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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalea Gardens Nursing Center	530 Hall St Wiggins, MS 39577

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, staff interview, record review, and facility policy review, the facility failed to post the daily nursing staffing hours in a location readily accessible to residents and visitors and failed to update the posted staffing for three (3) of four (4) days of survey. This deficient practice had the potential to affect all 63 residents residing in the facility. Findings included: A review of the facility's Nurse Staffing Posting Information Policy, dated 10/2023, revealed, .It is the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines 1. The nurse staffing information will be posted on a daily basis .2. The facility will post the nurse staffing data at the beginning of each shift. 3. The information posted will be presented a. Presented in a clear and readable format. B. In a prominent place readily accessible to residents and visitors . A record review of the facility's posted staffing information revealed that the last update was on 03/03/2025. On 03/03/2025 at 10:00 AM, during an observation, the staffing information was located at the back of the facility near the vending machines. No residents or family members were observed near the area. This location was identified as the staff entryway, not a central location accessible to residents or visitors. On 03/04/2025 at 9:55 AM, during an observation, the staffing information posted was dated 03/03/2025 and was not updated with current information. The posted form remained near the back door of the facility where there were no residents or family members observed. On 03/04/2025 at 1:00 PM, during an interview with a family member of Resident #11, she stated that she had not seen the staffing information posted and did not know where it was located. On 03/05/2025 at 3:15 PM, during an observation conducted with Licensed Practical Nurse (LPN) #1, the staffing information remained posted at the back door near the vending machines and was still dated 03/03/2025. No residents or family members were observed in the area. On 03/05/2025 at 3:45 PM, during an interview, the Director of Nursing (DON) and Administrator confirmed that the staffing information had not been updated since Monday, 03/03/2025. The DON acknowledged that she had gotten sidetracked and forgot to update the staffing information. The Administrator stated that she believed family members and residents frequently visited the back area to get drinks and snacks from the vending machines. However, both the Administrator and the DON later confirmed (continued on next page)

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

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

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	that the staffing information was not centrally located, and that residents and family members typically did not enter through this door, as it was primarily used as a staff entrance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to use hand hygiene, discard overly ripe produce, and failed to calibrate a food thermometer prior to checking food temperatures, for two (2) of two (2) kitchen observations. Findings included: A review of the facility's Food Safety Policy, dated November 2023, revealed, Food will . be stored, prepared . with professional standards for food service safety. Policy Guidelines 1. Food safety practices shall be followed throughout the facility's entire food handing process .Elements of the process include the following .b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from the growth of microorganisms . 3. Facility shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage .7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. a. Staff shall wash hands according to facility procedures . A review of the facility's Record of Food Temperatures Policy, dated November 2023, revealed, .It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled .Policy Guidelines .14. Food temperatures will be verified using a thermometer which is . calibrated to ensure accuracy . On 03/03/2025 at 10:17 AM, during an observation of the kitchen and an interview with the Certified Dietary Manager (CDM), seven (7) sweet potatoes and one (1) onion with soft spots and white biological growth were observed in the pantry. Additionally, a bag of raisins was found open and exposed. Dietary Aide (DA) #2 was observed placing cartons of juice in the refrigerator and retrieved a plastic drink lid from the floor, discarded it, and continued placing five (5) juice cartons into the refrigerator without washing her hands. The CDM acknowledged that the staff member should have performed hand hygiene after retrieving the plastic drink lid from the floor and confirmed the presence of overly ripe produce and opened and exposed food items in the pantry. The CDM further stated that she and the Assistant Dietary Manager (ADM) were the only staff responsible for selecting produce from storage for the food preparation area, ensuring that no staff member would have mistakenly used the overly ripe produce. On 03/03/2025 at 10:30 AM, during an interview, DA #2 confirmed that she retrieved the plastic drink lid from the floor and continued handling food items without performing hand hygiene. She acknowledged that she should have stopped and washed her hands before continuing food preparation. The Dietary Aide stated that staff receive monthly in-service training on infection control. On 03/04/2025 at 11:00 AM, during an observation of the meal tray line and an interview the [NAME] was unable to explain how to properly calibrate a food thermometer before checking and recording food temperatures. The [NAME] stated that the thermometer should be calibrated to 22 degrees but did not use ice to calibrate the thermometer, despite the ADM providing ice for the process. The [NAME] acknowledged that she failed to properly calibrate the thermometer and stated that she was nervous. The [NAME] further stated that she normally would have calibrated the food thermometer using ice. On 03/04/2025 at 11:20 AM, during an interview with the ADM, she confirmed that the [NAME] should have properly calibrated the food thermometer before use, which was why she had placed ice near her. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ADM emphasized the importance of ensuring thermometer accuracy to obtain correct food temperature readings. The ADM stated that her expectation was that all staff would correctly calibrate thermometers before use. The ADM also stated that staff receive monthly in-service training on infection control. On 03/06/2025 at 10:24 AM, during an interview, the Administrator acknowledged that she was aware of the presence of overly ripe and opened and exposed food items in the pantry, the Dietary Aide's failure to use hand hygiene after retrieving an item from the floor, and the Cook's failure to calibrate the food thermometer. The Administrator stated that she expected staff to correctly monitor food temperatures for safety reasons and to ensure that food items were not stored in a deteriorated state. The Administrator confirmed that staff were expected to follow appropriate handwashing procedures to maintain food safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a nurse performed hand hygiene, changed gloves, and discarded a feeding tube syringe after it was dropped onto the floor during a medication administration observation for one (1) of three (3) residents reviewed for medication administration. (Resident #31) Findings included: A review of the facility's Infection Prevention and Control Program Policy, dated February 2024, revealed, .The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Guidelines .d. Standard Precautions .b. Hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures .d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies .p. Staff Education .a. Facility staff receive training relevant to their specific roles and responsibilities regarding the facility's infection prevention and control program, including policies and procedures related to their job function . A record review of the facility's In-Service Attendance Record, dated 01/13/2025, 01/14/2025, and 01/17/2025, revealed that staff receiving training related to Infection Control Principles, including importance of hand hygiene . On 03/04/2025 at 8:16 AM, during a medication administration observation for Resident #31, Licensed Practical Nurse (LPN) #2, while wearing gloves, retrieved the Percutaneous Endoscopic Gastrostomy (peg) tube syringe, which fell to the floor. LPN #2 picked up the syringe and proceeded to administer medications via the resident's peg tube without discarding the contaminated syringe, performing hand hygiene, or changing her gloves. On 03/05/2025 at 8:20 AM, during an interview, LPN #2 confirmed she failed to change gloves, wash hands, or use a new syringe. LPN #2 stated the resident could develop an infection from using contaminated gloves and syringe. She explained that she should have removed the gloves, sanitized her hands, and used a new syringe. LPN #2 stated she was nervous and was not thinking clearly. On 03/05/2025 at 1:00 PM, during an interview, the Director of Nursing (DON) stated that LPN #2 should have changed her gloves, sanitized her hands, and used a new syringe to prevent the resident from developing an infection. On 03/06/2025 at 1:41 PM, during an interview, Registered Nurse (RN)#2/Infection Preventionist stated that the nurse should have changed her gloves, sanitized her hands, and used a new syringe. RN #2 also confirmed that LPN #2 had been trained regarding infection control practices. On 03/06/2025 at 1:43 PM, during an interview, the Administrator stated that she expects staff to follow infection control policies to prevent residents from acquiring infections. A record review of Resident #31's admission Record revealed the facility admitted the resident on 01/10/2024 with diagnoses including Unspecified Dementia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #31's Significant Change In Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/2024 revealed he had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired.