	F 725		

PM until 10:00 AM on Meal Supervision and Assistance Policy.

6. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPN's, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in- serviced on September 2, 2020 by the Owner of the facility from 2:30 PM until 3:00 PM on the accessibility of care plans and nutritional systems location.

7. Eight (8) of eight (8) RNs, 22 of 38 CNA's, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when, and how to report to the State Agency.

8. The Quality Assurance Committee (QA) comprised of the Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, Quality Assurance, Owner of facility, Certified Recreational Therapist, Certified Dietary Manager, Assistant Director of Nursing, Licensed Social Worker, Social Services Director, Admissions Nurse, Minimum Data Set Nurse, Medical Records Nurse and Care Plan Nurse met on September 2, 2020 at 1:00 PM. A plan of action was implemented at this time to ensure that all staff is in-serviced on supervising and monitoring risk for aspiration and choking

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 _____	C 09/06/2020

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 725	Continued From page 60	F 725		

hazards, Meal Supervision and Assistance Policy, systematic communication within the facility related to residents that are deemed to be at risk for aspiration or a choking hazard, implementation of the nursing/therapy communication form, accessibility of care plans and nutritional systems location. If a resident is identified as being a choking or aspiration risk, the resident will be assessed by a Speech Therapist to determine the adequate level of supervision needed. This determination will be based on the individual needs of the resident and identified hazards. A nursing/therapy communication form was implemented at this time to ensure all residents that are deemed at risk for aspiration or choking will be reviewed and discussed by the Interdisciplinary Team (IDT) and reviewed by the Quality Assurance Committee. The Care Plan Nurse will review all charts and diet orders of the resident who is at risk for aspiration or choking and refer to the Quality Assurance Committee for review and implementation of any negative outcomes. All residents' charts that were identified according to their prescribed diet and aspiration risk have been reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/Quality Assurance Nurse. A total of 64 residents care plans were updated on September 2, 2020 at 5:30 PM by the Care Plan Nurse. The IDT reviewed all policy and procedures related to the adverse event and deemed all policies and procedures do not require any revision at this time. QA reviewed the state and federal regulation and facility guideline requirements for reporting incidents to the State Agency and the Attorney General's office. All reported incidents will be reviewed in the monthly QA meeting.

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 _____	C 09/06/2020

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 725	Continued From page 61	F 725		

9. The QA Committee met on September 4, 2020 at 8:00 AM for review and implementation to have all 63 residents assessed for behaviors that may lead to self-injury or harm, to identify anyone who is at risk and implement person centered interventions, and to in-service all staff members on recognizing behaviors and potential for self-harm and injury and whom to report to. The findings were as followed: Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. The QA Committee determined all 63 residents will be assessed by the Speech Therapist for difficulty swallowing and choking and to review and implement a plan of care to prevent any adverse reactions related to findings by the Speech Therapist. The findings were as followed Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. All residents that have a diet order or diet changes will be reviewed during the weekly care plan meeting by the IDT to prevent any further adverse events. All residents that are reported on the Nurse/Therapy documentation form will be immediately reviewed

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 _____	C 09/06/2020

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 725	Continued From page 62	F 725		

by the IDT, recommendations discussed, and a plan of care will be put into effect. The Nurse/Therapy documentation forms will be reviewed weekly during the care plan meeting with the IDT to prevent any further adverse events.

No staff will be allowed to work until they are in-serviced.

The facility alleges the immediate jeopardy be removed on September 5, 2020.

The State Agency (SA) validated the facility's Corrective Actions through observation, interview, record review, and review of sign-in sheets.

1. The SA validated through interviews and record review of all residents were assessed by the licensed Social Worker and the director of Social Services for behaviors that may lead to self-injury or harm.

2. The SA validated through interviews and record review of all residents were assessed by the speech therapist for swallowing difficulties and choking aspiration.

3. The SA validated through interviews and were in-serviced on supervising and monitoring risk for aspiration and choking hazards.

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 _____	C 09/06/2020

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 725	Continued From page 63	F 725		

4. The SA validated through record review that all residents in the facility charts were reviewed by the care plan nurse for accuracy of all Residents diets.

5. The SA validated through interviews and in-services by the Social Worker on meal Supervision.

6. The SA validated through interview and in-services on the accessibility of care plans and nutritional systems location.

7. The SA validated through interview and in-services on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when and how to report to the State Agency.

8. The SA validated a Quality Assessment and Assurance Committee meeting was held on September 2, 2020 and September 4, 2020 by interview and review of the sign-in sheet.

9. The SA validated that all corrective actions listed were accomplished by 09/05/2020.

10. The SA validated through interviews and record review that staff were not allowed to work until in-serviced.

11. The SA validated that all corrective actions

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 _____	C 09/06/2020

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 725	Continued From page 64 were completed as of 09/05/2020, and the IJ was removed prior to exit on 09/05/2020.	F 725		
F 867 SS=J	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to implement an appropriate plan of action to monitor identified issues related to Resident #1's high risk for choking and/or aspirating, which resulted in the resident choking to death. This affected one (1) of four (4) residents identified as being high risk for choking/aspirating. The facility's failure to ensure an effective Quality Assurance and Performance Improvement (QAPI) process to implement measures to care for Resident #1's needs placed this resident and other residents, who required supervision due to their risk for choking/aspirating, in a situation that was likely to cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ), which began on 05/15/2020 when Resident #1, who required supervision due to being high risk for choking, was left unattended during the breakfast meal. Resident #1 shoveled food into his mouth and choked, which resulted in him choking to death. The facility failed to have a system in place for monitoring and communicating with Speech	F 867		

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 _____	C 09/06/2020

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 867	Continued From page 65	F 867		

Therapy related to dietary recommendations initiated for residents who were at high risk for choking. This resulted in staff having inaccurate and inconsistent information to use to prevent Resident #1 and other residents, who were high risk, from choking or aspirating. A Quality Assurance and Assessment (QAA) review, revealed, the QAA Committee was not aware of this systemic issue, and the QAA committee was not monitoring facility practices related to accurate and consistent communication of Resident #1's behavior and or food modifications.

The facility's Administrator was notified of the Immediate Jeopardy (IJ) on 09/02/2020. The State Agency (SA) received an acceptable, credible Removal Plan on 09/05/2020, in which the facility alleged that all corrective actions were completed as of 09/04/2020, and the IJ was removed on 09/05/2020.

The SA determined the IJ to be removed as of 09/05/2020, prior to exit. Therefore, the scope and severity for the IJ at 42 CFR(s): 483.75(g)(2)(ii) - QAPI/QAA Improvement Activities (F867) was lowered to a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

Review of the facility's "Quality Assessment and Assurance (QAA)" policy, dated 01/2019, revealed: It is this facility's policy to develop, implement, and maintain an effective, comprehensive, data-driven QAA program that focuses on outcomes of care, promotes individual

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 _____	C 09/06/2020

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 867	Continued From page 66	F 867		

choice and the improvement in quality of life. The QAA Committee shall be interdisciplinary and shall consist at a minimum of: The Administrator, the Medical Director, the Director of Nursing, the Infection Control Prevention Officer, two other members of the facility's staff. The QAA Committee will:

-Conduct scheduled monthly meetings.
-Develop and implement appropriate plans of action to correct identified quality concerns and deficiencies.
-Participate in development, implementation and monitoring of the facilities written QAPI Plan.
-Regularly review and analyze performance data, including data collected under the QAPI program, Infection Reports, Pharmacy, Psychological Reports, and recommendations.
-Identify issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program are necessary.
-Act on available data to make corrections or improvements.
-Review and evaluate all filed and completed grievances.
-Adverse events will be monitored in accordance with established procedures based on the type of adverse event. The data related to adverse events will be used to develop activities to prevent them.

Review of the facility's Quality Assessment and Assurance (QAA) sign-in sheet and meeting minutes, dated 05/15/2020, revealed, the Medical Director, Facility Owner, Administrator, Director of Nursing, QAA Coordinator, Infection Preventionist, Minimum Data Set Nurse, Therapist, and others attended the QA meeting. A

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 _____	C 09/06/2020

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 867	Continued From page 67	F 867		

review of the minutes, revealed: "IDT (Interdisciplinary Team) discussed (Name of Resident) Resident #1's incident that occurred, all statements and summary was reviewed, the medical chart was reviewed, discussed adverse event related to choking incident. IDT discussed increase monitoring at meal times for Daylily Memory Care. Recommendations: Increase monitoring at meal times for Daylily Memory Care."

Record review of the facility's Speech Therapy (ST) Plan of Care, dated 11/06/2019, revealed, Resident #1 was referred to Speech Therapy due to new onset of decreased safety during oral intake, coughing/choking during oral intake, risk for aspiration, decreased safety awareness, increased behaviors, decreased verbal communication, increased need for assistance from others, decreased ability to use compensatory strategies and cognitive-communicative deficits placing patient at risk for aspiration, weight loss and further decline in functions and falls. The ST Plan of Care also indicated precautions for Resident #1 included, an aspiration risk, had impulsive tendencies, to restrict the resident's performance in unsupervised tasks, reduce background noise, stand directly in front of the resident and speak in a deep voice when communicating.

Review of the ST's Plan of Care, dated 05/01/2020, revealed, Resident #1 was referred to ST after a new onset of decreased safety during a meal, which was evidenced by, Resident #1 severely choking during a meal when food was stuck in the resident's throat. As a result, nursing monitored Resident #1 and took Pneumonia precautions with X-ray after the

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 _____	C 09/06/2020

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 867	Continued From page 68	F 867		

resident's temperature spiked two days later. The Plan of Care revealed the Bedside Dysphagia evaluation was given to Resident #1, found and the resident to have both oral and pharyngeal dysphagia, which put him at risk for aspiration. The Plan of Care further indicated Resident #1 was impulsive and puts large spoons/bites in mouth and sometimes two (2) or more spoons/bites in his mouth causing severe choking episodes. Resident #1 was found to be a candidate for skilled dysphagia therapy to implement training strategies for both the resident and caregivers to decrease choking risk.

A record review instructions for Resident #1, dated 05/01/2020, given as an in-service to the Certified Nursing Assistants (CNA), by the Speech Therapist, revealed, CNA #1 and CNA #2 was in-serviced on: "Purpose of a small spoon, to encourage liquids between swallows during meal time, strategies to recognize impulsive behavior during meal time also have the ability to recognize mood of patient and determine level of assistance needed that day. Then, implement use of compensatory strategies (i.e. Hand over Hand, diet modifications "not giving roll", removing tray from patient and calming patient down, giving meal tray last, and being one-on-one, handing patient something to drink in between bites and ultimately removing tray from patient and feeding patient) to decrease impulsive behavior and to ensure meal time safety."

During an interview, on 09/03/2020 at 12:30 PM. CNA #1 stated she was assisting Resident #1 with his breakfast on 05/15/2020 (day of incident). CNA #1 stated another resident had came into the dining room. CNA #1 confirmed she left Resident #1 at the table to assist the other

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 _____	C 09/06/2020

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 867	Continued From page 69	F 867		

resident by unwrapping her food and setting up her tray. CNA #1 stated when she turned around to check on Resident #1, she noticed Resident #1 was stuffing food from his tray and another resident's tray into his mouth. She revealed, Resident #1 was turning gray and that she tried to get Resident #1 to open his mouth but he clenched his teeth together. CNA #1 stated she tried to assist Resident #1 to the bathroom to clean his mouth, but he started turning blue and fell to the ground in the day area by the nurses' station. CNA #1 stated CNA #2 called for a nurse. There were no nurses on the unit. CNA #1 stated the nurses were not on the unit during meals. CNA #1 revealed she was in-serviced by the Speech Therapist to give Resident #1 meals last, and to assist him with his meals because he stuffed food in his mouth that would choke him. CNA #1 confirmed Resident #1 should not have been left unattended because he was impulsive and had a history of shoving food in his mouth.

Interview on 09/04/2020 at 9:15 AM, with the Administrator, revealed, the Quality Assurance (QA)/Infection Nurse set up the QA meetings monthly and as needed. The Administrator stated the facility had a QA meeting on 05/15/2020 and Resident #1's death was discussed. The Administrator revealed, the QA team reviewed all the staff's statements, Resident #1's chart, and adverse event related to choking incident. The QA team recommended increase monitoring of all meals on the memory care unit. The Administrator stated the facility didn't do any disciplinary action towards the CNA that left Resident #1 unattended with food in the Memory Care dining room and the policies were not changed or updated.

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 _____	C 09/06/2020

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 867	Continued From page 70	F 867		

An interview with RN #3, on 09/04/2020 at 9:45 AM, confirmed the facility had a QA meeting on 05/15/2020. RN #3 revealed the QA committee discussed Resident #1's death and received statements from everybody involved. RN #3 revealed the committee recommended to increase monitoring at mealtimes for the Memory Care Unit. RN #3 stated the policies were not updated or changed and no disciplinary action was done.

Review of the facility's Removal Plan, revealed the facility took the following actions to remove the Immediate Jeopardy:

1. Sixty-three (63) residents were assessed by the Licensed Social Worker and the Social Services Director for behaviors that may lead to self-injury or harm on September 4th, 2020 completed at 12:30 PM. Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM.

2. Sixty-three (63) residents were assessed by the Speech Therapist for swallowing difficulties and choking. Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT),

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 _____	C 09/06/2020

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 867	Continued From page 71	F 867		

and the Dietician. No further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 2:30 PM.

3. Eight (8) of eight (8) Registered Nurses(RN), seven (7) of 13 Licensed Practical Nurses(LPN), 30 of 38 Certified Nursing Assistants (CNA), four (4) of 12 Dietary Aides, five (5) of seven (7) Housekeepers, five (5) of seven (7) Activity Personnel, two (2) of three (3) Laundry Personnel, one (1) of three (3) Therapist, four (4) of four (4) Administrative Staff were in-serviced on September 2, 2020 by the Assistant Director of Nursing (ADON) from 2:30 PM until 3:00 PM on supervising and monitoring risk for aspiration and choking hazards.

4. A total of 64 residents' charts were reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/ Quality Assurance Nurse. All 64 residents' charts were reviewed and assessed based on their prescribed diets and diagnosis related to those diets were found to be 100% accurate. A total of 64 residents care plans were reviewed at this time with 100% accuracy. The chart reviews were completed on September 2, 2020 at 5:30 PM.

5. Eight (8) of eight (8) RNs, 22 of 38 CNA's, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on September 2-3, 2020 by the Social Services Director and the ADON from 6:00 PM until 10:00 AM on Meal Supervision and Assistance Policy.

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 _____	C 09/06/2020

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 867	Continued From page 72	F 867		

6. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in- serviced on September 2, 2020 by the Owner of the facility from 2:30 PM until 3:00 PM on the accessibility of care plans and nutritional systems location.

7. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when, and how to report to the State Agency.

8. The Quality Assurance Committee (QA) comprised of the Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, Quality Assurance, Owner of facility, Certified Recreational Therapist, Certified Dietary Manager, Assistant Director of Nursing, Licensed Social Worker, Social Services Director, Admissions Nurse, Minimum Data Set Nurse, Medical Records Nurse and Care Plan Nurse met on September 2, 2020 at 1:00 PM. A plan of action was implemented at this time to ensure that all staff is in-serviced on supervising and monitoring risk for aspiration and choking hazards, Meal Supervision and Assistance Policy, systematic communication within the facility related to residents that are deemed to be at risk for aspiration or a choking hazard, implementation of the nursing/therapy communication form, accessibility of care plans

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 _____	C 09/06/2020

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 867	Continued From page 73	F 867		

and nutritional systems location. If a resident is identified as being a choking or aspiration risk, the resident will be assessed by a Speech Therapist to determine the adequate level of supervision needed. This determination will be based on the individual needs of the resident and identified hazards. A nursing/therapy communication form was implemented at this time to ensure all residents that are deemed at risk for aspiration or choking will be reviewed and discussed by the Interdisciplinary Team (IDT) and reviewed by the Quality Assurance Committee. The Care Plan Nurse will review all charts and diet orders of the resident who is at risk for aspiration or choking and refer to the Quality Assurance Committee for review and implementation of any negative outcomes. All residents' charts that were identified according to their prescribed diet and aspiration risk have been reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/Quality Assurance Nurse. A total of 64 residents care plans were updated on September 2, 2020 at 5:30 PM by the Care Plan Nurse. The IDT reviewed all policy and procedures related to the adverse event and deemed all policies and procedures do not require any revision at this time. QA reviewed the state and federal regulation and facility guideline requirements for reporting incidents to the State Agency and the Attorney General's office. All reported incidents will be reviewed in the monthly QA meeting.

9. The QA Committee met on September 4, 2020 at 8:00 AM for review and implementation to have all 63 residents assessed for behaviors that may lead to self-injury or harm, to identify anyone who is at risk and implement person centered

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 _____	C 09/06/2020

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 867	Continued From page 74	F 867		

interventions, and to in-service all staff members on recognizing behaviors and potential for self-harm and injury and whom to report to. The findings were as followed: Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. The QA Committee determined all 63 residents will be assessed by the Speech Therapist for difficulty swallowing and choking and to review and implement a plan of care to prevent any adverse reactions related to findings by the Speech Therapist. The findings were as followed Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. All residents that have a diet order or diet changes will be reviewed during the weekly care plan meeting by the IDT to prevent any further adverse events. All residents that are reported on the Nurse/Therapy documentation form will be immediately reviewed by the IDT, recommendations discussed, and a plan of care will be put into effect. The Nurse/Therapy documentation forms will be reviewed weekly during the care plan meeting with the IDT to prevent any further adverse events.

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 _____	C 09/06/2020

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 867	Continued From page 75	F 867		

No staff will be allowed to work until they are in-serviced.

The facility alleges the immediate jeopardy be removed on September 5, 2020.

The State Agency validated the facility's Corrective Actions through observation, interview, record review, and review of sign-in sheets.

1. The SA validated through interviews and record review of all residents were assessed by the licensed Social Worker and the director of Social Services for behaviors that may lead to self-injury or harm.

2. The SA validated through interviews and record review of all residents were assessed by the speech therapist for swallowing difficulties and choking aspiration.

3. The SA validated through interviews and were in-serviced on supervising and monitoring risk for aspiration and choking hazards.

4. The SA validated through record review that all residents in the facility charts were reviewed by the care plan nurse for accuracy of all Residents diets.

5. The SA validated through interviews and in-services by the Social Worker on meal Supervision.

6. The SA validated through interview and in-services on the accessibility of care plans and nutritional systems location.

7. The SA validated through interview and

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 _____	C 09/06/2020

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 867	Continued From page 76	F 867		

in-services on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when and how to report to the State Agency.

8. The SA validated a Quality Assessment and Assurance Committee meeting was held on September 2, 2020 and September 4, 2020 by interview and review of the sign-in sheet.

9. The SA validated that all corrective actions listed were accomplished by 09/05/2020.

10. The SA validated through interviews and record review that staff were not allowed to work until in-serviced.

11. The SA validated that all corrective actions were completed as of 09/5/2020, and the IJ was removed prior to exit on 09/05/2020.