

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

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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 07/23/2026
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and interview, the facility failed to immediately protect one (1) of three (3) resident reviewed for an allegation of abuse. Resident #62. Findings include:Record review of the facility policy Abuse Policy and Procedures, dated 1/24/2022, revealed, Each resident of this facility has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment, neglect and/or misappropriation of resident property. The facility will identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of funds occur .Record review of the facility investigation dated 7/22/26 revealed that on the morning of July 20, 2026, Resident #62 was receiving a shower when Licensed Practical Nurse (LPN) #7 and LPN #8 both heard Resident #62 hollering and both went into the shower room and witnessed Certified Nursing Assistant (CNA) #5 striking Resident #62 with a towel. On 7/20/2026 at 4:03 PM, Resident #62 was observed seated in a wheelchair at the nurses' station. The resident was oriented to person only.During an interview on 7/21/2026 at 3:43 PM, LPN #7 stated that she and LPN #8 were at the nurses' station when they heard yelling from the 300 Hall. Both nurses went to room [ROOM NUMBER] and observed CNA #5 providing shower care to Resident #62. Resident #62 was seated on a shower chair, screaming, and attempting to grab CNA #5's right arm. LPN#7 stated that CNA #5 took the towel she was using to bathe the resident and struck the resident twice. LPN#7 stated that the nurses initially left the doorway to notify Registered Nurse (RN) #3.During an interview on 7/21/2026 at 4:00 PM, LPN #8 stated that she and LPN#7 heard yelling and went to room [ROOM NUMBER]. LPN#8 stated that Resident #62 became combative during shower care. CNA #5 stepped backward, swung a towel at the resident twice, and struck the resident's left arm twice. LPN #8 stated that she went to notify RN #3.During an interview on 7/21/2026 at 4:08 PM, RN #3 stated that LPN #8 reported that the nurses had witnessed CNA #5 hit Resident #62. RN #3 stated that she sent CNA #5 home, notified the Director of Nursing (DON), completed an incident report, performed a body audit, and completed a pain assessment.During a telephone interview on 7/22/2026 at 9:33 AM, CNA #5 stated that Resident #62 became combative, screamed, hit her, grabbed the shower hose, and bent it. CNA #5 denied hitting the resident and stated that she stepped backward and removed the hose from the resident.During a second telephone interview on 7/22/2026 at 10:48 AM, CNA #5 stated that she remained alone with Resident #62 after the incident and dried the resident. CNA #5 stated that LPN #7 briefly entered the room, asked the resident if she was okay, and left the resident alone with her. CNA #5 stated that RN #3 entered the room while she was preparing to dress the resident.During an interview on 7/22/2026 at 3:44 PM, the DON stated that RN #3 notified her of the alleged incident. The DON stated that LPN #7 reported witnessing CNA #5 hit Resident #62 with a towel, while LPN#8 reported that CNA #5 was observed making contact with the towel with the resident's left arm. The DON stated that she was initially informed that staff had immediately removed CNA#5 from the (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident.During a follow-up interview on 7/22/2026 at 4:03 PM, LPN #8 stated that CNA #5 raised the towel and that she heard a sound consistent with the resident being struck, although her viewing angle prevented her from seeing the second contact. LPN #7 confirmed that both nurses stepped away from the doorway and lost visual contact with Resident #62 and CNA #5. She stated that one of the nurses should have remained with the resident until RN#3 arrived. LPN #8 stated that she returned approximately five minutes later.During an interview on 7/22/2026 at 4:24 PM, RN #3 stated that she was notified of the incident while LPN #7 was outside on the porch. RN #3 stated that approximately five minutes passed before she entered the room. When she entered, Resident #62 remained alone with CNA #5. RN #3 stated that she performed a body audit and did not identify signs or symptoms of injury.During a telephone interview on 7/22/2026 at 4:40 PM, LPN #8 confirmed that she witnessed CNA #5 strike Resident #62. LPN #8 stated that she and LPN #7 stepped away from the doorway to discuss what they had witnessed and lost visual contact with the resident and CNA #5 for approximately five minutes. LPN #8 confirmed that they should not have left Resident #62 alone with CNA #5.During an interview on 7/23/2026 at 2:17 PM, the DON stated that she had not been informed that the licensed nurses left Resident #62 alone with CNA #5 after witnessing the alleged abuse. The DON confirmed that the nurses should have immediately separated CNA #5 from the resident. She stated that leaving the resident with the alleged perpetrator placed the resident at risk for further abuse and that the facility's policy required removal of the alleged perpetrator.A record review of LPN #7's written statement revealed that she and LPN #8 heard Resident #62 screaming in room [ROOM NUMBER]. LPN #7 documented that Resident #62 was swatting at CNA #5 and that CNA #5 struck the resident with a towel twice. She documented that she could not see additional contact because of her viewing angle.A record review of LPN #8's written statement revealed that the resident was being combative during the shower and that CNA #5 was observed stepping back and making contact with towel with resident's left arm.A record review of CNA#5's written statement revealed that Resident #62 screamed, grabbed the shower hose, and bent it during shower care. CNA #5 denied striking or hitting the resident.A record review of Resident #62's admission Record revealed an admission date of 11/28/2023 and diagnoses that included severe unspecified dementia without other behavioral disturbance and unspecified Alzheimer's disease.A record review of Resident #62's Minimum Data Set assessment, with an Assessment Reference Date of 4/24/2026, revealed a Brief Interview for Mental Status score of 99, indicating the resident interview was not completed.A record review of Resident #62's body audit, dated 7/20/2026, revealed no visible signs of injury.A record review of Resident #62's pain assessment, dated 7/20/2026, revealed no pain was identified.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility policy review, and record review, the facility failed to store medications properly for one (1) of five (5) residents observed for medication administration. (Resident # 32) Findings include:Record review of the facility policy, Medication Storage in The Facility revised 2018 revealed, Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy, personnel, or staff members lawfully authorized to administer medications.An interview at 11:59 AM on 7/22/26, with Licensed Practical Nurse (LPN) #3 revealed she was taking care of Resident # 32 on 7/3/26. She stated that she wasn't thinking like a nurse when she was called away to take care of another resident who had fallen. She stated she left without grabbing the medications and was gone about 15 minutes. During that time, Resident #32's daughter came and identified the medications left at the bedside and notified the Registered Nurse (RN) Supervisor. LPN#3 noted that issues with leaving medications at the bedside could be that residents won't take them as in this case, missing a dose of medication, or another resident could come and take them and have a reaction. LPN #3 confirmed that an in-service was done on medication administration and professionalism on 7/15/26 which she signed and also noted that since then, herself and LPN #2 have switched out residents and nurses, so LPN # 3 does not take care of Resident # 32 anymore.An interview with RN #3 at 12:08 PM on 7/22/26, revealed she was the supervisor present on 7/3/26. On that day, she noted that the daughter of Resident # 32 came to get her and when she got into the resident's room there were two pills in a medication cup sitting on the resident's bedside table, that were not taken by the resident. RN #3 stated that the resident's daughter was concerned because she thought the resident wasn't taking her medication.An interview with the Director of Nursing (DON) at 12:20 PM on 7/22/26, revealed she was not present on the day of the incident, but had started an investigation. During the investigation it was identified that LPN #3 had left medications at the bedside of Resident #32. The DON noted that this is dangerous as medications being left out could either not be taken by the resident or kept until later and double dosed or you could see another resident come in the room and take them by mistake and lead to a reaction.On 7/22/26 at 12:28 PM, during an interview the Minimum Data Set (MDS) nurse/ LPN #1 stated she was in her office on the date of the incident, and the Social Worker brought the daughter of Resident # 32 to her office. She stated Resident #32's daughter was complaining that LPN #3 left medications at the bedside without making sure the resident took them. The MDS nurse/LPN#1 stated she updated her care plan that day to address these concerns and then switched out the nurses in charge of caring for Resident #32 to prevent any future issues. She noted that residents' meds are not supposed to be left at bedside. She stated the resident may not take their medications, or another resident could also have come in and taken the medications.An interview with Resident #32's daughter on 7/22/26 at 3:35 PM, revealed she was in the facility visiting her mother on 7/3/26 and came to the bedside and saw medicines left in a medicine cup that her mother had not taken. She was unsure of how long these medications were left on her table and noted that when she asked the nurse about these meds, the nurse tried to give them to the resident, but by then it was well past the time for them to be administered.Record review of the admission Record revealed Resident #32 was admitted on [DATE] with diagnoses that included seizures.Record review of the Minimum Data Set (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(MDS) with an Assessment Reference Date (ARD) of 6/5/26 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated moderate cognitive deficits. Validated Compliance :SA validated through staff interviews, record review, and facility policy review, the facility began an immediate investigation when the grievance was filed regarding medications left at bedside. SA interviewed LPN #3 to determine that she underwent an in-service pertaining to the grievance involving medication administration on 7/5/26. SA interviewed LPN #2 to confirm she has been taking care of the resident since the incident instead of LPN #3 and she noted that she hasn't seen any meds left at bedside in the room. An interview with the resident's daughter revealed she has not had this issue since then either. An interview with the Administrator at 11:31 AM on 7/23/26 revealed the facility handled the complaint of medications left on Resident #32's bedside table by LPN #3 by performing a one on one in-service and policy reading with the nurse regarding medication administration as well as the DON making rounds in the room along with the Social Worker and RN #3 to check for medications being left on bedside. He noted that it is his expectation that medications be administered per policy. An interview with the DON at 11:33 AM on 7/23/26 revealed she completed an in-service, policy review and write up for LPN #3 along with performing rounds herself into the room to check for unattended medications and having ancillary staff in this case, RN#3 and the Social Worker to round on the room to also check. She noted it is her expectation that nurses follow policy when administering medications. An interview with RN #2 on 7/23/26 at 12:02 PM revealed she makes rounds each shift to check for unattended medications at the bedside and has not seen any since this incident occurred and noted that she would investigate if this happened while also notifying the DON. An interview with the Social Worker at 12:10 PM on 7/23/26 revealed she makes daily rounds since the incident occurred to check on residents on the 300 Hall. She also noted that she checks for medications being left at bedside and has not ever witnessed this. The SA also made observations throughout survey on 7/20/26, 7/21/26, 7/22/26 and 7/23/26 and did not observe any medications on bedside table of the resident. A review of facility in-service record revealed LPN #3 was in-serviced on 7/5/26 regarding medication administration policy. A review of facility's grievance log dated 7/3/26 revealed a grievance was made by Resident # 32's daughter regarding medication administration. The facility returned to substantial compliance on 7/5/26 after completing its investigation, educating and disciplining LPN #3, revising Resident #32's care plan, reassigning the resident's medication administration, and implementing monitoring rounds. The facility sustained compliance through the survey ending on 7/23/26.		