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	10/29/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Based on interview, record review, and facility policy review the facility failed to ensure that the comprehensive person-centered care plan was implemented for one (1) of four (4) sampled residents (Resident #1).Findings included:Record review of the facility policy titled, Care Plans-Comprehensive dated 10/2016 revealed .Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s). Record review of the Care Plan Report for Resident #1 revealed Focus: Resident requires assistance with ADL's (activities of daily living) r/t (related to) muscle weakness/QUATDRIPLEGIA/PARESIS.Interventions.Requires the use of the total mechanical lift X 2 (with two) nursing staff members.Record review of the Care Plan Report date initiated 12/6/23 and revised on 10/20/25, revealed Focus: Resident is at risk for falls and fall related injuries. Interventions. Provide assistance as needed for transfers. 10/17/25 Resident returned from Hospital with X-ray results showing Acute displaced fracture of the left anterolateral rib 9.Record review of the Lift (Determination for Resident Lift/Transfer Assistance for Resident #1 dated 9/23/25 revealed the facility assessed that the resident was dependent for surface-to-surface transfers, and that conditions likely to affect transfer techniques included colostomy, contractures/spasms, paralysis and pressure ulcers and that the resident required two (2) staff and a total mechanical lift with a medium sling. Record review of the Progress Notes for Resident #1 dated 10/17/25 revealed nursing staff documented that the resident was observed on the floor of his room with the transfer sling beneath him, the mechanical lift over him, and his Geri-recliner on its side at the door of the room, was transferred to local hospital and returned to the facility with diagnosis of right rib fracture.Record review of the Incident Report dated 10/17/25 revealed Resident #1 was observed on the floor with the Geri-recliner lying on its side at the door and the resident reported he hit his head, and he was transported to local hospital for evaluation and treatment.Record review of the facility investigation dated 10/21/25 revealed that on 10/17/25 during a bed to Geri-recliner transfer CNA #1 attempted to transfer the resident without assistance and did not lock the Geri-recliner with resulted in a fall and an acute fracture of the left anterolateral rib#9. The resident has as needed pain meds, Oxycodone 5 milligrams by mouth every six hours and Tylenol 325 milligrams by mouth every four hours as needed for pain.Record review of the local hospital Emergency Medicine Attending Physician note dated 10/17/25 revealed documentation that Resident #1 had a mechanical fall from a Hoyer lift and assessment included radiographic imaging which indicated left rib fx (fracture).On 10/28/25 at 2:51 PM, during an interview the Director of Nurses (DON) confirmed that the facility had reported the fall of Resident #1 during a transfer using a full body mechanical lift which resulted in a fractured rib. The DON confirmed that all CNAs had access to and were expected to refer as needed to the computer software available on facility kiosk regarding resident care instructions including for surface-to-surface transfers. On 10/28/25 at 4:00 PM, during an interview Resident #1 stated that on 10/17/25 at approximately 10:40 AM, CNA #1 was using a full body mechanical lift to transfer him from his bed to a Geri-recliner in his room with CNA#2 in attendance. He stated that CNA#2 was in the room but did actively participate in the procedure and that the lift and the Geri-recliner turned over and he landed on the floor.On 10/28/25 at 5:00 PM, during an interview the Minimum Data Set (MDS) Nurse confirmed that she had contributed to the development of the care plan for Resident #1 and that his care plan on 10/17/25 had interventions in place which directed that two (2) nursing staff provide assistance with mechanical lift for surface-to-surface transfers. She confirmed that all CNA's had access via computer software on facility kiosk to the Tasks for each resident that pulled care information from the residents' care plans. She confirmed that the facility provided in-service training which included the responsibility of nursing staff to follow each residents' care plan and included that all surface-to-surface transfers required the participation of (2) staff members. On 10/29/25 at 10:10 AM, during an interview CNA #7 stated that the facility provided training for the transfers with and without mechanical lifts, including instructions that all transfers with lifts required two nursing staff. She confirmed that resident care instructions for all residents were available to CNAs in the software on the facility kiosk. On 10/29/25 at 11:33 AM during a telephone interview CNA #1 revealed she went to assist CNA #2 to transfer Resident #1 from his bed to his Geri-recliner on 10/17/25 and that she (CNA #1) attempted to transfer the resident without the assistance of CNA #2. She stated that she had not waited for CNA #2 to begin the procedure and that after the resident was secured in the sling she had lifted him from the bed, moved him over the Geri-recliner and was pulling the resident using the handlebar straps

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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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to ensure adequate supervision and the implementation of safety interventions to prevent accidents for two (2) of four (4) sampled residents (Resident #1 and Resident #2)Findings included:Record review of the facility policy titled, MODIFIED LIFTING POLICY with a revision date of September 2025 revealed .Use of a mechanical lift requires two (2) nursing assistants or nurses to perform the procedure each time that it is used.Record review of the facility policy titled, TRANSPORT OUT OF FACILITY dated 7/2008 (July 2008) revealed the policy did not address requirements, training for qualifications for staff who performed transportation of residents. Resident #1Record review of the Lift Determination for Resident Lift/Transfer Assistance for Resident #1 dated 9/23/25 revealed the facility assessed that the resident was dependent for surface-to-surface transfers, and that conditions likely to affect transfer techniques included colostomy, contractures/spasms, paralysis and pressure ulcers and that the resident required two (2) staff and a total mechanical lift with a medium sling. Record review of the Progress Notes for Resident #1 dated 10/17/25 revealed nursing staff documented that the resident was observed on the floor of his room with the transfer sling beneath him, the mechanical lift over him, and his Geri-recliner on its side at the door of the room, was transferred to local hospital and returned to the facility with diagnosis of right rib fracture.Record review of the Incident Report dated 10/17/25 revealed Resident #1 was observed on the floor with the Geri-recliner lying on its side at the door and the resident reported he hit his head and he was transported to local hospital for evaluation and treatment. Record review of the facility investigation dated 10/21/25 revealed that on 10/17/25 during a bed to Geri-recliner transfer CNA #1 attempted to transfer the resident without assistance and did not lock the Geri-recliner with resulted in a fall and an acute fracture of the left anterolateral rib#9. The resident has as needed pain meds, Oxycodone 5 milligrams by mouth every six hours and Tylenol 325 milligrams by mouth every four hours as needed for pain.Record review of the Emergency Medicine Attending Physician note dated 10/17/25 revealed documentation that Resident #1 had a mechanical fall from a Hoyer lift and assessment included radiographic imaging which indicated left rib fx (fracture).During an interview on 10/28/25 at 2:51 PM, the Director of Nurses (DON) confirmed that the facility had reported the fall of Resident #1 during a transfer using a full body mechanical lift which resulted in a fractured rib. The DON confirmed that all CNAs had access to and were expected to refer as needed to the computer software available on facility kiosk regarding resident care instructions including for surface-to-surface transfers. She stated that both CNA#1 and CNA #2 had their employment at the facility terminated because of the incident for failure to follow facility policy for transfer of a dependent resident using a full body mechanical lift. During an interview on 10/28/25 at 4:00 PM, Resident #1 stated that on 10/17/25 at approximately 10:40 AM, CNA #1 was using a full body mechanical lift to transfer him from his bed to a Geri-recliner in his room with CNA#2 in attendance. He stated that CNA#2 was in the room but did actively participate in the procedure and that the lift and the Geri-recliner turned over and he landed on the floor.During a telephone interview on 10/29/25 at 11:33 AM, CNA #1 revealed she went to assist CNA #2 to transfer Resident #1 from his bed to his Geri-recliner on 10/17/25 and that she (CNA #1) attempted to transfer the resident without the assistance of CNA #2. She stated that she had not waited for CNA #2 to begin the procedure and that after the resident was secured in the sling she had lifted him from the bed, moved him over the Geri-recliner and was pulling the resident using the handlebar straps on the back of the sling to position the resident correctly over the recliner and the resident's back made contact with the back of the recliner, which caused the Geri-recliner to tilt backwards and strike the lift and then the lift and recliner both fell over and the resident landed on the floor at the end of his bed. She stated that Resident #1 was hollering in pain and reported his head hurt. She stated that she and CNA #2 moved the Geri-recliner out of the way and CNA #2 summoned the nurse. She confirmed that the wheels of the Geri-recliner were not locked, and the base of the lift was not open. She confirmed that her employment at the facility had been terminated on 10/17/25 for failure to follow policy for transfers with mechanical lifts. During a telephone interview on 10/29/25 at 12:20 PM, CNA #2 revealed she was assigned to the care of Resident #1 on 10/17/25 and she was providing incontinent care for the resident's roommate at the time that CNA #1 entered the room and proceeded to perform a bed to Geri-recliner transfer with a full body mechanical lift without assistance. She stated that she had summoned CNA#1 for assistance for the transfer of Resident #1 because it was against facility policy to perform transfers with mechanical lifts by only one (1) CNA. She stated that she was concentrated on the procedure

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interviews, record review, and facility policy review the facility failed to ensure staff who perform resident transportation possessed and demonstrated the competencies necessary to carry out their responsibilities safely one (1) of four (4) residents dependent on the facility for transportation, Resident #2. Findings included:Record review of the facility policy titled, TRANSPORT OUT OF FACILITY dated 7/2008 (July 2008) revealed the policy did not address requirements, training for qualifications for staff who performed transportation of residents. Record review of the Incident Report for Resident #2 dated 10/22/25 revealed LPN #1 documented, STAFF REPORTED THAT WHILE THE RESIDENT WAS SITTING IN THE WHEELCHAIR IN THE VAN, (FACILITY TRANSPORTATION) THE WHEELCHAIR MOVED BACK AND TILTED.STAFF ASSISTED REISDENT AND PLACED WHEELCHAIR IN A STABLE POSITION. At 3:10 PM on 10/28/25, during a telephone interview, the Resident Representative (RR) for Resident #2 revealed she confirmed that facility staff had notified her that Resident #2 had an incident on the facility van as he was being transported back to the facility from a local hospital and that the wheelchair moved and tilted. She stated that she was not sure if the wheelchair turned completely over based on the report provided by facility staff but confirmed that Resident #2 told her that the wheelchair had fallen over backwards onto the floor of the facility van.At 4:25 PM on 10/28/25, during an interview Licensed Practical Nurse (LPN) #1 revealed she was working on the 3:00 PM through 11:00 PM shift on 10/22/25 when a local hospital had notified the facility that Resident #2, at the hospital for evaluation, was ready to be released and returned to the facility. She said that when Certified Nursing Assistant (CNA) #3 and CNA #4 returned the resident to his room following unloading him from the facility van following transport from the hospital, they reported that the wheelchair had moved back and tilted when they were at a red light. She said that the CNAs stated that the resident had not come out of the wheelchair or been on the floor of the van. She stated that she evaluated the resident immediately and noted no injury and the resident denied pain or discomfort related to the incident. She confirmed that she had notified the resident's RR and his primary healthcare provider, with no new orders noted, and she had notified the Director of Nurses (DON) and had completed an incident report. She clarified statement in the incident report, Resident did not fall by saying that she had not considered the incident a fall because the resident did not come out of the wheelchair. At 4:40 Pm on 10/28/25, during an interview Resident #2 reported that on 10/22/25 he had been transferred to a local hospital emergency department due to unstable vital sign. He stated that following the evaluation he had been released, and CNA #3 and CNA#4 arrived at the hospital in the facility van to transport him back to the facility. He stated that during the transport his wheelchair turned over backwards and landed on its back on the floor of the van. He said the CNAs immediately assisted him, still in his wheelchair back in an upright position and continued the transport to the facility. He stated that the nurse had conducted an evaluation, and he had not been injured by the fall. He said that he could not see how the CNAs secured the wheelchair when they had loaded him into the van at the hospital and did not know how or why the wheelchair turned over.At 1:44 PM on 10/29/25, during an interview CNA #3 stated that she had performed transportation for residents at a different facility where she worked prior to her employment at the facility and said that the securement system in the facility van was a lot like the one she had been trained to use at her previous employment. She stated that she had not received any formal training with demonstration and return demonstration or competency checkoff for the operation of the facility van, van lift or resident securement system. She stated that she thought she had the wheelchair secured correctly but confirmed that during a stop at a red light she observed in the rear-view mirror Resident #2's wheelchair turned over backwards and landed on the van floor. CNA#3 stated she had not received any training for the safe use of the securement system on or prior to 10/22/25.At 2:10 PM on 10/29/25, during an interview CNA #4 stated that she went with CNA #3 to pick up Resident #2 from a local hospital to return him to the facility. She stated that she observed Resident #2 turn over backwards with the back of the wheelchair landing on the floor of the van during the transport. She stated that she was riding along for accompaniment and supervision of the resident. She stated that she was not sure if CNA #3 secured the resident in the facility van appropriately or not and that she had not received any training for the safe use of the securement system on or prior to 10/22/25. She stated that Resident #2 had not complained of pain and did not have any obvious injury or change of level of consciousness. She confirmed that the resident did not leave the wheelchair during the fall. At 4:30 PM on 10/29/25, observation and interview revealed CNA #6 demonstrated use of the facility van lift and securement system. CNA #6