

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 06/24/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>42807</p> <p>Based on observations, staff and Resident Representative (RR) interview, record review and facility policy review the facility failed to notify the RR/family of a severely cognitively impaired resident of a change in the resident's condition, for one (1) of nine (9) sampled residents. Resident #6</p> <p>Findings include:</p> <p>Record review of the facility policy titled, Notification of Family/Resident Representative, with revision date 10/2016, revealed, Policy: It is the policy of this facility to notify family or resident representative of all services provided by this facility. This included changes in a resident's condition or status. The physician, family member or resident representative will be notified of the change .</p> <p>Record review of the Resident Grievance Investigation Form, dated 6/03/24 revealed . RR was upset .with regards to old, scattered scratches on his chest area .The scratches were documented in the body audit, but the nurse forgot to call the RR .</p> <p>On 6/18/24 at 1:18 PM, during an interview with the DON, she stated that she had pitched in to help the nurses on 5/27/24, and conducted the weekly body audit for Resident #6. She confirmed she had noted scratches on the chest of Resident #6 and forgot to notify the resident's RR.</p> <p>On 6/18/24 at 4:30 PM, an interview with the RR for Resident #6 revealed she had been upset and filed a grievance on 6/03/24, because she visited Resident #6 and noted multiple scratches on the resident's chest of which she had not been notified. She stated that she voiced her concerns to the Director of Nurses (DON). She stated that because of her grievance, the DON reported the facility nursing staff would provide fingernail care for Resident #6 every week. The RR said that the DON told her that she (the DON) had completed a body audit for Resident #6 on 5/27/24, noted the scratches but forgot to notify her of the change to the resident's skin.</p> <p>On 6/18/24 at 4:40 PM, during an observation, with the RR for Resident #6, she pointed out two (2) clean, dry scratches on the chest of Resident #6. There was one slightly curved two (2) inch scratch below the right breast and one (1) scratch that was one (1) inch on the resident's upper left chest.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Admission Record, for Resident #6, revealed the facility initially admitted the resident on 6/17/22. The resident had diagnoses that included Chronic Leukemia, Type 2 Diabetes, Chronic Kidney Disease, and Unspecified Dementia.</p> <p>Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/28/24 revealed the Resident #6 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42807</p> <p>Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure an allegation of resident-to-resident non-consensual sexual contact was reported to the State Agency (SA) for two (2) of nine (9) sampled residents. Residents #3 and #4</p> <p>Findings included:</p> <p>Record review of the facility policy titled, Abuse Policy and Procedure dated 3/21/2022, revealed, Policy Statement: Each resident of this facility has the right to be free from verbal, sexual, mental abuse. Residents are not to be subjected to abuse by anyone. This includes other residents. Abuse Policy Employee Responsibility. 7. Any alleged incident REPORTED must be investigated and REPORTED to the state within 24 hours of knowledge of such alleged incident. In addition, a written report must be submitted by Registered Mail within 72 hours.</p> <p>On 6/17/24 at 12:00 PM, an interview with License Practical Nurse (LPN) #1 revealed that on 6/09/24 she was assigned to the care of Residents #2, #3 and #4. She stated that at approximately 12:15 PM, (after lunch) she observed in the dining room of the locked dementia unit Resident #3 stand up from the dining table and Resident #2 stood up and stood directly behind Resident #3 and caressed her right buttock with his right hand from about waist level down to the bottom of Resident #3's buttock. She stated that she immediately spoke with Resident #2 and informed him that his behavior was inappropriate and requested he go to his room. She stated that she documented her observation in a Behavioral Progress Note for Resident #2 and notified the Registered Nurse (RN) Supervisor/RN #1 between 12:45 PM and 1:00 PM on 6/09/24. LPN #1 reported that in a separate incident during the evening meal on 6/09/24 at approximately 5:30 PM, she observed Resident #2 stand and rub resident #4 on her right buttock as Resident #4 exited the dining room after eating supper and provided a verbal reminder to Resident #2 that it was not appropriate to touch other residents, and Resident #2 went to his room. She stated she documented the observation in a Behavioral Progress Note.</p> <p>Record review of the Progress Notes Type: Behavior Note dated 6/09/24 at 12:06 PM and signed by LPN #1 revealed Inappropriate sexual language and conduct towards another resident .</p> <p>Record review of the Progress Notes: Type: Behavior Note dated 6/09/24 at 12:15 PM and signed by LPN #1 revealed Writer observed resident caressing the buttock of another resident .</p> <p>Record review of the Progress Notes: Type: Nurses Note dated 6/09/24 at 7:14 PM (19:14) signed by LPN #1 revealed At evening meal, resident was observed stroking another resident in a sexual manner .</p> <p>On 6/18/24 at 11:19 AM, an interview with the Social Service Director (SSD)revealed she became aware of the two (2) incidents related to sexually inappropriate behavior by Resident #2 on 6/12/24, when she conducted a Minimum Data Set (MDS) assessment and reviewed the resident's progress notes. She stated that she reported the incidents to the Interdisciplinary Team (IDT), including the Administrator and Director of Nurses (DON) on the morning of 6/12/24.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 1:18 PM, an interview with the DON revealed that she became aware of the allegation of sexual abuse of Resident #3 and #4 during the morning IDT meeting at approximately 9:00 AM on 6/12/24. The DON stated that she had not reported any allegation of sexual abuse on or following 6/09/24 to the SA or any other agency.</p> <p>On 6/18/24 at 1:25 PM, a telephone interview with RN #1 revealed that she was on duty as the RN Supervisor at the facility on 6/09/24 and said that LPN #1 had reported verbal remarks that Resident #2 had made to Resident #3 but said actual physical contact between residents was not reported to her. She said that if actual physical contact had been reported to her, she would have called the DON and suggested one-on-one supervision of Resident #2.</p> <p>On 6/18/24 at 3:35 PM, an interview with the Administrator revealed she was made aware of the 6/09/24 allegations involving Residents #2, #3, and #4 on the morning of 6/12/24. She confirmed that no report was submitted to any agencies. She said it was hard to say if she considered the contact between the residents as sexual abuse because all the residents involved residents had dementia. She stated that the DON was and is responsible for investigations. When asked if there were any barriers to reporting to outside agencies, the Administrator responded, All things that we think may be remotely reportable we run by corporate.</p> <p>Record review of the Admission Record for Resident #2 revealed the facility admitted the resident on 6/13/2019 with diagnoses that included Schizophrenia, Vascular Dementia with Behavioral Disturbances, and Wernicke's Encephalopathy.</p> <p>Record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 6/12/24 for Resident #2, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Further review of the MDS revealed in Section E that Resident #2 exhibited physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others for 1 (one) to 3 (three) days during the seven (7) day look back period.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42807</p> <p>Based on record review, staff interviews and facility policy review, the facility failed to ensure a care plan was implemented to prevent a resident's access to a medication cart, when a resident, without supervision, opened an unlocked medication cart and drank Lactulose liquid for one (1) of nine (9) sampled residents. Resident #1</p> <p>The facility's failure to implement care plan interventions placed this resident and other cognitively impaired residents at risk, in a situation that was likely to cause serious harm, injury, impairment, or death.</p> <p>The situation was determined to be an Immediate Jeopardy (IJ) that began on 6/4/24, when Resident #1 opened an unlocked and unattended medication cart and took a bottle of Lactulose and drank from the bottle. The facility Administrator was notified of the IJ on 6/20/24 at 4:25 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 6/21/24, in which they alleged all corrective actions to remove the IJ were completed on 6/21/24 and the IJ removed on 6/22/24.</p> <p>The SA validated the Removal Plan on 6/24/24 and determined that the IJ was removed on 6/22/24, prior to exit. Therefore, the scope and severity for CFR 483.21 (b) (1) Comprehensive Care Plans was lowered to a D while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.</p> <p>Findings include:</p> <p>Record review of the facility's policy titled, Care Plans - Comprehensive, dated 10/2016, revealed, An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident .</p> <p>Record review of the facility's policy titles, Following the Care Plan Policy, dated 1/2011, revealed, It is the Policy of this facility to follow a written and approved care plan for each resident. All employees will be trained upon hire and be required to follow the care plan . All employees will follow the written care plan that is developed in order to assure the residents needs are met.</p> <p>Record review of the Care Plan for Resident #1 with an initiation date of 3/14/22 revealed Focus: At risk for self-harm R/T (related to) removing edible and inedible items from med cart and placing in mouth Interventions: .Keep all medication carts locked and clean on top without any harmful items resting on top. Resident #1 also had a Care Plan created on 1/13/2020 Focus .Moderate cognitive impairment noted with impaired communication ability .Goal: Staff will supervise and cue resident if possible .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the Incident Report dated 6/04/24, revealed Incident Description .At approximately 5:30 PM, resident opened cart and took a bottle of Lactulose and proceeded to drink from the bottle Estimated 60 cc (cubic centimeters) was drank .Immediate Action Taken: Took bottle away from resident .Contacted Poison Control .Contacted NP (Nurse Practitioner) .</p> <p>During an interview on 6/17/24 at 12:00 PM, Licensed Practical Nurse (LPN) #1 confirmed that she was assigned to the care of Resident #1 on 6/04/24 from 7:00 AM through 7:00 PM. She stated that she was aware of previous incidents when the resident accessed unsecured liquids, not intended for consumption and consumed them. The nurse confirmed she observed Resident #1 seated in his wheelchair next to the cart with a medication cart drawer open and an open bottle of Lactulose in his hand with the bottle up to his mouth. LPN #1 stated that she was not aware of care plan interventions for Resident #1 related to his cognitive impairment/impaired communication or risk for self-harm.</p> <p>During an interview on 6/18/24 at 1:18 PM, the Director of Nurses (DON) she stated that limited communication ability, wandering behaviors and cognitive limitations were risk factors for accidents for Resident #1, which were addressed in the resident's care plan. She stated that following care plans for all residents are very important and she expected nursing staff to follow all residents' care plans to meet the needs of each resident.</p> <p>During an interview on 6/18/24 at 3:35 PM, the Administrator revealed that she was made aware of the incident in which Resident #1 obtained medication from an unattended, unlocked medication cart by the DON on the morning of 6/05/24. She stated that she was familiar with Resident #1 and the resident's history of rummaging and drinking inappropriate substances. She stated that she considered following care plans for all residents very important. The Administrator stated that she expected the resident's individualized care plans to be followed and that it was important and that the purpose of having them was to provide instructions for care of each resident.</p> <p>During an interview on 6/20/24 at 3:10 PM, with the Minimum Data Set (MDS)/Nurse #2, she confirmed that the Care Plan for Resident #2 was updated on 6/12/24. She stated that she frequently updated care plans as needed and that it was very important for care plans and the resident care instructions in the Kardex of Point Click Care (PCC) software to be followed. She stated that all nurses had access to all resident care plans via PCC. She explained that the Kardex pulled information directly from the care plan and that all Certified Nurse Aides (CNAs) had access to the Kardex information detailing each resident's care needs.</p> <p>During an interview on 6/20/24 at 3:35 PM, with MDS Nurse #1, she confirmed that she updated the Care Plan for Resident #2 on 6/06/24 and on 6/12/24. She stated that she frequently updated care plans as needed and that it was very important for care plans and the resident care instructions in the Kardex of Point Click Care (PCC) software to be followed for the of care of each resident.</p> <p>The facility submitted the following acceptable Removal Plan on 6/21/24:</p> <p>The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The care plan is being followed for Resident #1. Resident #1 is having one on one supervision at all times which began on 6/20/24 at 5:00pm. A nurse was assigned to the dementia unit each shift for increased supervision for cognitively impaired residents who reside there. This additional nurse began on 6/20/24 at 11:00pm. Resident #1 has been assessed for injuries with no adverse effects noted. Resident Representative attempted to be notified by phone at time of incident with no success. Several phone attempts were followed up by facility with no success. Letter mailed to resident representative on 6/21/24 for notification of incident.</p> <p>The Director of Nursing (DON), Staff Development, Administrator and Registered Nurse (RN) Supervisors provided education to staff whom are directly involved in passing medication and responsible for medication carts which began on 6/20/24 at 5:30pm. An emphasis was placed on ensuring all carts in the facility are always locked when not in attendance. In-service also including following the care plan for Resident #1. In-service is ongoing and continues until all nurses are educated prior to working their shift. There is a designated nurse assigned to the dementia unit each shift to increase supervision of cognitively impaired residents. The extra nurse began working at 11:00pm on 6/20/24. The Director of Nursing (DON), Staff Development, Administrator and Registered Nurse (RN) Supervisors provided education on the one on one supervision on Resident #1 beginning on 6/20/24 at 5:00pm. This in-service is ongoing and will continue until all nursing staff have been in-serviced prior to working their scheduled shift. The Minimum Data Set (MDS) nurse updated the care plan and Kardex to reflect the need for one on one supervision on 6/21/24. Behavior monitoring has been ongoing with this resident but was updated on 6/21/24 to include the behavior of rummaging.</p> <p>The DON or Staff Development Nurse has assigned a staff member each shift to make rounds every 30 minutes to check that all carts in the facility are locked. These rounds began on 6/20/24 at 5:30pm. The Director of Nursing, Staff Development Nurse or Registered Nurse Supervisor are assigned to audit the one on one supervision sheets on a daily basis for compliance with one on one supervision of Resident #1 beginning on 6/21/24.</p> <p>AD HOC Quality Assurance (QA) meeting held on 6/21/24 at 9:00am to review plans for removal of Immediate Jeopardy (IJ) tag.</p> <p>The facility alleges that the immediacy has been removed as of 6/22/2024.</p> <p>Validation:</p> <p>The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation CI #25376 through record review and interviews on 6/24/24. The SA determined that all corrective actions were completed on 6/21/24 and the IJ was removed on 6/22/24.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>42807</p> <p>Based on observation, staff interviews, record review and facility policy review the facility failed to provide an environment free from accident/hazards and supervision, as evidenced by leaving a medication cart unlocked and unattended, allowing a resident to remove and ingest a medication from the cart for one (1) of nine (9) sampled residents. Resident #1</p> <p>The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 6/4/24, when Resident #1 opened an unlocked and unattended medication cart and took a bottle of Lactulose and drank from the bottle. The facility's failure to ensure the resident was protected from accident/hazards placed this resident and other residents at risk and in a situation likely to cause serious injury, serious harm, serious impairment or death.</p> <p>The facility Administrator was notified of the IJ and SQC on 6/20/24 at 4:25 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 6/21/24, in which they alleged all corrective actions to remove the IJ were completed, and the IJ was removed on 6/22/24.</p> <p>The SA validated the Removal Plan on 6/24/24 and determined that the IJ was removed on 6/22/24, prior to exit. Therefore, the scope and severity for CFR 483.25(d)(2)-Accidents was lowered to a D while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.</p> <p>Findings include:</p> <p>Record review of the facility policy titled, .Medication Storage in the Facility, revised January 2018, revealed, Medications and biologicals are stored safely, securely, and properly .The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication .Procedures: .B . Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access .</p> <p>Record review of the Incident Report dated 6/04/24, revealed Incident Description: .At approximately 5:30 PM, resident opened cart and took a bottle of Lactulose and proceeded to drink from the bottle Estimated 60 cc (cubic centimeters) was drank .Immediate Action Taken: Took bottle away from resident .Contacted Poison Control .Contacted NP (Nurse Practitioner) .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/17/24 at 12:00 PM, an interview with LPN #1 revealed that she was familiar with Resident #1 and his care. She confirmed that she was assigned to the care of Resident #1 on 6/04/24 from 7:00 AM through 7:00 PM. She stated that she was aware of previous incidents when the resident accessed unsecured liquids not intended for consumption and consumed them. She stated that drugs or other therapeutic agents should be stored in the secure medication rooms or medication carts, which should be always locked. LPN #1 stated that Resident #1's risk factors for accidents included his behaviors of getting into carts and drinking anything he can get a hold of. LPN #1 stated that at approximately 5:30 PM, she was standing at her med cart cleaning it and stepped into the medication room and didn't realize the push-in locking mechanism on the medication cart had not engaged. She stated that upon exiting the medication room she observed Resident #1 seated in his wheelchair next to the cart with a medication cart drawer open and an open bottle of Lactulose in his hand with the bottle up to his mouth. She stated she immediately retrieved the bottle from the resident. She stated the cause of the incident was that she accidentally left the medication cart unlocked and unattended.</p> <p>On 6/18/24 at 1:18 PM, an interview with the Director of Nurses (DON) revealed that she became aware of the 6/04/24 incident, involving Resident #1, on 6/04/24 at approximately 6:05 PM, when she was notified by telephone by LPN #1. She said LPN #1 told her that she had gone to the medication room and upon exiting the medication room, she observed Resident #1 with a bottle of lactulose up to his lips. The DON stated she instructed LPN #1 to contact poison control, the primary healthcare provider Nurse Practitioner (NP) #1 and the resident's Resident Representative (RR) and to monitor the resident. She stated that limited communication ability, wandering behaviors and cognitive limitations were risk factors for accidents for Resident #1. She stated that the cause of the incident was the resident's mentality. She stated that following the incident, Certified Nurse Aides (CNAs) and nurses did hourly rounds to monitor and assess the resident for seventy-two (72) hours and focused on ensuring the resident displayed no adverse reactions including nausea or diarrhea.</p> <p>On 6/18/24 at 3:35 PM, an interview with the Administrator revealed that she was made aware of the incident in which Resident #1 obtained medication from an unattended, unlocked medication cart by the Director of Nurses (DON) on 6/05/24. She stated that medications carts should be kept locked when unattended to provide safety for all residents. She stated that she was familiar with Resident #1 and the resident's history of rummaging and drinking inappropriate substances.</p> <p>On 6/20/24 at 12:05 PM, during an observation and interview with LPN #2 of the medication cart for the 800 Hall revealed that the drawer where the bottles of Lactulose were stored also contained bottles of liquid Valproic Acid, Colace, Iron Supplement, and Tussin Cough Syrup. Additionally, the drawer contained boxes of Zofran, Fosamax, Immodium and Tylenol tablets. All liquid medications in the drawer had child resistant screw on lids, including the Lactulose containers. She stated that she was familiar with Resident #1 and his care and that he was independent with mobility and able to propel his wheelchair throughout the facility, without assistance, using his legs. She stated that Resident #1 had behaviors of wandering and taking items from carts and drinking them or putting them into his mouth. She stated that Resident #1 required supervision and redirection when he was up in his wheelchair to ensure he did not get anything that he should not put into his mouth. LPN #2 stated that medication carts should always be locked and should never be left unattended for the safety of all residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/26/24 at 11:30 AM, the facility Medical Director returned a telephone call post exit from the facility. During the telephone interview, he stated that he had been made aware of the 6/04/24 incident involving Resident #1. The Medical Director stated that it was an unfortunate incident that should not have happened. He stated that he was not overly concerned about the resident's consumption of Lactulose, a laxative. He stated that he had continued to follow the care of Resident #1 following the incident and that the resident had no adverse effects. The Medical Director stated that concerns related to the incident included that Resident #1 had gained access to other significant medications, as well as the Lactulose.</p> <p>Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 6/24/05. The resident had diagnoses that included Dementia with Behavioral Disturbance, Impulse Disorder, Psychotic Disorder with Hallucinations due to Known Physiological Condition, and Personal History of Traumatic Brain Injury (TBI).</p> <p>Record review of the Quarterly Minimum Data Set (MDS), with Assessment Reference Date of 4/12/24, for Resident #1 revealed the resident had no Brief Interview for Mental Status (BIMS) score, as the interview was not conducted. Section C was coded to indicate that the resident is rarely/never understood, therefore the BIMS should not be conducted. Further review of the MDS documented that the resident had a memory problem and modified independence with cognitive skills for daily decision making. Review of the MDS also revealed that Resident #1 used a wheelchair and required no assistance for mobility.</p> <p>The facility submitted the following acceptable Removal Plan on 6/21/24:</p> <p>The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome.</p> <p>The care plan is being followed for Resident #1. Resident #1 is having one on one supervision at all times which began on 6/20/24 at 5:00pm. A nurse was assigned to the dementia unit each shift for increased supervision for cognitively impaired residents who reside there. This additional nurse began on 6/20/24 at 11:00pm. Resident #1 has been assessed for injuries with no adverse effects noted. Resident Representative attempted to be notified by phone at time of incident with no success. Several phone attempts were followed up by facility with no success. Letter mailed to resident representative on 6/21/24 for notification of incident.</p> <p>The Director of Nursing (DON), Staff Development, Administrator and Registered Nurse (RN) Supervisors provided education to staff whom are directly involved in passing medication and responsible for medication carts which began on 6/20/24 at 5:30pm. An emphasis was placed on ensuring all carts in the facility are always locked when not in attendance. In-service also including following the care plan for Resident #1. In-service is ongoing and continues until all nurses are educated prior to working their shift. There is a designated nurse assigned to the dementia unit each shift to increase supervision of cognitively impaired residents. The extra nurse began working at 11:00pm on 6/20/24. The Director of Nursing (DON), Staff Development, Administrator and Registered Nurse (RN) Supervisors provided education on the one on one supervision on Resident #1 beginning on 6/20/24 at 5:00pm. This in-service is ongoing and will continue until all nursing staff have been in-serviced prior to working their scheduled shift. The Minimum Data Set (MDS) nurse updated the care plan and Kardex to reflect the need for one on one supervision on 6/21/24. Behavior monitoring has been ongoing with this resident but was updated on 6/21/24 to include the behavior of rummaging.</p> <p>(continued on next page)</p>		

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 06/24/2024
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The DON or Staff Development Nurse has assigned a staff member each shift to make rounds every 30 minutes to check that all carts in the facility are locked. These rounds began on 6/20/24 at 5:30pm. The Director of Nursing, Staff Development Nurse or Registered Nurse Supervisor are assigned to audit the one on one supervision sheets on a daily basis for compliance with one on one supervision of Resident #1 beginning on 6/21/24.</p> <p>AD HOC Quality Assurance (QA) meeting held on 6/21/24 at 9:00am to review plans for removal of Immediate Jeopardy (IJ) tag.</p> <p>The facility alleges that the immediacy has been removed as of 6/22/2024.</p> <p>Validation:</p> <p>The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) MS #25376 through record review and interviews on 6/24/24. The SA determined that all corrective actions were completed on 6/21/24 and the IJ was removed on 6/22/24.</p>		