STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255103	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Health & Rehabilitation	205 Byram Parkway Byram, MS 39272

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 42807 Based on interviews, record review, and facility policy review, the facility failed to timely manage and treat complaints of pain for two (2) of four (4) sampled residents, when the unit the residents resided on did not have a licensed nurse to assess, monitor, or treat complaints of pain from approximately 7:00 PM on 3/22/24 until approximately 1:47 AM on 3/23/24. Residents #2 and #4 Findings Include: Record review of the facility policy titled, Pain Assessment/Management, revised 9/10, revealed, It is the policy of this facility to provide guidelines in the identification and treatment of residents at risk for acute and chronic pain. Each residents pain will be assessed in an approach designed to increase comfort and promote dignity through administering alternative interventions or medications .Staff members providing direct care . will use an interdisciplinary approach observing pain symptoms in the resident and report it to the nurse. If possible, the nurse will discuss with the resident the severity and quality of pain using the pain reference scale. This will be documented on the pain assessment. When a resident demonstrates pain, whether verbally or non-verbally, the nurse is to administer pain med per PRN (as needed) orders . Resident #2 On 4/01/24 at 4:30 PM, an interview with Resident #2 revealed the resident reported that there was not a licensed nurse on the 500 Hall from 7:00 PM on Friday, 3/22/24 until between 1:00 AM and 2:00 AM on Saturday, 3/23/24. Resident #2 stated that she reported all over body pain, which she rated nine (9) on a 0-10 pain scale, to her Certified Nurse Aide (CNA). The resident explained that the CNA told her that there was not a nurse to give her any medicine. The resident stated that she had not been able to go to sleep until she received her medication later that night. Record review of the Order Summary Report, with active orders as of 3/1/24 for Resident #2, revealed a physician order for Norco Tablet 7.5-325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours for pain as needed for Moderate Pain, with an order date of 12/02/21. There was also an order, dated 1/26/21 to Evaluate pain per pain scale (0-10) every shift PRN. If pain is present document interventions and follow up on effects. Notify MD (Medical Doctor) of persistent pain unrelieved by intervention, every shift. Record review of the Admission Record for Resident #2 revealed the facility admitted the resident on 1/26/21, with diagnoses that included Type 2 diabetes and Peripheral autonomic neuropathy. (continued on next page)

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 3/19/24, for Resident #2, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #4 On 4/03/24 at 11:30 AM, an interview with Resident #4 revealed the resident recalled having had surgery and having surgical related pain on the evening of 3/22/24, that was untreated for several hours. The resident recalled she had been told by the CNA that there was no nurse on their unit to give her any pain medication. The resident stated she was still real sore at the surgical site and rated her pain on the evening of 3/22/24, as 5 to 6 on a 0-10 pain scale. Record review of the Order Summary Report, with active orders as of 3/1/24 for Resident #4, revealed physician orders dated 2/2/24, Evaluate Pain Per Pain Scale (0-10) every shift and as needed and if pain is present document interventions and follow up on effects. Notify MD (Medical Doctor) of persistent pain unrelieved by intervention, every shift, Acetaminophen Oral Tablet 500 MG, give 2 tablets by mouth every 6 hours PRN, Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG, give 2 tablets by mouth every 6 hours PRN, and Tramadol HCL (hydrochloride) Oral Tablet 50 MG, give 1 tablet by mouth every 6 hours PRN. Record review of the Admission Record for Resident #4 revealed that the facility admitted the resident on 2/2/24, with diagnoses that included Encounter for orthopedic aftercare following surgical amputation and Peripheral vascular disease. Record review of the 5 Day MDS with ARD of 2/09/24, for Resident #4, revealed the resident had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. On 4/01/24 at 6:40 PM, an interview with Registered Nurse (RN)#1 revealed that she worked at the facility as the RN Supervisor for the 3:00 PM to 11:00 PM (3-11) shift and that she was responsible for the entire building. RN #1 confirmed that she did not go on the 500 Hall the entire time she was on duty on the evening of 3/22/24. She stated that Licensed Practical Nurse (LPN) #1 counted the narcotics and took the cart for outgoing LPN #2 and that LPN #1 did not request assistance during the shift. On 4/01/24 at 7:00 PM, an interview with LPN #1 revealed that she counted the narcotics with LPN #2 at approximately 6:50 PM on 3/22/24 because she was under the impression that the Float Nurse was coming in to take care of and administer medications to the residents on the 500 Hall. LPN #1 reported that she had been busy with her assigned residents on the 600 and 800 Halls and did not go on the 500 Hall during her shift until LPN #3 arrived at approximately 1:47 AM on 3/23/24. LPN #1 said that at 1:47 AM she and LPN #3 counted the narcotics for the 500 Hall medication cart and LPN #3 assumed responsibility for the residents on 500 Hall. LPN #1 confirmed that she did not provide any supervision or monitoring, including pain monitoring or administration of any medications, for the residents on the 500 Hall. She explained she felt the situation occurred because LPN #4 called-in, the Float Nurse did not show up, the RN Supervisor did not assume responsibility for the 500 Hall, and the On-Call Nurse did not answer calls from the facility. LPN #1 stated that she notified RN #1 at or around 8:00 PM on 3/22/24, that there was no nurse on the 500 Hall. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 4/02/24 at 2:15 PM, an interview with LPN #3, revealed that he was made aware that there was no nurse on the 500 Hall after 7:00 PM on 3/22/24, sometime after midnight on the morning of 3/23/24. He stated he reported to the facility at 1:47 AM, completed a narcotic count with LPN #1 and administered medications to the residents on the 500 Hall. He stated that he was concerned about the report of no nurse on the 500 Hall because Resident #2 can't go to bed without her bedtime medicine. He stated that he had contacted the Nurse Practitioner (NP) and notified her of the delay in delivery of services, with no new orders noted. LPN #3 confirmed that Resident #2 was awake when he reported to work at 1:47 AM. On 4/02/24 at 4:00 PM, during a telephone interview with the NP for Residents #2 and #4, she stated that she expected the physician orders to be followed to provide for each resident's needs. She stated that failure to receive pain assessments and pain medication as prescribed could result in prolonged pain and discomfort and said, I don't want any of my patients to be in pain, that's why I write orders for pain management and said she felt that failure to assess residents for pain and failure to administer prescribed pain management medications was unacceptable. On 4/02/24 at 4:10 PM, a follow-up interview with RN #1 revealed that she stated that she was shocked that a resident could report pain or the need for medication to a CNA that was not communicated to a licensed nurse. She stated that the CNAs should not have told residents that there were no nurses to give them medications or assess them for pain management needs. She stated that the CNAs should have reported resident needs to a nurse and denied having any such requests reported to her on the evening of 3/22/24. On 4/02/24 at 4:20 PM, during an interview CNA #1 confirmed that on 3/22/24 she had worked the 3PM-11PM shift and was assigned to rooms 507-B through 511. CNA #1 reported that no licensed nurse came on to the 500 Hall after 7:00 PM. She stated that Resident #4 reported pain and requested pain medication and I told her the nurse wasn't there yet. I told (LPN #1) and she said she would let the nurse know when they got there. CNA #1 confirmed that LPN #1 did not assess Resident #4 for pain or come to the 500 Hall. On 4/02/24 at 4:30 PM, during an interview CNA #3 reported that she had worked from 3PM-11PM at the facility on 3/22/24 and was assigned to rooms 512 through 520. CNA #3 confirmed that no nurse came to the 500 Hall after 7:00 PM. CNA #3 stated that Resident #2 and other residents requested their medications and she had told them that their nurse had not made it yet. CNA #3 revealed that she had not notified any licensed nurse of the resident's requests. CNA #3 confirmed that some of her assigned residents were still awake when she left the facility at 11:00 PM. On 4/03/24 at 12:11 PM, during an interview the Director of Nurses (DON) confirmed that the facility utilized the (0-10) Pain Scale for pain assessment of residents and that nurses are encouraged to anticipate pain management needs of residents. The DON confirmed that pain interventions were not utilized from 7:00 PM on 3/22/24 through approximately 1:47 AM on 3/23/24, due to a break in staff communication. The DON further confirmed the facility did not have a licensed nurse on the 500 Hall during this time, to monitor and administer medications to the residents on the 500 Hall for approximately six (6) hours and 45 minutes. 7:00 PM on 3/22/24, until approximately 1:47 AM. The DON stated that LPN #1 should have been made aware of resident complaints of pain and requests for medications, as LPN #1 had the keys to the 500 Hall medication cart. She stated that she expected that residents' physician orders to be followed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 4/03/24 at 1:15 PM, an interview with the Administrator revealed the Administrator was unaware of the staffing issue that occurred on 3/22/24, until inquiries were made regarding the incident by the State Agency on 4/01/24. Record review of the facility MEDICATION PASS TIMES dated 12/01/23, revealed the facility defined scheduled medication administration times for physician orders for HS (bedtime) as 8:00 PM.