| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **255233** | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED **09/10/2026** |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **AZALEA GARDENS NURSING CENTER** | | STREET ADDRESS, CITY, STATE, ZIP CODE **530 HALL ST , WIGGINS, Mississippi, 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 |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted a follow-up revisit at the facility on 9/10/26 related to an annual recertification survey that was conducted from 8/3/26 thru 8/6/26. The SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid and recommends the facility be placed back in compliance effective 9/7/26.<br><br>The facility held a license of 99 beds and the census at the time of the survey was 58. | F0000 | | |

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 reverse for further 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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