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	08/01/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48669 Based on observation, interviews, and facility policy review, the facility failed accommodate the needs of a resident, as evidenced by, leaving a resident who was dependent on staff for eating, unassisted and unfed during a meal, for one (1) of 23 sampled residents. Resident #70. Findings Include: A review of the facility's policy titled Residents Rights dated 1/24/22 revealed, Policy Statement .Residents' rights policies and procedures shall ensure that each resident admitted to the center .Policy Interpretation and Implementation .9. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs . On 07/29/24 at 12:44 PM, an observation with Resident #70 revealed she was sitting up in her electric wheelchair. Both of her arms were contracted down by her sides. There was a blow call light to the right side of Resident #70. The resident had a mouth stylus pen that she was using to scroll and type on her phone. In an interview, Resident #70 indicated that Certified Nursing Assistant (CNA) #1 who worked the 3:00 PM - 11:00 PM shift, was just beginning to feed her dinner on 7/3/24, when Licensed Practical Nurse #1 (LPN) came to the door and demanded CNA #1 stop what she was doing to attend a meeting at the nurse station. She said the CNA left her sitting there with the tray in front of her. On 7/30/24 at 12:46 PM, in a follow-up interview, Resident #70 mentioned that the reason she was irritated by the whole incident that occurred on 7/3/24 was because she was hungry and ready to eat. She explained that she had to wait to be fed, and it seemed like it took forever for CNA #1 to return, and her food had gotten cold. Resident #70 expressed that she felt disrespected because CNA #1 should not have been made to stop feeding her, as she could not feed herself, and the nurse was wrong in her opinion for making her do so. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 10:08 AM, in a phone interview, CNA #1 confirmed she was the CNA assigned to feed Resident #70 on 7/3/24 for the dinner meal. She indicated the trays had just come out and she was putting the second spoonful of food in Resident #70's mouth when LPN #1 asked her to stop feeding the resident and come to a meeting with all CNAs at the nurse's desk. CNA #1 said that she initially continued to feed the resident because she did not want to leave her, but about five minutes later, the nurse returned and in a demanding tone said, Stop what you're doing and come here now. You can finish feeding the resident when you get back! CNA #1 expressed her belief that it was unfair to abandon the resident during her meal, as the resident was totally dependent upon her to provide her nourishment. When she was finally able to return to the resident, it was about twenty to thirty minutes later. She realized the resident's food was cold, so she took the necessary steps to get her some warm food to eat, which further delayed the resident's meal. On 8/1/24 at 1:32 PM, in an interview with the Director of Nursing, she stated that the resident should have been fed first. If it was not an emergency, such as a resident code, the nurse should have waited until the CNA finished feeding the resident. She added that the nurse's actions were inappropriate. A record review of the Admission Record revealed the facility admitted Resident #70 on 11/04/2021. Her current medical diagnoses included Quadriplegia, C5-C7 Complete Muscle Weakness, and Lack of Coordination. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/13/2024 revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37415 Based on interviews, record review, and facility policy review, the facility failed to notify the Physician or the Resident Representative (RR) when a resident experienced pain to her right knee after a resident transfer which resulted in a femoral fracture that was diagnosed the following day for one (1) of ten (10) sampled residents that require a mechanical lift for transfers. (Resident #5) Findings Include: A review of the facility's policy Resident Change in Condition revised 2016, revealed, .It is the policy of this facility to promptly notify the resident, his or her attending physician, and the resident representative (RR) of changes in the resident's condition .Procedure 1. The Charge Nurse will notify the resident's attending physician when: a. The resident is involved in any accident or incident that results in an injury .b. There is a significant change in the resident's physical, mental or psychosocial status .g. Deemed necessary or appropriate in the best interest of the resident. 2. Unless otherwise instructed by the resident, the charge nurse will notify the resident representative when: a. The resident is involved in any accident or incident that results in an injury .b. There is a significant change in the resident's physical, mental, or psychosocial status . A record review of the facility's investigation summary dated 7/6/24 and a follow up investigation dated 7/11/24 as reported to the State Agency revealed that on the morning of 7/3/24, Resident #5 complained of right leg pain to the nurse and her daughter via phone. The daughter called the nurse and requested an X-ray of her right leg at this time. The X-ray was completed, and the results came back in the early morning hours of 7/4/24. The interviews conducted included two (2) Certified Nursing Aides (CNAs) involved in transferring Resident #5 from the chair to the bed, the cart nurse, and the resident's roommate. The CNAs stated that upon attempting to transfer Resident #5 from the chair to the bed that afternoon, the lift battery was dead, rendering them unable to lift Resident #5 out of the chair. While the nurse was fetching the battery, Resident #5 began sliding out of the chair. To prevent her from falling, one CNA reclined the back of the chair. Then, one CNA grabbed the two handles at the top of the lift pad and the other grabbed the bottom two handles of the lift pad. The resident yelled out during the transfer. The sitter was in the room at the time of the transfer, she stated that she heard the resident yell out and the resident's knee was on the bed, but her foot was on the floor. During an interview on 7/30/24 at 10:20 AM, Licensed Practical Nurse (LPN #3) confirmed the incident occurred on 7/2/24 at approximately 2:15 PM when CNA #3 asked for assistance with transferring Resident #5 using a mechanical lift. LPN #3 explained she got another battery for the lift, but that battery was also not charged, so she unhooked the resident from the Hoyer and went to get another lift. When she returned with another lift, CNA #3 and CNA #4 informed her the resident had to be manually transferred to the bed because she had started sliding from the wheelchair. On 7/2/24, LPN #3 assessed the resident. CNA #3 reported that Resident #5 was moaning and pointing at her leg. LPN #3 confirmed the sitter also told her at that time Resident #5 was complaining of pain because the CNAs had manually transferred her. She admitted she did not notify the Unit Manager, Medical Director, DON, or Resident Representative (RR) about Resident #5's complaint of knee pain after the manual transfer. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/30/24 at 10:50 AM, CNA #3 admitted she did not notify LPN #3 that Resident #5 had screamed or yelled out in pain during the manual transfer. In an interview on 7/30/24 at 11:20 AM, CNA #4 also confirmed she did not notify LPN #3 that Resident #5 screamed or yelled out in pain during the manual transfer. On 8/1/24 at 11:00 AM, during an interview with the DON, she confirmed the physician, DON, and RR should have been notified of Resident #5's incident on 7/2/24 and resident yelling out in pain at the time of the transfer. She emphasized that it was the facility's policy to notify the Unit Manager, Medical Director, DON, and RR of any changes in residents' conditions and expected the nursing staff to adhere to this policy. On 8/1/24 at 2:17 PM, in an interview with the Administrator, he confirmed that on 7/2/24, the facility did not follow the facility's policy regarding notification of a change in a resident's condition. He stated that he expected the facility staff to comply with the policy and notify the physician and RR. A record review of the Admission Record revealed the facility admitted Resident #5 on 3/2/2018 and she had current diagnoses including Hemiplegia, and Hemiparesis following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 5/17/24 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37415 Based on interviews, record review, and facility policy review, the facility failed to implement care plan approaches or interventions related to pain when Resident #5 yelled out in pain during a transfer for one (1) of 23 residents reviewed for care plans. (Resident #5) Findings Include: A review of the facility's 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 .required to follow the care plan. Procedure .All employees will follow the written care plan that is developed in order to assure the residents needs are met. A record review of the Comprehensive Care Plan with an initiation date of 6/2/23 revealed Focus: Resident is at risk for pain .Interventions initiated on 6/2/2023 .Document type, location and severity of pain .Give medications as ordered . A record review of the facility's investigation summary dated 7/6/24 and a follow up investigation dated 7/11/24 as reported to the State Agency revealed that on the morning of 7/3/24, Resident #5 complained of right leg pain to the nurse and her daughter via phone. The daughter called the nurse and requested an X-ray of her right leg at this time. The X-ray was completed, and the results came back in the early morning hours of 7/4/24. The physician was notified of the results and gave an order for Resident #5 to be sent out for further examination. At approximately 4:37 PM on 7/4/24, the Registered Nurse (RN) Supervisor called the receiving facility to check on Resident #5 and was informed that she was being admitted with a fracture. The Certified Nursing Assistants (CNAs) stated that upon attempting to transfer Resident #5 from the chair to the bed that afternoon .the resident yelled out. The sitter who was in the room, stated that the resident's knee was on the bed, but her foot was on the floor. A record review of the local hospital orthopedic Consult Orders, dated 07/05/24, revealed, .Subjective .right distal periprosthetic femur fracture .A Hoyer lift is used for transfers. Patient had a fall during the transfer and was found to have a right distal femur fracture. She was admitted to the hospitalist for her medical care and orthopedics was consulted for fracture care. Objective: Right lower extremity: Moderate swelling about the fracture site . A record review of the electronic Medication Administration Record (eMAR) for July 2024 revealed an order dated 09/08/20 for Tramadol 50 milligrams (mg) Give 1 tablet by mouth every six (6) hours as needed (PRN) for moderate or severe pain. There was no documentation Resident #5 received any pain medication on 7/2/24, the day the incident occurred. Resident #5 received a routine Duragesic patch for pain on 7/3/24, which was the day following the manual transfer incident in which Resident #5 had screamed out in pain. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	In an interview on 07/30/24 at 10:20 AM, with Licensed Practical Nurse (LPN) #3, she confirmed on 7/2/24 at approximately 2:15 PM, Resident #5 was manually transferred from her wheelchair to her bed. Shortly after, CNA #3 reported to the nurse that Resident #5 was complaining of pain. LPN #3 confirmed she failed to administer any pain medication to Resident #5 on 07/02/24 when she complained of pain. In an interview with the Director of Nursing (DON) on 8/1/24 at 11:00 AM, she confirmed care plan interventions were not implemented regarding pain when LPN #3 failed to administer the as needed pain medication that was ordered for Resident #5 and did not report the pain to the oncoming nurse. The DON explained that care plans were in place for the staff to use to take care of the residents, and she expected the staff at the facility to follow care plan interventions on the residents. During an interview on 8/1/24 at 2:17 PM, the Administrator confirmed the staff failed to follow the care plan by not administering pain medication and documenting the pain to Resident #5. She expected the staff to follow the care plan. A record review of the Admission Record revealed the facility admitted Resident #5 on 2/24/2023, and she had current diagnoses including Age-related Osteoporosis, Hemiplegia, and Hemiparesis following Cerebral Infarction.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37415 Based on record review, interviews, and facility policy review, the facility failed to ensure a resident was free of accidents and/or hazards when facility staff were aware a resident who was care planned for a mechanical lift was sliding from a wheelchair and the staff detached the lift pad from the mechanical lift, causing the resident to further slide and be manually transferred which resulted in a right femur fracture for one (1) of ten (10) sampled residents that required transfers via mechanical lift. (Resident #5) Findings Include: A review of the facility's Responsibility for Accident/Incident Report Policy dated [DATE] revealed, .It is the policy of this facility for all Incidents and Accidents involving resident's to be investigated immediately upon knowledge of the incident. Procedure .Procedure .They are to document on the proper forms and notify the Administrator and/or DON (Director of Nursing) immediately when there is an injury . A record review of the facility's investigation summary dated [DATE] and a follow up investigation dated [DATE] as reported to the State Agency revealed that on the morning of [DATE], Resident #5 complained of right leg pain to the nurse and her daughter via phone. The daughter called the nurse and requested an X-ray of her right leg at this time. The X-ray was completed, and the results came back in the early morning hours of [DATE]. The physician was notified of the results and gave an order for Resident #5 to be sent out for further examination. At approximately 4:37 PM on [DATE], the Registered Nurse (RN) Supervisor called the receiving facility to check on Resident #5 and was informed that she was being admitted with a fracture. The Administrator and Director of Nursing (DON) were notified at approximately 4:58 PM on [DATE], and a verbal report was made to the State Agency (SA). An investigation was initiated immediately. The interviews conducted included two (2) Certified Nursing Aides (CNAs) involved in transferring Resident #5 from the chair to the bed, the cart nurse, and the resident's roommate. The CNAs stated that upon attempting to transfer Resident #5 from the chair to the bed that afternoon, they connected the lift to the lift pad while she was in the chair. However, the lift battery was dead, rendering them unable to lift Resident #5 out of the chair. The nurse went to retrieve a new battery to re-attempt the transfer. While the nurse was fetching the battery, Resident #5 began sliding out of the chair. To prevent her from falling, one CNA reclined the back of the chair. Then one CNA grabbed the two handles at the top of the lift pad and the other grabbed the bottom two handles of the lift pad. Securing the lift pad at both top and bottom, they were able to slide Resident #5 from the chair to the bed safely. The CNA stated that they slid her over in her bed without incident. The sitter was in the room at the time of the transfer but was sitting on the other side in a chair next to the door with the curtain closed. The sitter stated she saw them lift her but then went back to watching her phone. When she heard the resident yell out, she looked up from her phone to check on the resident. She stated that the resident's knee was on the bed, but her foot was on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of the local hospital orthopedic Consult Orders, dated [DATE], revealed, .Subjective .right distal periprosthetic femur fracture .A Hoyer lift is used for transfers. Patient had a fall during the transfer and was found to have a right distal femur fracture. She was admitted to the hospitalist for her medical care orthopedics was consulted for fracture care. Objective: Right lower extremity: Moderate swelling about the fracture site . A record review of the Lift (Determination for Resident Lift/Transfer Assistance), dated [DATE], for Resident #5, revealed .A. Resident's Level of Assistance .Dependent - Resident requires more than 50 % assistance by staff, or is unpredictable in the amount of assistance offered .B. Can the Resident bear weight? . NO .C. Does the Resident have upper extremity strength to support his/her weight during the transfer .NO .G .1. Equipment used to transfer to and from .total lift . During an interview with Resident #5's daughter on [DATE] at 10:39 AM, she said she received a phone call from the sitter on [DATE] at approximately 8:02 AM, stating that her mother was moaning, groaning, and crying, and that her right knee was hurting. The sitter informed her that the staff transferred the resident on [DATE] at approximately 2:15 PM without using a Hoyer (type of mechanical lift). The daughter explained the sitter informed her that the nurse and the CNA attempted to transfer the resident via the Hoyer when the battery for the Hoyer failed. The nurse went to get another battery. The two CNAs transferred the resident by lifting the Hoyer pad manually. The daughter stated that the sitter heard a loud scream and looked over and noticed her mother's foot was on the floor. The daughter stated that she called the facility and asked for an X-ray. During an interview with the sitter on [DATE] at 10:50 AM, she stated on [DATE] at approximately 2:15 PM, she was sitting across the room with her chair facing the resident's bed. The sitter stated the roommate's privacy curtain was closed, but Resident #5 did not have a privacy curtain on her side. The sitter explained CNA #3 and LPN #3 were attempting to transfer Resident #5 via the Hoyer, however, the battery did not allow them to lift the resident. The nurse left to go and get another battery. CNA #4 entered the room along with the nurse and they attempted to use another battery, but that battery also did not work. CNA #4 stated, We can transfer the resident without using the Hoyer. LPN #3 replied, No, we're going to do the right thing. I know there's another battery around here. LPN #3 exited the room with the Hoyer lift. The sitter stated she was looking down at her phone when she heard Resident #5 scream. She looked up and noticed Resident #5's knee was on the bed and her foot was on the floor. The sitter asked CNA #3 and CNA #4 how the resident's foot got on the floor, but neither CNA responded. The nurse returned with a Hoyer lift and both CNAs informed her the resident was already transferred to the bed. The sitter stated that Resident #5 complained of her right knee hurting her at that time and she notified CNA #3. The sitter stated she left the facility at approximately 3:00 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:20 AM with Licensed Practical Nurse (LPN #3), she said the incident occurred on [DATE] when CNA #3 asked for assistance with a lift for Resident #5. LPN #3 explained that the battery for the lift died and she left the room to get a battery. When she returned to the room, CNA #4 had entered the room and suggested they lift Resident #5 manually by the lift straps because the battery still did not work. LPN #3 insisted to both CNAs that they are going to do this right and she and CNA #3 unhooked the lift pad from the Hoyer lift. LPN #3 left the room with the Hoyer lift. LPN #3 explained that once she returned with a new Hoyer lift, both CNAs told her the resident was sliding and they manually transferred the resident to the bed. LPN #3 stated that she assessed the resident after CNA #3 informed her Resident #5 was moaning and pointing at her leg. The nurse said she did not know the resident screamed during the transfer because the CNAs did not tell her. The nurse admitted she did not investigate to see if anything occurred during the transfer and did not report it to the unit manager or DON. During an interview and observation on [DATE] at 10:50 AM, CNA #3 revealed Resident #5 was sitting in her wheelchair on a lift pad and she started to slide. Therefore, she and LPN #3 hooked all four straps of the lift pad to the mechanical lift, but the battery went out. After trying a different battery, she and LPN #3 unhooked the resident from the lift pad and the nurse went to get another lift. CNA #3 stated Resident #5 started to slide out of the wheelchair and she and CNA #4, manually lifted the resident from the chair to the bed. CNA #3 confirmed the resident screamed when they transferred her and admitted she did not tell the nurse the resident screamed because she moaned all the time. CNA #3 stated that she informed the nurse the resident complained of pain shortly after the transfer. CNA #3 and LPN #3 completed a demonstration of the incident, and CNA #3 explained Resident #5's lift pad straps should have stayed strapped onto the first Hoyer and a fresh battery should have been used. CNA #3 stated Resident #5 would not have slid out of the chair if the lift pad had been secured to the Hoyer and they should have waited for a new battery. An interview with CNA #4 on [DATE] at 11:20 AM, revealed she was asked by CNA #3 to assist her with transferring Resident #5 to her bed via Hoyer. CNA #4 stated that she was taking care of another resident, so LPN #3 was going to assist with the transfer. CNA #4 went to Resident #5's room when she finished and the nurse left the room to get a new battery, but it did not work. Therefore, LPN #3 removed the Hoyer lift from the resident's room to get another one. Resident #5 started to slide out of the wheelchair, so she tilted the wheelchair backward, but the resident continued to slide. CNA #4 stated they used the sling/lift pad to transfer the resident to the bed. CNA #4 stated she grabbed the top of the resident and CNA #3 transferred the resident's legs to the bed. CNA #4 confirmed she did not tell anybody the resident screamed during the transfer because she thought CNA #3 said something because it was her resident, and the resident frequently complained of pain when you touched her. CNA #4 confirmed the resident would not have slid out of the chair if the lift pad she was in had been connected to the Hoyer and they should have waited for a charged battery. During an interview with LPN #6 on [DATE] at 12:00 PM, she stated she was administering medication to Resident #5 on the morning of [DATE] when Resident #5 began crying, stating that her right knee hurt. LPN #6 said she looked at Resident #5's knee and did not see any swelling at that time. She called the Nurse Practitioner (NP) and received an order for an X-ray on [DATE] at 9:30 AM. LPN #6 stated she called the daughter and explained the resident was complaining of right knee pain and that the NP had ordered a mobile X-ray. LPN #6 revealed the X-ray team came later that afternoon, and the results came in during the morning hours the next day ([DATE]). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with the DON on [DATE] at 11:00 AM, she stated that she did not know about the incident regarding Resident #5 being transferred without a mechanical lift until [DATE]. The DON stated the facility called her explaining Resident #5 had a femur fracture and she came to the facility to investigate the event. The DON said that she interviewed the sitter and was told the CNAs transferred the resident manually and that she had been looking down at her phone and heard the resident cry out and when she looked up and saw the resident's foot on the floor. The DON explained she was told the resident started sliding while sitting in her wheelchair and LPN #3 and CNA #4 attempted to transfer her via the Hoyer lift when the battery would not work. The DON stated LPN #3 also said she went to get a battery and when she returned, the CNAs had already transferred the resident to the bed. The DON explained that LPN#3 said she did not know the resident was in any distress. The DON stated she was unaware that the staff removed the lift pad straps from the mechanical lift and that LPN#3 removed the lift from the room to get another one. The DON also stated that she was not aware Resident #5 had screamed during the transfer until she was conducting the investigation. The DON explained LPN #3 and CNA #3 should have left the lift pad straps secured to the Hoyer lift until a charged battery was found. All the staff were trained on the no-lift policy, in which the staff are not allowed to manually lift residents who are required to be transferred with a mechanical lift. During an interview on [DATE] at 2:17 PM, the Administrator stated she was aware of the incident with Resident #5 and was told two (2) CNAs and an LPN were in the room with the resident when the battery in the Hoyer lift died . LPN #3 left the room and CNA #3 and CNA #4 manually transferred Resident #5 from the wheelchair to the bed because she was sliding. The CNAs told her that it would be easier to lift Resident #5 than to let her slide out of the chair onto the floor. The Administrator stated this facility has a no-lift policy, and everyone had been in-serviced A record review of the Admission Record revealed the facility admitted Resident #5 on [DATE] and she had current diagnoses including Age-related Osteoporosis, Hemiplegia, and Hemiparesis following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #5 had a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact.

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	08/01/2024

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. 37415 Based on interviews, record review, and facility policy review, the facility failed to ensure pain management was provided to a resident who complained of pain after a manual transfer from her wheelchair to the bed and was subsequently diagnosed with a femoral fracture for one (1) of 23 residents reviewed for pain, Resident #5. Findings Include: A record review of the facility's policy Pain Assessment/Management revised 09/10, revealed, It is the policy of this facility to provide guidelines in the identification and treatment of the residents at risk of acute and chronic pain. Each resident's pain will be assessed in an approach designed to increase comfort and promote dignity through administering alternative interventions or medications .pain will be assessed and recorded on the medication administration record. The nurse will document the type of nonverbal or verbal pain the resident is experiencing when documenting the reason the medication is being given. The nurse will also document the intensity of the pain each time a PRN pain medication is given using the rating scale . A record review of the facility's investigation summary dated 7/6/24 and a follow up investigation dated 7/11/24 as reported to the State Agency revealed that on the morning of 7/3/24, Resident #5 complained of right leg pain to the nurse and her daughter via phone. The daughter called the nurse and requested an X-ray of her right leg at this time. The X-ray was completed, and the results came back in the early morning hours of 7/4/24. The physician was notified of the results and gave an order for Resident #5 to be sent out for further examination. At approximately 4:37 PM on 7/4/24, the Registered Nurse (RN) Supervisor called the receiving facility to check on Resident #5 and was informed that she was being admitted with a fracture. The CNAs stated that upon attempting to transfer Resident #5 from the chair to the bed on 7/2/24, they connected the lift to the lift pad while she was in the chair. However, the lift battery was dead, rendering them unable to lift Resident #5 out of the chair. The nurse went to retrieve a new battery to re-attempt the transfer. While the nurse was fetching the battery, Resident #5 began sliding out of the chair. To prevent her from falling, one CNA reclined the back of the chair. Then one CNA grabbed the two handles at the top of the lift pad and the other grabbed the bottom two handles of the lift pad. Securing the lift pad at both top and bottom, they were able to slide Resident #5 from the chair to the bed. When she heard the resident yell out, she looked up from her phone to check on the resident. She stated that the resident's knee was on the bed, but her foot was on the floor. A record review of the electronic Medication Administration Record (eMAR) for July 2024 revealed an order dated 09/08/20 for Tramadol 50 milligrams (mg) Give 1 tablet by mouth every six (6) hours as needed (PRN) for moderate or severe pain. There was no documentation Resident #5 received any pain medication on 7/2/24, the day the incident occurred. Resident #5 received a routine Duragesic patch for pain on 7/3/24, which was the day following the manual transfer incident in which Resident #5 had screamed out in pain. (continued on next page)

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	08/01/2024

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

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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 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/30/24 at 10:20 AM, with Licensed Practical Nurse (LPN) #3, she confirmed on 7/2/24 at approximately at 2:15 PM, Resident #5 was manually transferred from her wheelchair to her bed. Shortly after, CNA #3 reported that Resident #5 was complaining of pain. LPN #3 confirmed she failed to administer any pain medication to Resident #5 on 07/02/24 when she complained about pain. In an interview with the Director of Nursing (DON) on 08/01/24 at 11:00 AM, she confirmed the LPN#3 failed to follow the pain policy by not administering pain medication when Resident #5 complained of pain. During an interview on 08/01/24 at 2:17 PM, the Administrator confirmed that on 07/02/24, the facility did not follow the pain policy and should have medicated Resident #5 for pain. She expected the staff to follow the policy and procedures of the facility. A record review of the Admission Record revealed the facility admitted Resident #5 on 2/24/2023, and she had current diagnoses including Age-related Osteoporosis, Hemiplegia, and Hemiparesis following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 05/17/24 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.