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	08/01/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48669 Based on observation, interviews, and facility policy review, the facility failed accommodate the needs of a resident, as evidenced by, leaving a resident who was dependent on staff for eating, unassisted and unfed during a meal, for one (1) of 23 sampled residents. Resident #70. Findings Include: A review of the facility's policy titled Residents Rights dated 1/24/22 revealed, Policy Statement .Residents' rights policies and procedures shall ensure that each resident admitted to the center .Policy Interpretation and Implementation .9. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs . On 07/29/24 at 12:44 PM, an observation with Resident #70 revealed she was sitting up in her electric wheelchair. Both of her arms were contracted down by her sides. There was a blow call light to the right side of Resident #70. The resident had a mouth stylus pen that she was using to scroll and type on her phone. In an interview, Resident #70 indicated that Certified Nursing Assistant (CNA) #1 who worked the 3:00 PM - 11:00 PM shift, was just beginning to feed her dinner on 7/3/24, when Licensed Practical Nurse #1 (LPN) came to the door and demanded CNA #1 stop what she was doing to attend a meeting at the nurse station. She said the CNA left her sitting there with the tray in front of her. On 7/30/24 at 12:46 PM, in a follow-up interview, Resident #70 mentioned that the reason she was irritated by the whole incident that occurred on 7/3/24 was because she was hungry and ready to eat. She explained that she had to wait to be fed, and it seemed like it took forever for CNA #1 to return, and her food had gotten cold. Resident #70 expressed that she felt disrespected because CNA #1 should not have been made to stop feeding her, as she could not feed herself, and the nurse was wrong in her opinion for making her do so. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 10:08 AM, in a phone interview, CNA #1 confirmed she was the CNA assigned to feed Resident #70 on 7/3/24 for the dinner meal. She indicated the trays had just come out and she was putting the second spoonful of food in Resident #70's mouth when LPN #1 asked her to stop feeding the resident and come to a meeting with all CNAs at the nurse's desk. CNA #1 said that she initially continued to feed the resident because she did not want to leave her, but about five minutes later, the nurse returned and in a demanding tone said, Stop what you're doing and come here now. You can finish feeding the resident when you get back! CNA #1 expressed her belief that it was unfair to abandon the resident during her meal, as the resident was totally dependent upon her to provide her nourishment. When she was finally able to return to the resident, it was about twenty to thirty minutes later. She realized the resident's food was cold, so she took the necessary steps to get her some warm food to eat, which further delayed the resident's meal. On 8/1/24 at 1:32 PM, in an interview with the Director of Nursing, she stated that the resident should have been fed first. If it was not an emergency, such as a resident code, the nurse should have waited until the CNA finished feeding the resident. She added that the nurse's actions were inappropriate. A record review of the Admission Record revealed the facility admitted Resident #70 on 11/04/2021. Her current medical diagnoses included Quadriplegia, C5-C7 Complete Muscle Weakness, and Lack of Coordination. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/13/2024 revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873 Based on observation, record review, policy review, and interviews, the facility failed to ensure a resident was free from physical restraints, as evidenced by not completing an assessment and evaluation for an upper body harness vest and by not ensuring the upper body vest was the least restrictive device for one (1) of one (1) sampled residents for restraints. Resident #88 Findings Included: A record review of the facility's policy titled Physical Restraint, dated 2/20/12, revealed .Restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully .1. Restraints will only be used after alternatives have been tried unsuccessfully, and only with informed consent from the resident, physician, and/or responsible party . A record review of the facility's policy titled, Restraint Decision Policy, dated 10/2016, revealed, Policy: It is the policy of this facility to provide the least restrictive, restraint-free environment for our residents . 1. The Restraint Decision Form will be completed prior to the application of restraints with exception of emergency situation that threatens the safety and well-being of the resident or others . A record review of the physical restraint record of informed consent dated 7/23/2024 for Resident #88 revealed a type of restraint involving a wheelchair harness vest. The Resident's Representative had been informed of options regarding the use of physical restraints and the possible negative outcomes. The resident understood the right to be free from physical restraints and acknowledged that it would be used for protection from possible physical injury with the least restrictive device. A record review of Resident #88's Restraint (Initial Assessment for Use of Physical Restraint) with an effective date of 7/23/2024 revealed Reason for the use of Physical Restraint .4. Frequent falls 5. Sliding out of chair/wheelchair .Physician order received .May use wheelchair harness vest as a restraint to prevent unassisted rising . Record review of the Admission Record revealed Resident #88 was admitted to the facility on [DATE] with diagnoses that included Metabolic encephalopathy. A record review of Resident #88's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/2024 revealed a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating the resident's cognition was moderately impaired. On 07/29/24 at 12:50 PM, in an observation, Resident #88 was in a wheelchair with an upper body harness vest in place. The RR stated that this harness had been used for the past few weeks to prevent the resident from leaning too far forward and falling out of the wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview, on 8/1/24 at 10:52 AM, the Director of Nursing (DON) revealed that the vest was brought in by Resident #88's family member, who insisted on using it. The corporate office was contacted for approval, and the doctor signed off on its use. The DON admitted that the assessment and evaluation for the device was missed, as well as the in-service training for all staff involved in care since it was not a regularly used facility device. In an interview on 08/01/24 at 12:15 PM, the Physical Therapist (PT) revealed that Resident #88 was on caseload from March through April. The PT confirmed the resident had not recently been evaluated regarding posture and verified that PT would not recommend restraints of any type without a thorough assessment, always starting with the least restrictive measures.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure proper storage of respiratory equipment as evidenced by tubing not dated or bagged when not in use for one (1) of one (1) resident sampled for respiratory care. Resident #88 Findings Include: A record review of the facility policy titled Nebulizer and Oxygen Tubing Storage Policy, dated April 2007, revealed, POLICY It was the policy of the facility to decrease the risk of potential and/or direct exposure to infectious diseases, air contaminants, and bacterial exposure. We will provide our residents with the proper storage and cleaning of respiratory equipment . The facility will replace all respiratory tubing weekly. These tubings will be dated and stored in a dated plastic bag when not in use. The plastic bags will also be changed out weekly . A record review of Resident #88's Order Summary Report with active orders as of 7/30/24, revealed an order 3/5/24 O2 (oxygen) at 2 (two) liters per nasal cannula PRN (as needed) for SOB (shortness of breath). An additional order dated 3/5/24 revealed Change nebulizer/O2 tubing weekly (on Sunday nights on the 7P-7A shift) date the tubing & (and) new storage bag when changed. Cleaning nebulizers/O2 concentrators and filters at this time . Observations on 07/29/24 at 10:19 AM and at 12:50 PM, revealed oxygen tubing on Resident #88's wheelchair was not dated and stored in a dated plastic bag while not in use, as the resident was in bed and using a bedside concentrator. Observation on 07/29/24 at 1:15 PM, Resident #88 was noted to be in a wheelchair with portable oxygen tubing in use. The tubing remained undated. Observation on 07/30/24 at 10:19 AM, revealed portable oxygen tubing on Resident #88's wheelchair was still not dated or in a dated storage bag. Observation on 7/30/24 at 3:14 PM, revealed portable oxygen tubing on the wheelchair. Again the oxygen tubing was not in a storage bag or labeled with a date. In an interview on 07/31/24 at 09:36 AM, Licensed Practical Nurse (LPN) #4 stated that the facility policy required replacing all respiratory tubing weekly, dating the tubing, and storing it in a dated plastic bag when not in use. When asked about the availability of bags, she revealed that she had never seen a bag since working there. In an interview on 07/31/24 at 10:36 AM, LPN #1 explained that the policy required changing the tubing every week and turning it off when not in use. She emphasized that the policy aimed to decrease the risk of exposure to infectious diseases, air contaminants, and bacterial exposure. During an interview on 07/31/24 at 11:20 AM, the Director of Nursing (DON) stated that it was the cart nurse's responsibility to change, label, and care for oxygen and nebulization tubing and that changes typically occurred on the Sunday night to Monday morning shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #88's Admission Record revealed an admitted [DATE] with an original admitted [DATE] with current diagnoses that included Metabolic Encephalopathy.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181 Based on observations, interviews, and policy review, the facility failed to store food and use sanitary practices in accordance with professional standards for food service safety related to unlabeled food items, food items exposed, overly ripe produce, improperly stored foods, and contaminated dry bin items for one (1) of two (2) kitchen observations. This has the potential to affect all residents who receive meals from the dietary department. Findings Include: A review of the facility's policy titled Food Storage Labeling, dated ,d+[DATE], revealed, . All food items that are not in their original containers must be labeled with the common name of the food and the use-by date Foods stored in storage units will be surveyed routinely to identify and discard foods that have passed the manufacturer use-by date or expiration date . A review of the facility's policy titled Storage of Canned and Dry Food, dated ,d+[DATE], revealed, .Opened packages are stored in tightly covered containers intended for food that are durable, leak proof, and can be tightly sealed or covered and labeled . Dry food products such as flour, cornmeal, sugar, etc, that are stored in bins are removed from their original packaging . Scoops are stored in covered containers and not in the storage bin . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:32 AM, an interview with the Dietary Manager (DM) and observation of the kitchen revealed the following: In Refrigerator #1, there were nineteen (19) overly ripe green tomatoes with black and white biological growth (bio-growth), five (5) overly ripe cucumbers with soft discolored areas and white bio-growth, and eight (8) overly ripe green bell peppers with white and black bio-growth. One (1) pan contained three (3) baked sweet potatoes, as described by the DM, with no label, and the plastic wrap over the pan was pulled back, leaving the food exposed. One (1) plastic container of tomato soup, as described by the DM, had a written date of [DATE] with no indication of what the date meant. Three (3) trays containing thirty-five (35) portioned glasses each of cranberry and orange juice, as described by the DM, had no labels. One (1) pan of scrambled eggs, as described by the DM, had no label and was not completely covered with plastic wrap, leaving the food exposed. One (1) pan of gravy, as described by the DM, had no label and was not completely covered with plastic wrap, leaving the food exposed. One (1) pan of bacon had no date label and was not completely covered with plastic wrap, leaving the food exposed. Additionally, there were three (3) unopened bags of salad mix containing lettuce, shredded carrots, and purple cabbage with a manufacturer's best-if-used-by date of [DATE]. In Refrigerator #2, one (1) tray contained seven (7) thickened teas, seven (7) thickened waters, with no labels. Another tray contained one (1) thickened orange juice, one (1) thickened cranberry juice, and eight (8) thickened waters, with no labels. In Refrigerator #3, there were two (2) opened 46-ounce cartons of thickened orange juice that had a date of [DATE] written on the carton. The DM described the date as the date it was received in the facility. There was no indication of an open date on the cartons. There was also one (1) opened 46-ounce carton of thickened cranberry juice that had a date of [DATE] written on the carton. The DM described the date as the date it was received in the facility. There was no indication of an open date on the carton. Five (5) unlabeled condiment cups contained what the DM described as hibachi sauce. One (1) unlabeled 52-ounce bottle of smoothie was present. The DM stated she did not know to whom the smoothie belonged. On the bottom shelf of a food preparation table, there was a box of bananas containing thirty-five (35) overly ripe bananas with several small flying insects in the box. The banana skins were split, leaving the inside of the bananas exposed and with white bio-growth. In the pantry, the scoop for the flour bin was found inside the bin. Two (2) containers of garlic seasonings had the lids open, leaving the seasoning exposed. There was also one (1) opened container of chicken-flavored base, one (1) opened 7-pound 8-ounce container of chocolate sauce, one (1) opened gallon of teriyaki sauce, and one (1) opened 22-ounce container of caramel-flavored sauce, each of which had a manufacturer's label that read refrigerate after opening. On [DATE] at 10:32 AM, in an interview, the Dietary Manager confirmed there was overly ripe produce, exposed foods, unlabeled foods, and the failure to refrigerate perishable items. The DM stated the produce did not look like this when she left on Friday and indicated the weekend cook should have checked for spoiled and expired foods. The DM mentioned she conducted daily checks to monitor for outdated foods. On [DATE] at 12:34 PM, during an interview, the Administrator was made aware of the findings observed in the kitchen. The Administrator stated she expected the kitchen staff to monitor food storage and labeling daily and promote food safety.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 48669 Based on observations, staff and resident interviews, record review, plan of correction review, and facility policy review, the facility failed to sustain an effective Quality Assurance and Performance Improvement (QAPI) committee as evidenced by one (1) re-cited deficiency originally cited in July 2023 on an annual recertification survey. Findings Include: A record review of the facility policy Quality Assurance and Performance Improvement (QAPI) Plan of Action dated 4/1/2021 revealed on page seven and page eight: Quality Assurance Program Tools: This facility's QAPI systems and processes are maintained within an ongoing program that is dynamically designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and resolve identified problems .Focus Indicators: the QAPI provides comprehensive oversight but maintains a priority focus which follows indicators that are high risk, problem-prone, and low volume with the potential for undesirable outcomes such as .IV. Restraint Management . F604: During this recertification survey, the facility failed to ensure a resident was free from physical restraints by not assessing for a least restrictive restraint for one (1) of one (1) sampled residents for restraints. During the recertification survey on 7/24/23, the facility failed to obtain a physician order for the use of a restraint for one (1) of three (3) residents reviewed for restraints. On 8/1/24 at 3:34 PM, during an interview with the Administrator, she revealed that staff had been in-serviced and they performed weekly audits as part of their correction for addressing hazards related to restraints. She also noted that they had a high-risk meeting coming up where the topic of restraints was to be discussed and any problems would have been identified during that meeting.