

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and facility policy review, the facility failed to maintain dining room furniture in a safe/clean/comfortable/homelike environment for two (2) of four (4) days of survey. Findings include:Record review of the facility policy review of the facility policy titled Safe and Homelike Environment, dated 7/2025, revealed, Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility . does not pose a safety risk Policy Explanation and Compliance Guidelines: 9.e. Report any furniture in disrepair to Maintenance promptly .During an observation on 7/20/2026 at 10:46 AM, two damaged chairs were on the left side of the main dining room near the front of the room. One chair had missing screws in the padded armrest component. The component moved freely back and forth, exposing rough metal hardware at the end of the chair arm. The second chair had no padded component on the left armrest. Rough metal hardware was exposed at the end of the chair arm.On 7/21/2026 at 9:55 AM, during an observation and interview observed a third chair on the right side of the main dining room near the front of the room. The chair had no padded component on the left armrest, leaving rough metal hardware exposed at the end of the chair arm. The Activity Director verified that the chair was missing the padded armrest component and that the exposed, rough metal could create a safety and injury hazard for residents. The Activity Director removed the chair from use and provided it to maintenance staff.During an interview on 7/22/2026 at 2:16 PM, the Maintenance Director stated that he and the Nursing Home Administrator (NHA) had planned to replace the dining room chairs, but replacement had not occurred. The Maintenance Director stated that he knew about the chair with the loose armrest component but did not know about the two chairs with missing armrest components. He confirmed that no maintenance ticket or log entry had been completed for the damaged chairs. The Maintenance Director further confirmed that exposed rough metal could create a safety hazard and that the loose armrest component could pinch a resident's arm.During an interview on 7/22/2026 at 2:45 PM, the NHA stated that the facility was in the process of obtaining new dining room chairs. The NHA confirmed that chairs with missing or damaged padded armrest components presented a potential safety hazard to residents.		

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record review, interviews, and facility policy review, the facility failed to complete the discharge Minimum Data Set (MDS) in accordance with the Center for Medicare and Medicaid Services (CMS) guidelines for one (1) of (22) sampled residents. Resident #104. Findings include: Record review of the facility policy, Minimum Data Set (MDS) assessment dated 05/2006, revealed, It is the policy of this facility to follow the Resident Assessment Instrument (RAI) process as set for by Centers for Medicare and Medicaid Services (CMS) protocol . On 7/23/26 at 10:27 AM, during an interview, MDS Nurse #1, explained that the discharge MDS was never initiated or completed, acknowledging that it should have been done. Furthermore, she pointed out that completing the discharge assessment is crucial to ensure that the resident's status is accurately reported to CMS. MDS Nurse #2, revealed that it was her responsibility to complete the discharge MDS for Resident #104 but failed to do so. She acknowledged that she should have initiated the assessment on March 13, 2026, the day after Resident #104 discharged . Furthermore, she stated it should have been submitted to CMS on March 18, 2026, to ensure timely submission. She pointed out that accurate and timely submission is needed to ensure correct information is reported to CMS. Review of the facility's, admission record revealed the facility admitted Resident #104 on 2/17/26 with diagnoses including Chronic Kidney Disease, Stage 4, Severe. Record review of the MDS with an Assessment Reference Date (ARD) of 10/21/22 revealed Resident #104 had a Brief Interview for Mental Status (BIMS) score of 11 indicating the resident had moderate cognitive impairment.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review, interview, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the resident's use of an indwelling suprapubic catheter and colostomy for one (1) of (22) sampled residents. Resident #22. Findings include:Record review of the facility's Minimum Data Set (MDS) Assessment policy dated 05/2006, revealed, It is the policy of this facility to follow the Resident Assessment Instrument (RAI) process as set for by Centers for Medicare and Medicaid Services (CMS) protocol .On 7/20/2026 at 1:56 PM, Resident #22 was observed in bed with a colostomy intact to the abdomen and a suprapubic catheter draining yellow urine into a catheter collection bag.During an interview on 7/21/2026, the Registered Nurse (RN)/ Minimum Data Set (MDS) nurse reviewed Resident #22's Quarterly MDS assessment with an Assessment Reference Date (ARD) of 4/15/2026. The MDS nurse stated, Oh, I forgot to put her suprapubic catheter and colostomy on there. The MDS nurse confirmed that the assessment did not accurately reflect Resident #22's status but would be corrected and resubmitted.A record review of Resident #22's Medication Review Report with active orders as of 7/21/26 revealed orders dated 3/6/26 for suprapubic catheter care and suprapubic catheter changes. An order was dated 1/27/26 indicated the resident had a colostomy.A record review of Resident #22's Quarterly MDS assessment, with an Assessment Reference Date (ARD) of 4/15/2026, revealed in Section H0100A the Appliance section was coded as none of the above indicating the resident did not have an indwelling catheter or ostomy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview record review and facility policy review, the facility failed to follow infection prevention practices during medication administration for one (1) of five (5) residents observed. Resident #103. Findings Include:Record review of the facility policy Infection Prevention and Control Program with a revision date of 5/26 revealed, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . During an observation on 7/22/26 at 8:01 AM, observed Licensed Practical Nurse (LPN) #2 administer medications to Resident# 103. During the observation, LPN#2 was observed placing medications and a box of Fluticasone 50 mcg and a box of Budesonide on the resident's bedside table without first disinfecting the surface or using a barrier. After administering the medications LPN #2 placed the two medication boxes containing the resident's nasal spray (Fluticasone) and Inhaler (Budesonide) in the cart, allowing the boxes to come in contact with other resident medications. During an interview at 8:07 AM on 7/22/26, LPN #2 confirmed she should have used a barrier or disinfected the table prior to placing the medications on the table. She noted that infection could possibly spread to other medications due to the possible contact of sputum or mucus from the resident's handling an inhaler and nasal spray which could spread respiratory infection to other residents.During an interview at 2:49 PM, on 7/22/26 with the Director of Nursing (DON) revealed the nurse should have used a barrier to prevent the medications from touching the bedside table and disinfected the bedside table prior to placing the medications on the table to avoid spreading infection to other residents when the medication containers touched other resident's medications in the medication cart.During an interview on 7/23/26 at 10:30 AM, the facility's Infection Preventionist (IP) confirmed that LPN #2 should have disinfected the table with a disinfectant wipe before placing items on the bedside table. She noted that the facility also has medication barriers that nurses can use to prevent cross contamination during administration. She also mentioned that during this instance, the nurse could have also disinfected the medication containers before placing them in the medication cart and failure to do any of these actions resulted in a greater risk to spread infection to other residents.Record review of Resident # 103's admission Record revealed the resident was admitted on [DATE] with diagnoses that included Other cerebral infarction due to occlusion or stenosis of small artery.Record review of Resident # 103's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.Record review of Resident #103's Order Summary Report with active orders as of 7/22/26 revealed an order dated 6/14/23 for Fluticasone Propionate nasal suspension and an order dated 6/27/26 for Budesonide-Formoterol Fumerate Inhalation Aerosol.A record review of the Medication Administration Record for July 2026 revealed Fluticasone nasal suspension and Budesonide were both given on 7/22/26 during the 8:00 AM medication observation.		