

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Edgewood Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure the environment was free from accident hazards and residents received adequate supervision to prevent a resident from ingesting a cleaning solution retrieved from an unsecured housekeeping cart for one (1) of two (2) residents reviewed with wandering behaviors. (Resident #1)</p> <p>Findings include:</p> <p>Record review of the facility policy titled, Hazardous Chemical Storage, dated 10/2003, revealed, Policy: Environmental services shall maintain all hazardous chemicals in a safe, clean, and locked location when not in use. All hazardous chemicals shall be in control of facility personnel while being used. Procedure: 1. Hazardous chemicals will be maintained in a locked storage area at all times. 2. Hazardous chemicals in use by environmental services shall remain under direct control by facility personnel while in common traffic areas. 3. Hazardous chemicals placed on environmental services cleaning carts shall be locked in the provided container after each use or when not in direct use by facility personnel .</p> <p>Record review of the Facility Incident Report dated 4/11/24, revealed that at 10:30 AM, staff noticed Resident #1 had a cleaning supply bottle in his hand and consumed a small amount of the contents of the bottle.</p> <p>On 4/22/24 at 2:06 PM, an interview with the Director of Nurses (DON) revealed that Resident #1's nurse, Licensed Practical Nurse (LPN) #1, had reported to her on 4/11/24 at approximately 10:30 AM, that she had witnessed Resident #1 consume a gulp of fluid from a bottle of cleaning solution from one of the housekeeping carts. The DON stated that Registered Nurse (RN) #1/Nurse Supervisor had contacted the Nurse Practitioner (NP) and poison control and received instructions to provide increased amounts of oral fluid intake for Resident #1 and monitor for adverse reactions. The DON reported that Facility Investigation into the incident revealed Resident #1 had obtained the bottle of cleanser from the housekeeping cart of Housekeeper #1 on the 500 Hall.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/24 at 2:20 PM, an interview with Housekeeper #1 revealed that she had been cleaning the bathroom attached to room [ROOM NUMBER], with her cleaning cart parked outside the door of room [ROOM NUMBER] with the wheels unlocked, and the supply cabinet door unlocked and aligned with the door to room [ROOM NUMBER]. She mentioned that upon returning to the room from the bathroom, she noticed that the cart had been moved, but was later notified by nursing staff, that Resident #1 had taken a bottle of cleaning solution and had consumed some of it. She confirmed she had had been instructed by the Housekeeping Supervisor to keep housekeeping carts locked or lined-up with the room of the door in which they were working. Housekeeper #1 stated she was familiar with Resident #1 and was aware that he had a behavior of removing items from carts in the hallways. She stated, He can tear a cart up if no one's watching. She stated that while Resident #1's room was on the 800 Hall and she was working on the 500 Hall on 4/11/24, she had been aware that the resident had wandering behaviors and was able to move about the facility to all hallways.</p> <p>On 4/22/24 at 2:30 PM, an interview with the Housekeeping Supervisor and observation of the spray bottle of the cleanser that the Housekeeping Supervisor reported was the bottle retrieved from Resident #1 on 4/11/24, the Housekeeping Supervisor stated that when housekeeping carts were in the hallways, cleaning supplies were supposed to be kept in the locked storage box on the cart when not in use by the housekeeper. Observation revealed the bottle was labeled CLOROX Healthcare Bleach Germicidal Cleaner. The label stated, Physical or Chemical Hazards: Strong Oxidizing Agent .Directions for Use .This product is not to be used as a terminal sterilant/high-level disinfectant on any surface or instrument that (1) is introduced directly into the human body, either into or in contact with the bloodstream or normally sterile areas of the body, or (2) contacts intact mucous membranes . Review of the Caution section of the label revealed, Causes moderate eye irritation .First Aid: If in Eyes: . Call poison control center or doctor for further treatment advice .</p> <p>On 4/23/24 at 10:45 AM, an interview with Housekeeper #2 revealed she said that when working out of direct observation of the housekeeping cart, including in the resident's bathroom, the supplies lock box should be locked, and the cart should be positioned with the door of the lock box aligned with the door of the room in which the housekeeper was working for the safety of the residents.</p> <p>On 4/23/24 at 1:00 PM, during an interview with RN #1, she confirmed that she was the RN Supervisor for the 800 Hall on 4/11/24, and had contacted the NP and Poison Control following an incident on 4/11/24 at approximately 10:30 AM, during which Resident #1 had obtained a spray bottle of cleaning solution and consumed some of the contents. RN #1 stated that she was familiar with Resident #1, his care, and his behaviors. She stated, He roams around, and we are aware of his behavior. She explained that Resident #1 had wandering behaviors and had been known to take unsecured items from medication carts and place the items into his mouth.</p> <p>Record review of the Admission Record, for Resident #1, revealed the facility admitted the resident on 6/24/2005. The resident's diagnoses included Unspecified Dementia with Behavioral Disturbance, Impulse Disorder, Psychotic Disorder with Hallucinations, and Personal History of Traumatic Brain Injury.</p> <p>Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/17/24, revealed the resident had no Brief Interview for Mental Status (BIMS) score. Section C revealed Resident #1 was not able to participate in the interview because he is rarely/never understood and had memory problems.</p>		