

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2022
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 530 HALL ST WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Focused Infection Control (FIC) survey and Complaint Investigation (CI), MS #18810, MS #19037, and MS #19424, at the facility from 7/29/22 to 8/03/22. The facility was found to be in compliance with infection control regulations and the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 and there were no deficiencies cited related to the FIC survey. During the complaint investigation, the SA determined that the facility was in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate MS #19424 for safety due to a resident fall and MS #18810 for verbal abuse, medications not administered properly, staffing, dietary services, and call lights not answered timely. MS #19037 was not substantiated for misappropriation, not treating residents with dignity/respect, nursing services, and medication not given according to physician instructions. There were no deficiencies cited. The facility held a license for 103 beds, with a census of 69.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/16/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.