

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  01/13/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observations, interviews, record review and facility policy review the facility failed to provide assistance with turning and repositioning per standards of care for two (2) of nine (9) sampled residents who required assistance with activities of daily living (ADL) and repositioning. Resident #1 and Resident #2. Findings include: Record review of the facility policy titled ADL CARE POLICY dated 8/23 (August 2023) revealed, it is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis, while attaining or maintaining the residence of highest, practicable, physical, mental and social well-being. Resident #1 On 1/12/26 at 9:30 AM observation revealed Resident #1 was resting in bed on her back with head of bed elevated. She had a family member (niece) seated in a chair next to her bed. On 1/12/26 at 2:00 PM, during an interview the family member that was sitting with Resident #1 revealed she had not left the resident's room since she arrived and Resident #1 had not been turned or repositioned since she arrived prior to 9:30 AM. On 1/12/26 at 2:56 PM, during an interview Certified Nursing Assistant (CNA) #2 confirmed she was assigned to the care of Resident #1 on the 7:00 AM through 3:00 PM shift on 1/12/26. She confirmed that she had turned/repositioned Resident #1 one time on 1/12/26 prior to 9:30 AM and that was the only time. She stated she was familiar with the care instructions for Resident #1 and that she was supposed to be turned/repositioned every two hours while in bed. Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 7/21/24 with diagnoses that included cerebral infarction (stroke) and dysphagia. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/12/25 revealed Resident #1 rarely/never understood and had severely impaired cognitive skills for daily decision making. Section GG revealed the facility assessed Resident #1 for being dependent for bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed). Resident #2 On 1/12/26 at 11:15 AM, observation and interview with Resident #2 revealed he was lying on his back in his bed. Resident #2 was alert and oriented to person, place and time and reported that both of his legs were uncomfortable and that he needed to be repositioned and had not been assisted to turn or reposition since approximately 5:00 AM when a male CNA turned him onto his back. On 1/12/26 at 11:22 AM, observation and interview revealed CNA #1 entered the room of Resident #2 and repositioned him in bed onto his left side with foam wedge for positioning. CNA #1 stated that it was the first time she had turned/repositioned Resident #2 on 1/12/26. On 1/12/25 at 3:22 PM, during an interview CNA #1 revealed Resident #2 required repositioning every two (2) hours and she had no idea when the last time he was turned on the morning on 1/12/26 before 11:22 AM. She stated Resident #2 was alert and oriented. On 1/12/26 at 3:30 PM, during an interview the Registered Nurse (RN) Supervisor revealed he arrived at the facility at approximately 6:43 AM and was not aware that Resident #2 had not been turned or repositioned during the 7:00 AM through 3:00 PM shift on 1/12/26 until 11:22 AM and added he had assumed everything had been taken care of. He stated he had been responsible for Resident</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  255103	Facility ID:  255103  If continuation sheet Page 1 of 3

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>#1's care and Resident #2's care until approximately noon on 1/12/26. He stated that he had not had a chance to check on Resident #2 on 1/12/26. He stated that he felt the postponement of care of Resident #1 and Resident #2 was lack of communication. He stated he was not aware that Resident #1 was not turned/repositioned for approximately five (5) hours on 1/12/26. He said he had training for turning/repositioning residents in bed and would have gladly provided care if he had known the CNAs were overwhelmed or needed assistance for resident ADLs. He stated, I can't make excuses, I just wish staff would have told me. He stated possible complications for dependent residents not being turned/repositioned routinely every two hours included discomfort and damage to skin integrity. On 1/12/26 at 4:45 PM, during an interview the Administrator revealed he expected the nurses and the RN Supervisors to supervise the care of the residents and that all residents receive care according to their abilities and needs. On 1/13/26 at 4:00 PM, during an interview the Director of Nurses (DON) stated she expected direct care staff to provide residents with assistance to turn/reposition in bed as needed every two hours and as needed or requested in order to avoid complications that included discomfort and damage to skin integrity. Record review of the admission Record for Resident #2 revealed the facility admitted the resident on 12/16/25 with diagnoses that included congestive heart failure and cervical region spondylosis with myelopathy.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on interviews and record review the facility failed to ensure accurate labeling of medication for one (1) of three (3) medication carts. The 400 Hall Medication Cart. Findings include:Record review of the facility policy titled, Medical SUPPLY STORAGE POLICY dated 3/2011 (March 2011) revealed the policy did not address storage of one medication in another's package.Record review of the MEDICATION ERROR REPORT signed by the DON and dated 12/29/25 revealed, .Individual Restasis vial were inside of nebulizer box.family reported wrong vial was brought into the room .On 1/12/26 at 4:45 PM, during an interview the Administrator revealed he expected the nurses to maintain accurate storage of medications in a manner that would provide for safe administration of medications. He stated that storing one medication in the box of a different medication could lead to administration of the wrong medication and cause complications for the resident.On 1/12/26 at 5:00 PM, during an interview the Director of Nurses (DON) confirmed that on 12/29/25 she had been notified by Resident #1's family that a nurse entered the resident's room with an incorrect medication vial for a nebulizer treatment. The DON said she immediately investigated and discovered multiple vials of Restasis eye drops in the Albuterol Sulfate Inhalation Solution package labeled with the name of Resident #1. She stated she removed the incorrect vials of Restasis eye drops and completed an audit of all medications to ensure there were no other incorrectly stored medications on any of the medication carts. She stated that storing one medication in the box of a different medication could lead to administration of the wrong medication and cause complications for the resident.On 1/13/26 at 1:00 PM, during an interview with the Resident Representative for Resident #1, she reported that on 12/29/25 a nurse entered the resident's room with a vial and announced that she was going to administer a nebulizer treatment due to the resident's congestion but that it was obviously not the correct medication and she pointed this out to the nurse and the nurse left the room and did not put the medication into the nebulizer unit. Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 7/21/24 with diagnoses that included cerebral infarction (stroke) and dysphagia.Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/12/25 revealed Resident #1 was rarely/never understood and had severely impaired cognitive skills for daily decision making.</p>		