Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

| 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 03/02/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Edgewood Health & Rehabilitation | 205 Byram Parkway<br>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) |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on policy review, record review and interviews, the facility failed to ensure the residents' right to be free from abuse and failed to protect Resident #1 from abusive and degrading treatment by Certified Nurse Aide (CNA) #1 and CNA #2 during the provision of care on the evening of 2/10/26. The abusive conduct included the use of disparaging, derogatory, and humiliating language and intimidation toward Resident #1 while the resident requested assistance and complained of pain during care for one (1) of four (4) sampled residents. Resident #1.The State Agency (SA) identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 2/26/26. The IJ began on 2/14/26, when the facility failed to protect residents from abuse, failed to report alleged abuse timely, failed to promptly investigate allegations of abuse, and Administration failed to implement and enforce the facility's abuse policies.The facility's failure to report, protect, and investigate abuse placed all residents residing in the facility at risk in a situation likely to cause serious injury, serious harm, serious impairment, or death.On 2/26/26 at 4:05 PM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the IJ templates.IJ and SQC existed at:42 CFR(s) 483.12(a)(1) - Abuse and Neglect (F600) - Scope and Severity (S/S) - JThe facility submitted an acceptable Removal Plan on 2/27/26 in which the facility alleged all corrective actions to remove the IJ and SQC were completed on 2/27/26, and the IJ was removed as of 2/28/26. Therefore, the scope and severitywere lowered from a J to a D while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Included:Record review of the facility policy titled, Abuse Policy and Procedure dated 1/24/22 revealed Each resident of this facility has the right to be free from verbal, sexual, physical and mental abuse.1. Verbal abuse' is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.4. Mental abuse' includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation.Residents are not to be subjected to abuse by anyone. This includes, but is not limited to, facility staff . Record review of the Facility Investigation dated 2/19/26 revealed that on 2/14/26 at approximately 8:40 AM the Resident Representative (RR) for Resident #1 reported an allegation of abuse to the Registered Nurse (RN) Supervisor (RN #2). RN #2 notified the Director of Nurses (DON) of the allegation by telephone at approximately 8:50 AM on 2/14/26. The DON notified the Administrator at 9:01 AM on 2/14/26. The Investigation Timeline revealed that on the evening of 2/10/26 after the evening meal on Unit A Resident #1 was verbally abused by CNA #1 and CNA # 2 who used disparaging, demeaning and derogatory language and deliberate actions to intimidate Resident #1 during provision of care.Record reviews of the timesheets for 2/05/26 through 2/18/26 revealed CNA #1 was on duty at the facility on the evening shift (3:00 PM through 11:00 PM) on 2/10/26.Record review of the timesheets for 2/05/26 through 2/16/26 revealed CNA #2 was on duty at the facility on the evening shift (3:00 PM through 11:00 PM) on 2/10/26, 2/11/26, 2/12/26 and 2/16/26.Record review of the Assignment Sheet 3-11 GROUP 9 dated 2/10/26 revealed CNA #1 was assigned to work with residents in rooms<br>(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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | that included Resident #1's room on the evening shift on 2/10/26 and had been assigned to CNA #1 to provide care.On 2/25/26 at 4:30 PM, during an interview with RN #1 revealed that she was notified of an allegation of the verbal abuse of Resident #1 on 2/14/26 at approximately 8:45 AM by RN #2 who told her Resident #1's RR had voiced a complaint of verbal abuse by staff with audio recording. RN #1 said with Resident #1 and her RR in the resident's room, she listened to the recording but could not identify the voices in the audio. She confirmed that the RR for Resident #1 said that she recognized the voice of CNA #2 but did not know the CNA's name and described her as a big, female with short braids and that #2 was the only staff that matched the description. She stated neither the Director of Nurses (DON) nor the Administrator came to the facility on 2/14/26 and that no interviews were conducted 2/14/26. She reported the only intervention initiated on 2/14/26 was the relocation of Resident #1 to Unit B upon request of the RR. RN #1 described Resident #1 as frail and confirmed that the resident was admitted by the facility following a fall, right hip fracture and surgery and needed assistance for activities of daily living (ADLs). RN #1 added regardless of documented functional abilities if asked for assistance the staff should provide requested assistance in a respectful manner. She stated that she listened to the recording on the morning of 2/10/26 and was shocked any staff spoke to any resident in such a cruel, degrading manner.On 2/25/26 at 12:37 PM, during an interview the DON revealed that on 2/14/26 at approximately 8:50 AM she was notified by RN #2 that Resident #1's RR reported an allegation of abuse with audio recording of the incident that was awful. She was unable to provide any interventions to protect residents from further abuse initiated on 2/14/26 or 2/15/26. She stated she reported the allegation to SA on 2/16/26 and began training and interviews with staff, including a 10:30 AM interview with CNA #2 who confirmed she was in the room on 2/10/26 during the incident with CNA#1. She stated she contacted the RR for Resident #1 for the first time on 2/16/26 at 11:00 AM for interview and requested the recording which was received at 11:16 AM. She said that she and the Lead CNA Supervisor listened to the recording, and the Lead CNA Supervisor recognized the voices of Resident #1 and CNA #1 and CNA #2. She confirmed that the recording contained verbal abuse of Resident #1 and stated It was awful. If I could have had them (CNA #1 and CNA #2) arrested, I would have. The DON said that CNA #1 was scheduled to work 2/15/26 but did not report and her last day of employment was 2/10/26 and CNA #2 was on duty 2/11/26 evening shift and 2/16/26 day shift (7:00 AM to 3:00 PM) and clocked out at 11:16 AM on 2/16/26 after CNA #2 confirmed that one of the voices on the recording was hers. She and CNA #2 were working on Unit A on the evening of 2/10/26, entered the room of Resident #1, who was assigned to CNA #1, witnessed CNA #2 having a bad attitude towards the resident and that she was present in the resident's room throughout the incident and not think that she had done anything wrong because she said I didn't curse her (the resident) but was guilty by association. The DON said she informed CNA #2 that her employment at the facility was terminated for verbal abuse of a resident due to the way she spoke to Resident #1 on the evening of 2/10/26 and failure to report abuse.During an interview with the Administrator on 2/26/26 at 10:17 AM, revealed he had been notified by the DON on 2/14/26 at 9:00 AM via telephone that the RR for Resident #1 had reported an allegation of verbal abuse at approximately 8:40 AM. He said the DON was responsible for the investigation and the outcome was that the facility substantiated the allegation of verbal abuse of Resident #1 and resulted in the termination of the employment of CNA#1 and CNA #2 on 2/16/26 for verbal abuse of a resident. On 2/26/26 at 12:45 PM, during an interview CNA #3 confirmed that she was in the room of Resident #1 on the evening of 2/10/26 with Resident #1, CNA #1, CNA #2 and CNA #4 overheard CNA #1 speak the exact words presented as evidence of verbal abuse in an audio recording by the RR. She stated that she only heard the first part of the interaction that she did not perceive as abusive at the time and left the room, closed the door and did not report the interaction.On 2/26/26 at 12:55 PM during an interview CNA #4 confirmed that she was in the room of Resident #1 on the evening of 2/10/26 with Resident #1, CNA #1, CNA #2 and CNA #3 and overheard CNA #1 repeatedly tell Resident #1 to get up and that she was not handicapped and observed the resident attempt to stand without success. She<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | stated that she only heard the first part of the interaction that she did not perceive as abusive at the time and she and CNA #3 left the room, and she did not report the interaction.On 2/26/26 at 1:40 PM, during an interview with the Lead CNA Supervisor revealed that on 2/16/26 at approximately 11:16 AM, she received a recording from the RR for Resident #1 who reported that Resident #1 made the recording. The Lead CNA Supervisor confirmed that the Facility had accepted the recording as evidence of abuse of Resident #1 and had identified the voices on the recording as Resident #1, CNA #1 and CNA #2. She stated that she had listened to the recording and considered the things that both CNA #1 and CNA #2 said and the way they said them were abusive, derogatory and demeaning and said in a malicious manner. She confirmed that based on the recording the resident had requested help repeatedly and was scorned, criticized, and insulted by CNA #1 and CNA #2. She confirmed that Resident #1's concerns were dismissed and her complaints of discomfort and pain were ignored or as well as her complaint that they treated her rough.On 3/02/26 at 11:58 AM, during a telephone interview with RN #2 revealed she was the RN Supervisor on Unit A on the morning of 2/14/26. She reported that the RR for Resident #1 reported verbal abuse of Resident #1 at approximately 8:40 AM and she had notified the DON by telephone at approximately 8:50 AM. She said she listened to a recording presented by the RR of Resident #1 which she described as demeaning, degrading making fun of her (Resident #1), laughing at her, insulting her and intimidating her and she heard the elder cry, scream, complain of pain and beg them to quit. She said she was not aware of any interventions to protect residents from further abuse or investigate the allegation on 2/14/26. She confirmed the resident could be heard on the recording crying, screaming, complaining about ?rough' treatment and asking the CNAs to ?quit' and that both CNA s responded by mocking and laughing at the resident, and described the recording as shocking and terrible.Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 11/04/25 and the resident had diagnoses of encounter for other orthopedic aftercare, fracture of right femur, and dementia.Record review of the Quarterly Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 2/6/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Section GG revealed Resident #1 required a wheelchair for mobility and partial/moderate assistance for dressing, to roll from lying on back to left and right side, and to transfer to and from a bed to a chair.Record review of the KARDEX for Resident #1 revealed care instructions included SAFETY.Provide assistance as needed for ADL's (activities of daily living). Provide assistance as needed for transfers & ambulation.Transferring: Requires 1 person stand pivot Weight bearing as tolerated for transfers. Caution with right hip due to surgery. Dressing: Resident requires 1 person assistance with upper and lower body dressing. Resident Care: Anticipate and meet my needs per physical/non-verbal indicators of discomfort/distress.The facility submitted an acceptable Removal Plan on 2/27/26, and the IJ was removed on 2/28/26. Removal PlanThe facility took the following actions to address the citations and prevent any additional residents from suffering an adverse outcome. On 2/14/2026, the facility's administration was notified of an allegation of abuse from Resident #1's Resident Representative (RR) concerning an audio recording at approximately 9:00 AM. The Resident Representative (RR) stated that she believed the incident happened on 2/11/2026. Later investigation would reveal incident occurred on 2/10/2026. After Director of Nursing (DON) and Facility Administrator were notified by Registered Nurse (RN) #1 and Registered Nurse (RN) #2, the facility's administration failed to report the allegation of abuse within the two-hour time frame to the proper organizations. The facility also did not begin a formal investigation until the following day, Sunday February 15, 2026. Although the resident was moved to a different unit in the building, The facility failed to immediately implement protective measures, and staff alleged to be involved continued to provide resident care through 2/16/26. Resident #1 was still at risk for continued abuse. The actions of the facility's administration put Resident #1 at risk for continued abuse as well as the other residents of the facility at risk for potential abuse. The facility failed to ensure all residents were free from abuse after being notified on 2/14/26 at approximately 9:00 AM of an allegation of (continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | verbal abuse supported by an audio recording validated by facility administration capturing staff cursing at Resident #1 while the resident was heard screaming.The State Agency (SA) notified the facility of (IJ) Immediate Jeopardy and provided the IJ templates to the facility on 2/26/27 at 4:05 PMCorrective Actions:On 2/14/2026 Resident #1 was moved at approximately 10:00 AM from Unit A to Unit B at the request of the family after discussion with Registered Nurse #1 . On 2/15/2026 at approximately 9:00 AM , the Director of Nursing interviewed Resident #1 regarding the allegations of alleged abuse, and she denied any such happenings. On 2/15/2026 at approximately 9:00 AM, the Director of Nursing(DON) assessed the resident for any physical or emotional effects.On 2/16/2026, Psychosocial support began at approximately 11:15 AM and was conducted for 72 hours by the Social Services Director (SSD). Resident #1 was referred to the Psychiatric Nurse Practitioner for evaluation on 2/18/2026 at approximately 1:46 PM. The Director of Nursing (DON), Staff Development, and Lead CNA (Certified Nursing Assistant) provided education with all staff regarding the Facility Abuse Policy and Procedures beginning on 2/16/2026 at approximately 11:00 PM.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. CNA #1 that was identified was a no show on 2/15/2026 and 2/16/2026 and had not worked since 2/10/26. CNA #1 was contacted multiple times on 2/16/2026 beginning at approximately 11:30am to be terminated but did not return phone calls. CNA #2 was terminated upon review of the recording on 2/16/2026 at 11:16 AM, due to her voice being recognized using aggressive language. All staff will be educated on Abuse Policy and Procedure as well as the timeline for reporting and investigation of allegations of abuse beginning on 2/16/2026 at approximately 12:00 PM by Director of Nursing (DON), Staff Development Nurse, Lead CNA and RN Supervisor. No staff will be allowed to work until in-serviced.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. AD HOC Quality Assurance (QA) meeting held on 2/27/2026 at 8:30 AM to review plan for removal of Immediate Jeopardy (IJ) tag. Policy was reviewed with no changes. Attendees for QA included: Director of Nursing, Medical Director, Administrator, Corporate Nurse, Business Office Manager, Social Services Director, MDS Nurses, Medical Records Nurses, Registered Nurse Supervisors, Activity Director, Therapy Director, Housekeeping Director, Lead CNA, Staff Development Nurse, Infection Control Nurse and Wound Nurse.The facility alleges all corrective actions were completed on 2/27/2026 and the IJ removed on 2/28/2026.Validation:The SA validated the Removal Plan on 3/2/26 and determined the IJ was removed on 2/28/26 prior to exit on 3/2/26. |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on policy review, record review and interviews, the facility failed to report an allegation of verbal abuse of a resident within the required timeframe of two (2) hours after the allegation was reported to facility staff. The allegation was reported to the facility on 2/14/26 at approximately 8:40 AM but was not reported to the State Agency until 2/16/26 at 11:30 AM. This was for one (1) of four (4) sampled residents. Resident #1.This failure resulted in Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 02/14/26 and placed Resident #1 and all other residents in a situation that was likely to cause serious harm, serious impairment, serious injury or death.The IJ and SQC existed at:CFR 483.12(c)(1)(4) Reporting of Alleged ViolationsScope and Severity (S/S) JThe SA notified the facility Administrator of the Immediate Jeopardy on 02/26/26 at 4:05 PM and provided the IJ template.The facility submitted an acceptable removal plan on 02/27/26 in which the facility alleged all corrective actions were completed on 02/27/26 and the IJ was removed on 02/28/26. The scope and severitywere lowered from a J to a D while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings included:Record review of the facility policy titled, Abuse Policy and Procedure dated 1/24/22 revealed . Any alleged incident REPORTED must be investigated and REPORTED to the state within 2 hours of knowledge of such alleged incident. In addition, a written report must be submitted by Registered Nurse within 72 hours.Record review of the Facility Investigation dated 2/19/26 revealed that on 2/14/26 at approximately 8:40 AM the Resident Representative (RR) for Resident #1 reported an allegation of abuse to the Registered Nurse (RN) Supervisor (RN #2). RN #2 notified the Director of Nurses (DON) of the allegation by telephone at approximately 8:50 AM on 2/14/26 via telephone. The DON notified the Administrator at 9:01 AM on 2/14/26. The allegation of abuse was initially reported to the State Agency (SA) on 2/16/26 at 11:30 AM and the final investigative findings were submitted to SA on 2/19/26.During an interview on 2/25/26 at 12:37 PM, the DON revealed on 2/14/26 at approximately 8:50 AM she was notified by RN #2 of an allegation of abuse of Resident #1 by the resident's RR along with a request to speak with the Administrator. The DON notified the Administrator of the allegation by telephone at approximately 9:01 AM. The DON said she notified SA on 2/16/26 at 11:30 AM.During a telephone interview on 2/26/26 at 9:33 AM, the RR for Resident #1 revealed she had reported an allegation of verbal abuse of Resident #1 on 2/14/26 at approximately 8:40 AM to RN #1 and provided access of the recording to RN #1 and RN #2 and requested to speak to someone in Administration.During an interview on 2/26/26 at 10:30 AM, the Administrator revealed he had been notified by the DON on 2/14/26 at 9:00 AM via telephone that the RR for Resident #1 had reported an allegation of verbal abuse at approximately 8:40 AM. He said that the DON reported the allegation to SA on 2/16/26 at 11:30 AM. The Administrator confirmed the facility failed to report allegations of abuse within required timeframe according to state and federal requirements.During a telephone interview on 3/02/26 at 11:58 AM, RN #2 revealed she was the RN Supervisor on Unit A on the morning of 2/14/26. She stated the RR for Resident #1 reported verbal abuse of Resident #1 at approximately 8:40 AM on 2/14/26 and she had notified the DON by telephone at approximately 8:50 AM.The facility submitted an acceptable Removal Plan on 2/27/26, and the IJ was removed on 2/28/26.Removal PlanThe facility took the following actions to address the citations and prevent any additional residents from suffering an adverse outcome. On 2/14/2026, the facility's administration was notified of an allegation of abuse from Resident #1's Resident Representative (RR) concerning an audio recording at approximately 9:00 AM. The Resident Representative (RR) stated that she believed the incident happened on 2/11/2026. Later investigation would reveal incident occurred on 2/10/2026. After Director of Nursing (DON) and Facility Administrator were notified by Registered Nurse (RN) #1 and Registered Nurse (RN) #2, the facility's administration failed to report the allegation of abuse within the two-hour time frame to the<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | proper organizations. The facility also did not begin a formal investigation until the following day, Sunday February 15, 2026. Although the resident was moved to a different unit in the building, The facility failed to immediately implement protective measures, and staff alleged to be involved continued to provide resident care through 2/16/26. Resident #1 was still at risk for continued abuse. The actions of the facility's administration put Resident #1 at risk for continued abuse as well as the other residents of the facility at risk for potential abuse. The facility failed to ensure all residents were free from abuse after being notified on 2/14/26 at approximately 9:00 AM of an allegation of verbal abuse supported by an audio recording validated by facility administration capturing staff cursing at Resident #1 while the resident was heard screaming.The State Agency (SA) notified the facility of (IJ) Immediate Jeopardy and provided the IJ templates to the facility on 2/26/27 at 4:05 PMCorrective Actions:On 2/14/2026 Resident #1 was moved at approximately 10:00 AM from Unit A to Unit B at the request of the family after discussion with Registered Nurse #1 . On 2/15/2026 at approximately 9:00 AM , the Director of Nursing interviewed Resident #1 regarding the allegations of alleged abuse, and she denied any such happenings. On 2/15/2026 at approximately 9:00 AM, the Director of Nursing(DON) assessed the resident for any physical or emotional effects.On 2/16/2026, Psychosocial support began at approximately 11:15 AM and was conducted for 72 hours by the Social Services Director (SSD). Resident #1 was referred to the Psychiatric Nurse Practitioner for evaluation on 2/18/2026 at approximately 1:46 PM. The Director of Nursing (DON), Staff Development, and Lead CNA (Certified Nursing Assistant) provided education with all staff regarding the Facility Abuse Policy and Procedures beginning on 2/16/2026 at approximately 11:00 PM.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. CNA #1 that was identified was a no show on 2/15/2026 and 2/16/2026 and had not worked since 2/10/26. CNA #1 was contacted multiple times on 2/16/2026 beginning at approximately 11:30am to be terminated but did not return phone calls. CNA #2 was terminated upon review of the recording on 2/16/2026 at 11:16 AM, due to her voice being recognized using aggressive language. All staff will be educated on Abuse Policy and Procedure as well as the timeline for reporting and investigation of allegations of abuse beginning on 2/16/2026 at approximately 12:00 PM by Director of Nursing (DON), Staff Development Nurse, Lead CNA and RN Supervisor. No staff will be allowed to work until in-serviced.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. AD HOC Quality Assurance (QA) meeting held on 2/27/2026 at 8:30 AM to review plan for removal of Immediate Jeopardy (IJ) tag. Policy was reviewed with no changes. Attendees for QA included: Director of Nursing, Medical Director, Administrator, Corporate Nurse, Business Office Manager, Social Services Director, MDS Nurses, Medical Records Nurses, Registered Nurse Supervisors, Activity Director, Therapy Director, Housekeeping Director, Lead CNA, Staff Development Nurse, Infection Control Nurse and Wound Nurse.The facility alleges all corrective actions were completed on 2/27/2026 and the IJ removed on 2/28/2026.Validation:The SA validated the Removal Plan on 3/2/26 and determined the IJ was removed on 2/28/26 prior to exit on 3/2/26. |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on policy review, record review, and interviews, the facility failed to thoroughly investigate an allegation of abuse in a timely manner to prevent further potential abuse. The facility failed to initiate a prompt and thorough investigation after an allegation of verbal abuse of Resident #1 was reported on 2/14/26. The facility did not immediately interview staff or residents, did not initiate protective interventions, and delayed investigative actions until 2/16/26. This deficient practice affected one (1) of three (3) reviewed incidents with documented indications of possible abuse. Resident #1.The facility's failure to initiate a timely investigation and implement protective measures created the likelihood of continued abuse of Resident #1 and other residents and placed them in a situation that was likely to cause serious harm, serious injury, serious impairment or death. Staff confirmed that the allegation involved demeaning and abusive language toward Resident #1, yet no interviews, resident assessments, or protective interventions were implemented on 2/14/26 when the allegation was first reported. This failure placed Resident #1 and other residents at risk for continued abuse.This failure resulted in Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 02/14/26.The IJ and SQC existed at:CFR 483.12(c)(2) Investigation of Alleged ViolationsScope and Severity (S/S) JThe SA notified the facility Administrator of the IJ and SQC on 02/26/26 and provided the IJ template at 4:05 PM.The facility submitted an acceptable removal plan on 02/27/26 in which the facility alleged all corrective actions were completed on 02/27/26 and the IJ was removed on 02/28/26. The scope and severitywere lowered from a J to a D while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings included:Record review of the facility policy titled, Abuse Policy and Procedure dated 1/24/22 revealed .The facility will IDENTIFY, correct, intervene in situations in which abuse, neglect and/or misappropriation of funds occur.The facility will thoroughly INVESTIGATE all alleged violations under the direct supervision of the Administrator. The facility will take all necessary steps to prevent further potential abuse while the investigation is in progress. Any employee of the facility suspected of abuse or neglect will be suspended pending investigation until the facility investigation is complete. During and after the investigation, the resident(s) will be PROTECTED from harm through frequent supervision and reassurance by staff. Record review of the Facility Investigation dated 2/19/26 revealed that on 2/14/26 at approximately 8:40 AM the Resident Representative (RR) for Resident #1 reported an allegation of abuse to the Registered Nurse (RN) Supervisor (RN #2). RN #2 notified the Director of Nurses (DON) of the allegation by telephone at approximately 8:50 AM on 2/14/26 via telephone. The DON notified the Administrator at 9:01 AM on 2/14/26. The DON reported to the facility on 2/15/26 and interviewed Resident #1 and attempted to locate the audio recording on the resident's cell phone without success.In an interview on 2/25/26 at 12:37 PM, the DON revealed on 2/14/26 at approximately 8:40 AM she was notified by RN #2 of an allegation of abuse of Resident #1 by the resident's RR along with a request to speak with the Administrator and that the Administrator be notified of the allegation by telephone at approximately 9:01 AM. The DON said she had instructed RN #1 to follow up on 2/14/26 at approximately 10:00 AM and was not aware of any interviews of other residents or staff on 2/14/26. She said RN #1 and RN #2 had told her that they had heard an audio recording that the RR for Resident #1 played for them that indicated verbal abuse. The DON said that on 2/15/26 she reported to the facility on 2/15/26 at approximately 10:00 AM and conducted one interview with Resident #1 and tried to locate the recording on the resident's cell phone without success and did not contact the RR for Resident #1 or conduct any other interviews. The DON said that on 2/16/26 she contacted the RR for Resident #1 and obtained the audio recording and interviewed staff. She reported that interviews of residents were delegated to the Social Services Director (SSD). She described how on 2/16/26 she was able to ascertain the date of the incident was 2/10/26 and that CNA #2 was present during the incident and that at approximately 11:00 AM on<br>(continued on next page) |

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

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2/16/26 she spoke with the RR for Resident #1, for the first time since notification, by telephone and heard the description that matched CNA #2. The RR provided the audio recording at 11:16 AM she and the Lead CNA Supervisor listened to the recording and the Lead CNA Supervisor positively identified voices on the recording as those of Resident #1, CNA #1 and CNA#2.In an interview on 2/25/26 at 4:30 PM, RN #1 revealed that on 2/14/26 RN #2 notified her at approximately 8:40 AM of an allegation of verbal abuse of Resident #1 brought forth by the resident's RR. She confirmed that the RR was present and requested to speak with the Administrator. RN #1 said that the RR had an audio recording made by Resident #1 on either 2/10/26 or 2/11/26. She said she listened to the recording, played by the RR, on the morning of 2/14/26 and that she was able to identify the voice of Resident #1, but unable to recognize the voices of the two (2) staff members. She stated that she had spoken with the Director of Nurses' (DON) and that they had discussed the RR's requests and the DON instructed her to transfer Resident #1 to Unit B and that there were no further instructions provided. She stated that the DON nor the Administrator came to the facility on 2/14/26. She said she had not conducted any interviews, assessed any residents or placed any interventions in place to protect residents on 2/14/26. RN #1 confirmed that she considered the way Resident #1 was spoken to by staff on the recording as abusive.In a telephone interview on 2/26/26 at 9:33 AM, the RR for Resident #1 said that the resident had voiced complaints of rough treatment by staff, which she had not reported. The RR said she visited Resident #1 on 2/11/26 and while looking at the resident's cellular telephone (cell phone) noticed that the resident had recordings and forwarded the recordings to her own cell phone, listened to them on 2/13/26 at approximately 10:30 PM and heard verbal abuse of Resident #1 which she described as mean, demeaning. She said she reported an allegation of verbal abuse of Resident #1 on 2/14/26 at approximately 8:40 AM to Registered Nurse (RN) #1 and provided access of the recording to RN #1 and RN #2 and requested to speak to someone in Administration. She stated that on 2/16/26 the DON had telephoned her at approximately 11:00 AM and she reported to the DON that she recognized the voice of CNA #2, whose name she did not know, but provided description. She said on 2/16/26 the DON requested she send the recording to staff, which she did at approximately 11:15 AM. In an interview on 2/26/26 at 10:30 AM, the Administrator revealed he had been notified by the DON on 2/14/26 at 9:00 AM via telephone that the RR for Resident #1 had reported an allegation of verbal abuse at approximately 8:40 AM. He said that he had delegated responsibility for investigating the allegation to the DON. He confirmed that he was unaware of any staff interviews conducted to investigate the allegation prior to 2/16/26. He stated that the results of failure to thoroughly investigate an allegation of abuse could include continued abuse of residents. In an interview on 2/26/26 at 12:35 PM, the Lead CNA Supervisor revealed that she was notified of the allegation of verbal abuse of Resident #1 on 2/16/26 at approximately 8:00 AM by the DON. She described her involvement in the investigation as receipt and review of a recording provided by the RR for Resident #1 at approximately 11:16 AM on 2/16/26, during which she was able to identify the voices of Resident #1, CNA #1 and CNA #2.In an interview on 2/27/26 at 12:50 PM, the Social Services Director (SSD) revealed she interviewed four (4) residents (only on the 400 Hall) on 2/19/26 as part of the investigation into the verbal abuse of Resident #1. She stated that the results of failure to thoroughly investigate an allegation of abuse could include continued abuse of residents.In an interview on 3/02/26 at 11:58 AM, during a telephone interview with RN #2 revealed she was the RN Supervisor on Unit A on the morning of 2/14/26 and the RR for Resident #1 reported verbal abuse of Resident #1 at approximately 8:40 AM on 2/14/26. She stated she had notified the DON by telephone at approximately 8:50 AM. She said she was unaware of any interviews or physical assessments of other residents for complaints or signs or symptoms of abuse conducted on 2/14/26. She confirmed she had listened to the recording provided by the RR of Resident #1 and considered the interaction abusive toward the resident.The facility submitted an acceptable Removal Plan on 2/27/26, and the IJ was removed on 2/28/26.Removal PlanThe facility took the following actions to address the citations and prevent any additional residents from suffering an adverse outcome. On 2/14/2026, the (continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | facility's administration was notified of an allegation of abuse from Resident #1's Resident Representative (RR) concerning an audio recording at approximately 9:00 AM. The Resident Representative (RR) stated that she believed the incident happened on 2/11/2026. Later investigation would reveal incident occurred on 2/10/2026. After Director of Nursing (DON) and Facility Administrator were notified by Registered Nurse (RN) #1 and Registered Nurse (RN) #2, the facility's administration failed to report the allegation of abuse within the two-hour time frame to the proper organizations. The facility also did not begin a formal investigation until the following day, Sunday February 15, 2026. Although the resident was moved to a different unit in the building, The facility failed to immediately implement protective measures, and staff alleged to be involved continued to provide resident care through 2/16/26. Resident #1 was still at risk for continued abuse. The actions of the facility's administration put Resident #1 at risk for continued abuse as well as the other residents of the facility at risk for potential abuse. The facility failed to ensure all residents were free from abuse after being notified on 2/14/26 at approximately 9:00 AM of an allegation of verbal abuse supported by an audio recording validated by facility administration capturing staff cursing at Resident #1 while the resident was heard screaming.The State Agency (SA) notified the facility of (IJ) Immediate Jeopardy and provided the IJ templates to the facility on 2/26/27 at 4:05 PMCorrective Actions:On 2/14/2026 Resident #1 was moved at approximately 10:00 AM from Unit A to Unit B at the request of the family after discussion with Registered Nurse #1 . On 2/15/2026 at approximately 9:00 AM , the Director of Nursing interviewed Resident #1 regarding the allegations of alleged abuse, and she denied any such happenings. On 2/15/2026 at approximately 9:00 AM, the Director of Nursing(DON) assessed the resident for any physical or emotional effects.On 2/16/2026, Psychosocial support began at approximately 11:15 AM and was conducted for 72 hours by the Social Services Director (SSD). Resident #1 was referred to the Psychiatric Nurse Practitioner for evaluation on 2/18/2026 at approximately 1:46 PM. The Director of Nursing (DON), Staff Development, and Lead CNA (Certified Nursing Assistant) provided education with all staff regarding the Facility Abuse Policy and Procedures beginning on 2/16/2026 at approximately 11:00 PM.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. CNA #1 that was identified was a no show on 2/15/2026 and 2/16/2026 and had not worked since 2/10/26. CNA #1 was contacted multiple times on 2/16/2026 beginning at approximately 11:30am to be terminated but did not return phone calls. CNA #2 was terminated upon review of the recording on 2/16/2026 at 11:16 AM, due to her voice being recognized using aggressive language. All staff will be educated on Abuse Policy and Procedure as well as the timeline for reporting and investigation of allegations of abuse beginning on 2/16/2026 at approximately 12:00 PM by Director of Nursing (DON), Staff Development Nurse, Lead CNA and RN Supervisor. No staff will be allowed to work until in-serviced.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. AD HOC Quality Assurance (QA) meeting held on 2/27/2026 at 8:30 AM to review plan for removal of Immediate Jeopardy (IJ) tag. Policy was reviewed with no changes. Attendees for QA included: Director of Nursing, Medical Director, Administrator, Corporate Nurse, Business Office Manager, Social Services Director, MDS Nurses, Medical Records Nurses, Registered Nurse Supervisors, Activity Director, Therapy Director, Housekeeping Director, Lead CNA, Staff Development Nurse, Infection Control Nurse and Wound Nurse.The facility alleges all corrective actions were completed on 2/27/2026 and the IJ removed on 2/28/2026.Validation:The SA validated the Removal Plan on 3/2/26 and determined the IJ was removed on 2/28/26 prior to exit on 3/2/26. |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>Based on policy review, record review, and interviews, the facility failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure administrative leadership implemented timely actions to respond to and manage an allegation of verbal abuse involving Resident #1. The Administrator was notified of the allegation on 2/14/26 at approximately 9:00 AM but failed to ensure the allegation was reported within required timeframes, failed to ensure the alleged perpetrator was immediately removed from resident contact, and failed to ensure a prompt investigation was initiated. This deficient practice affected one (1) of four (4) sampled residents. Resident #1.The facility's failure to provide effective administrative oversight resulted in delays in reporting the allegation to the State Agency (SA) and delays in initiating investigative actions. The alleged perpetrator, Certified Nurse Aide (CNA) # 2, continued to work in the facility after the allegation was reported on 2/14/26 and remained on duty until approximately 11:16 AM on 2/16/26 when employment was terminated. Staff confirmed that neither the Administrator nor the Director of Nurses (DON) reported to the facility on 2/14/26 to initiate investigative actions and that no staff interviews were conducted on that date. The only intervention implemented on 2/14/26 was relocating Resident #1 to another unit at the request of the Resident Representative (RR).The facility's failure to implement effective administrative leadership and ensure timely response to allegations of abuse prevented prompt protection of residents and delayed regulatory reporting and investigation. This failure placed Resident #1 and other residents at risk for continued abuse and harm.The IJ began on 2/14/26, when the facility failed to protect residents from abuse, failed to report alleged abuse timely, failed to promptly investigate allegations of abuse, and Administration failed to implement and enforce the facility's abuse policies.The IJ existed at:CFR 483.70 Administration-Scope and Severity (S/S) JThe SA notified the facility Administrator of the Immediate Jeopardy on 02/26/26 and provided the IJ template at 4:05 PM.The facility submitted an acceptable removal plan on 02/27/26 in which the facility alleged all corrective actions were completed on 02/27/26 and the IJ was removed on 02/28/26. The scope and severitywere lowered from a J to a D while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings included:Record review of statement by the Administrator dated 3/02/26 revealed that the facility does not have an Administration Policy.Record review of the facility's Administrator Job Description (undated) revealed the document included ADMINISTRATOR JOB DESCRIPTION.Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents.Responds and resolves complaints and concerns when necessary.Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation, etc. are reported to the correct entity within the stated regulatory requirement. Record review of the facility policy titled Abuse Policy and Procedure dated 1/24/22 revealed the policy required that residents be free from verbal, physical, mental, and sexual abuse and that allegations of abuse are to be reported and investigated in accordance with regulatory requirements. Record review of the facility investigation dated 2/19/26 revealed that on 2/14/26 at approximately 8:40 AM the Resident Representative (RR) for Resident #1 reported an allegation of verbal abuse with an audio recording to the Registered Nurse (RN) Supervisor (RN #2). RN #2 notified the Director of Nurses (DON) at approximately 8:50 AM and the DON notified the Administrator at approximately 9:01 AM on 2/14/26. Record review of staff schedules revealed that CNA#2, an alleged perpetrator, continued to work in the facility after the allegation was reported on 2/14/26 and worked on 2/16/26 until approximately 11:16 AM when employment was terminated. During an interview on 2/25/26 at 12:37 PM, the DON confirmed the allegation was not reported to the SA until 2/16/26 and (continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | that staff interviews did not begin until 2/16/26. During an interview on 2/25/26 at 4:30 PM, RN #1 confirmed that neither the Administrator nor the DON came to the facility on 2/14/26 and that no staff interviews were conducted on that date. RN #1 confirmed the only intervention implemented on 2/14/26 was relocating Resident #1 to another unit at the request of the RR. During an interview on 2/26/26 at 10:17 AM, the Administrator confirmed he had been notified of the allegation of verbal abuse on 2/14/26 at approximately 9:00 AM. He confirmed that he was aware of state and federal regulatory timeframes for reporting allegations of abuse. The facility submitted an acceptable Removal Plan on 2/27/26, and the IJ was removed on 2/28/26.Removal PlanThe facility took the following actions to address the citations and prevent any additional residents from suffering an adverse outcome. On 2/14/2026, the facility's administration was notified of an allegation of abuse from Resident #1's Resident Representative (RR) concerning an audio recording at approximately 9:00 AM. The Resident Representative (RR) stated that she believed the incident happened on 2/11/2026. Later investigation would reveal incident occurred on 2/10/2026. After Director of Nursing (DON) and Facility Administrator were notified by Registered Nurse (RN) #1 and Registered Nurse (RN) #2, the facility's administration failed to report the allegation of abuse within the two-hour time frame to the proper organizations. The facility also did not begin a formal investigation until the following day, Sunday February 15, 2026. Although the resident was moved to a different unit in the building, The facility failed to immediately implement protective measures, and staff alleged to be involved continued to provide resident care through 2/16/26. Resident #1 was still at risk for continued abuse. The actions of the facility's administration put Resident #1 at risk for continued abuse as well as the other residents of the facility at risk for potential abuse. The facility failed to ensure all residents were free from abuse after being notified on 2/14/26 at approximately 9:00 AM of an allegation of verbal abuse supported by an audio recording validated by facility administration capturing staff cursing at Resident #1 while the resident was heard screaming.The State Agency (SA) notified the facility of (IJ) Immediate Jeopardy and provided the IJ templates to the facility on 2/26/27 at 4:05 PMCorrective Actions:On 2/14/2026 Resident #1 was moved at approximately 10:00 AM from Unit A to Unit B at the request of the family after discussion with Registered Nurse #1 . On 2/15/2026 at approximately 9:00 AM , the Director of Nursing interviewed Resident #1 regarding the allegations of alleged abuse, and she denied any such happenings. On 2/15/2026 at approximately 9:00 AM, the Director of Nursing(DON) assessed the resident for any physical or emotional effects.On 2/16/2026, Psychosocial support began at approximately 11:15 AM and was conducted for 72 hours by the Social Services Director (SSD). Resident #1 was referred to the Psychiatric Nurse Practitioner for evaluation on 2/18/2026 at approximately 1:46 PM. The Director of Nursing (DON), Staff Development, and Lead CNA (Certified Nursing Assistant) provided education with all staff regarding the Facility Abuse Policy and Procedures beginning on 2/16/2026 at approximately 11:00 PM.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. CNA #1 that was identified was a no show on 2/15/2026 and 2/16/2026 and had not worked since 2/10/26. CNA #1 was contacted multiple times on 2/16/2026 beginning at approximately 11:30am to be terminated but did not return phone calls. CNA #2 was terminated upon review of the recording on 2/16/2026 at 11:16 AM, due to her voice being recognized using aggressive language. All staff will be educated on Abuse Policy and Procedure as well as the timeline for reporting and investigation of allegations of abuse beginning on 2/16/2026 at approximately 12:00 PM by Director of Nursing (DON), Staff Development Nurse, Lead CNA and RN Supervisor. No staff will be allowed to work until in-serviced.A Corporate Nurse conducted an in-service with Director of Nursing (DON) and Facility Administrator regarding Abuse Allegations, investigations and proper reporting timeliness on 2/27/2026 at 8:00 AM. AD HOC Quality Assurance (QA) meeting held on 2/27/2026 at 8:30 AM to review plan for removal of Immediate Jeopardy (IJ) tag. Policy was reviewed with no changes. Attendees for QA included: Director of Nursing, Medical Director, Administrator, Corporate Nurse, Business Office Manager, (continued on next page) |

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