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	03/20/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from abuse for two (2) of seven (7) sampled residents reviewed, Resident #1 and Resident #2. Findings include: Record review of the facility policy titled Preventing Resident Abuse, with a revision date of 8/16/2016, revealed .1. The facility's goal is to achieve and maintain an abuse-free environment .3. Residents have the right to be free from all forms of abuse. Abuse includes conduct that causes or has the potential to cause the resident to experience humiliation, fear, shame, agitation, or degradation. Resident #1 Record review of the facility's Final Investigation dated 2/22/25-2/23/25 revealed the facility's documentation stated that on 2/24/25, the roommate of Resident #1 (Resident #6) reported to the Director of Nursing (DON) and Social Services Director (SSD) that on the night of 2/22/25 or early morning of 2/23/25, she heard Resident #1 say, Stop hitting me, while Certified Nurse Aide (CNA) #1 was rendering care. Resident #6 provided a written statement that read: Saturday midnight shift 11-7 the CNA came in the room around 1:00 AM to change (Resident #1's) brief when I heard a lot of touching, and I heard (Proper name of Resident #1) say, Stop, you hurting me and I heard a pop on her body. Resident #1 scream loud Stop hitting me! and the CNA said, ' You stop hitting me. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Final Investigation with the date of incident as 3/13/2025 revealed an allegation of verbal abuse by CNA #2. Resident #1's roommate (Resident #6) provided an audio recording-obtained with permission from Resident #1's Responsible Party (RP)-as evidence of inappropriate speech and verbal abuse. The investigation revealed that CNA #2 made belittling, mocking, and profane remarks to Resident #1 during care. Specific comments recorded included the CNA referring to the resident's alopecia by saying, You got a few strands in the back. CNA #2 commented, Look at your feet, how they are overlapping, and You have hair on your chin. She stated, You probably didn't whip your kids ass, but you're up here trying to whip ours. When the resident said she was going out on pass with her daughter, the CNA replied, Well, I want to see that. When discussing the resident's previous work, CNA #2 said, Oh, I couldn't have worked there. I would have been a dead nigga. She remarked, Once an adult and twice a child. When the resident said, That hurts, the CNA said, I bet it didn't hurt when that man was down there. When the resident mentioned her breast, the CNA said, I don't like women. I like men. I don't lick and lap. On 3/18/25 at 11:25 AM, an interview with the SSD revealed she was made aware of the abuse allegation involving Resident #1 and CNA #1 on 2/24/25 at approximately 12:00 PM, as reported by Resident #6. The SSD confirmed the allegation included hearing a pop and Resident #1 screaming out during care. She stated she was informed of the abuse allegation involving Resident #2 on the same day by the resident's RP. Additionally, the SSD reported she learned of the verbal abuse allegation against CNA #2 during a meeting with Resident #1's RP on 3/3/25, concerning abuse that occurred in January and February 2025. On 3/18/25 at 10:50 AM, during observation and interview, Resident #1 was resting in bed, alert and oriented to self, but unable to recall any incidents of abuse or mistreatment. On 3/18/25 at 11:54 AM, during an interview with Resident #6, she confirmed that she had reported both the physical abuse by CNA #1 and verbal abuse by CNA #2. She described the 2/22/25 incident involving CNA #1, confirming that she heard Resident #1 say, Stop hitting me, followed by a pop and Resident #1 screaming. She also described CNA #2 as a bully who used cruel language during care and stated she had helped facilitate the recordings with RP permission due to Resident #1's memory impairment. On 3/18/25 at 12:03 PM, an interview with the Medical Director revealed he had been made aware of the allegations by the Administrator. He stated that both a Nurse Practitioner (NP) and a contract psychiatric NP had assessed the residents, and neither required hospitalization or medical intervention. He reported no change in either resident's condition since the incidents. On 3/20/25 at 2:52 PM, during a telephone interview, the Resident Representative for Resident #1 reported she had heard the audio recording shared by Resident #6 and described CNA #2's language as disrespectful and humiliating. She stated the CNA sounded like a bully and that the language used was degrading, including references to the resident's appearance and sexually inappropriate remarks. Record review of the Admission Record for Resident #1 revealed the resident was admitted on [DATE] with diagnoses that included Unspecified dementia, Brain disorder, and Hypertension. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 Record review of the facility's Final Investigation dated 2/23/25 revealed that Resident #2 reported to the DON that CNA #1 had struck her on the hands during care. The incident occurred on the 11:00 PM-7:00 AM shift. Resident #2 stated that CNA #1 was assisting her to turn in bed and that she was holding onto a positioner. When she didn't release her grip, CNA #1 struck her on the knuckles and repeated, Let go. Resident #2 said she told the CNA, Give me time. I'm [AGE] years old. The facility's investigation revealed CNA #1 had been assigned to Resident #2 and had documented care for that shift. On 3/18/25 at 1:00 PM, during observation and interview, Resident #2 recalled that CNA #1 struck her knuckles during care on 2/23/25, while she was holding a positioner. She said the CNA told her to let go, then struck her, prompting her to respond, Give me time. I'm [AGE] years old. On 3/19/25 at 11:00 AM, the Administrator confirmed that both CNA #1 and CNA #2 had been suspended immediately after their respective allegations and that both were terminated based on the facility's investigations. On 3/20/25 at 1:48 PM, an interview with the DON revealed she was notified of the abuse allegations involving Resident #1 and Resident #2 on 2/24/25. She confirmed CNA #1 was not on duty at the time but was immediately suspended. She stated the roommate of Resident #1 described hearing the resident scream out, Stop hitting me! and hearing CNA #1 respond, You stop hitting me! The DON confirmed CNA #1's employment was terminated, and the incident was reported to the State Agency (SA) certification division.The DON reported she was made aware of the verbal abuse allegation against CNA #2 on 3/13/25. She confirmed CNA #2 was immediately suspended. The resident's RP had shared recordings of the abuse, and Resident #6 confirmed that CNA #2 made mocking and inappropriate comments during care. The DON stated she had previously corrected CNA #2 for making inappropriate remarks about another staff member. Following investigation, CNA #2's employment was terminated, and she was also reported to the SA certification division. Record review of the Admission Record for Resident #2 revealed the resident was admitted on [DATE] with diagnoses that included Atrial fibrillation, Congestive heart failure, and Hypertension. Record review of the Annual MDS with an ARD of 3/4/25 revealed a BIMS score of 10, indicating moderate cognitive impairment. On 3/19/25 at 2:46 PM, during a telephone interview, CNA #2 confirmed familiarity with Residents #1 and #4 and admitted making the statement about that man down there, though she claimed she was quoting someone else. She confirmed her suspension and termination. On 3/20/25 at 2:42 PM, the SA attempted to contact CNA #1 by telephone and text but was unsuccessful.

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F 0656 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interview, record review, and facility policy review, the facility failed to implement care plan interventions on the Activities of Daily Living (ADL) care plan for Resident #7 when the resident's drink was left unopened, her cereal was served dry, and her utensils were placed out of reach during the evening meal on 3/20/25 for one (1) of seven (7) sampled residents reviewed. Resident #7. Findings include: Record review of the Care Plan dated 7/07/24 for Resident #7 revealed a focus of Resident requires assistance with ADLs related to muscle weakness and diagnosis of Alzheimer's Disease .Interventions . Provide assistance as needed for ADLs .Resident able to feed self with tray set-up but does require nursing staff to assist with feeding at times due to visual impairment On 3/20/25 at 5:30 PM, during a dining observation and interview, Resident #7 and her roommate were alone in their room. Resident #7 was sitting in bed with her supper tray on her over-the-bed table. She had her soda can unopened in her hand, and her utensils were out of reach on the opposite side of the tray. Resident #7 confirmed that she wanted to eat and drink but could not open the can and did not know where her utensils were. Licensed Practical Nurse (LPN) #3 and the Director of Nursing (DON) arrived and confirmed that the drink should have been opened and the utensils placed within reach during tray set-up as part of meal assistance. On 3/20/25 at 4:40 PM, during an interview with the DON and Administrator, both confirmed that ADL assistance for eating included opening containers and ensuring that residents could reach utensils at the time of tray set-up. They confirmed that care plans were essential for appropriate care and staff were expected to follow them. Record review of the Admission Record for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Glaucoma, Muscle weakness, and Diabetes.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interview, record review, and policy review, the facility failed to provide appropriate services to maintain the ability to carry out activities of daily living (dining/eating) when the resident's drink was left unopened and her utensils were left out of reach during the evening meal on 3/19/25, which prevented her from feeding herself for one (1) of seven (7) sampled residents reviewed. Resident #7 Findings include: Record review of the facility policy titled, Meal Assistance and Assistance Policy, dated May 2024, revealed Policy . Compliance Guidelines . 5. Check the tray before serving it to the resident to be sure that it is correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow . Arrange the dishes and silverware so that the resident can reach them easily . 8. Open all cartons and remove all lids from items on the tray. Give the napkin to the resident . 17. Encourage the resident to participate with his or her meal as much as possible. On 3/19/25 at 5:30 PM, during a dining observation and interview, Resident #7 and her roommate were alone in their room without staff present. Resident #7 was sitting in bed with her supper tray in front of her on an over-the-bed table. Her soda can was unopened in her hand, and her utensils were out of reach on the opposite side of the tray across her plate. There was a bowl of cereal on the tray without milk. Resident #7 confirmed that she wanted to drink her soda and eat but could not open the can and did not know where her utensils were. Licensed Practical Nurse (LPN) #3 and the Director of Nursing (DON) arrived and confirmed that the drink should have been opened and the utensils should have been placed within reach as part of meal set-up assistance. On 3/20/25 at 4:40 PM, during an interview with the DON and the Administrator, both confirmed that activities of daily living (ADL) assistance for eating included opening containers, pouring milk over cereal, and ensuring residents could reach their utensils during tray set-up. Record review of the Admission Record for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Glaucoma, Muscle weakness, and Diabetes. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/24 for Resident #7 revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interview, record review, and policy review, the facility failed to provide a meal that was palatable in appearance when the facility posted Club Sandwich and French Fries on the menu for the evening meal on 3/19/25 and the sandwiches served were not palatable in appearance and did not match the facility's recipe for two (2) of seven (7) sampled residents reviewed. Resident #3 and Resident #4. Findings include: Record review of the facility policy titled MENUS, dated 4/21/22, revealed the policy stated: Policy . Foods will be served as planned on the menu unless there is a legitimate and extenuating circumstance . Standardized recipes are available for all items included on the cycle menu. Computerized recipes may be used. Record review of the posted menu for the evening meal on 3/19/25 revealed the menu listed Club Sandwich, Potato Chips, Cookie of Choice, Fruit of Choice, Iced Tea, and Milk. Record review of the Menu Calendar Report, Week 4, revealed that the Wednesday dinner menu included Club Sandwich, Potato Chips, Cookie of Choice, Fruit of Choice, Iced Tea, and Milk. The alternate menu included chicken strips, tater tots, mixed vegetables, turkey sandwich, and French fries. Record review of the Recipe Report for Club Sandwich revealed the ingredients included bacon, sliced white bread, mayonnaise, fresh sliced tomatoes, fresh iceberg lettuce, pre-sliced pork, ham, lunch meat, and turkey. On 3/19/25 at 5:00 PM, observation and interview with Resident #4 in the dining room revealed she had a slice of ham and an intact hoagie bun (not sliced into halves) on her supper plate with no vegetables. There were no chips or French fries on her plate. Resident #4 stated she was not able to eat the bun, picked it up and held it near her mouth, then stated, How can I eat it? I can't even get it in my mouth. When asked if she would like an alternate meal, she stated that staff were getting her some French fries and she would eat her meat and French fries. Observation revealed the meal served did not match the posted menu and did not appear palatable. On 3/20/25 at 10:00 AM, during an interview, the Administrator confirmed that posted menus were to be followed and that a club sandwich typically included bacon, more than one type of meat, and dressings such as tomato and lettuce. On 3/20/25 at 10:15 AM, during an interview with Resident #4 in her room, she stated she did not know what kind of sandwich was served on the evening of 3/19/25, but it was not a kind she was accustomed to or aware of. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 10:35 AM, during an interview with the Dietary Manager in Training (DMIT) and the contract Certified Dietary Manager (CDM), the CDM confirmed that posted menus were generated from prescheduled Menu Reports that could be adjusted based on resident preferences. Recipes were available online and were expected to be followed. She confirmed that sandwiches were customarily served with lettuce, tomato, and fresh vegetables to allow residents to dress their sandwiches as preferred. The DMIT stated she was not completely sure of the correct ingredients for a club sandwich. Record review of the Admission Record for Resident #4 revealed the resident was admitted on [DATE] with diagnoses of Cervical spondylosis, Atrial fibrillation, and Anemia. Record review of the BIMS dated 1/10/25 revealed a score of 15, indicating no cognitive impairment. Resident #3 On 3/19/25 at 5:25 PM, observation and interview with Resident #3 revealed the resident was served an evening meal tray by facility staff that included a sandwich listed on the posted dinner menu as a club sandwich. The sandwich consisted of small ham squares and mayonnaise on a hoagie bun, with no vegetables. The resident looked at the sandwich and sneered. She stated it looked terrible and asked what it was supposed to be. She said she liked club sandwiches but that the item served was not a club sandwich. She attempted to eat it but had to remove the top bun in order to fit it in her mouth. Observation revealed the sandwich did not appear palatable and did not match the description or expectations of a club sandwich. Record review of the Admission Record for Resident #3 revealed the resident was admitted on [DATE] with diagnoses including Hypertensive heart disease, Cerebral infarction, Diabetes, and Dementia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 12/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment.