STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676326	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Rehabilitation and Care Center	1101 Windbell Dr Mesquite, TX 75149

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49415 Based on observation, interview and record review the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 had adequate supervision when she was placed on her side and was left unsupervised by CNA D, causing her to fall to the floor on 04/24/24. This deficit practice could place residents at risk for accidents and injury. The findings include: Record review of Resident #1's face sheet reflected a [AGE] year-old female with an admitted [DATE]. Resident #1 had diagnoses which included: Displaced Intertrochanteric Fracture of Left Femur (type of hip fracture), Neuropathy (disease/dysfunction of one or more peripheral nerves, causing numbness or weakness), Unilateral primary osteoarthritis, right and left hip (degeneration of joint cartilage and underlying bone, causes pain and stiffness), Anxiety disorder, Muscle Wasting and Atrophy (decrease in size of muscle tissue), Muscle Weakness, Unspecified Abnormalities of Gait and Mobility, Unspecified Lack of Coordination and Cognitive Communication Deficit. Record review of Resident #1's initial MDS, dated [DATE], reflected a BIMS score of 11, which indicated cognitively intact cognition. Record review of Resident #1's Care Plan, dated 4/15/24, reflected the resident has ADL deficits and requires assist .at risk for falling related to impaired ADLs, balance, and history of falls .difficulty making self-understood related to cognitive deficits. Record review of Resident #1's progress notes, dated 4/19/24, reflected Resident remains non weight bearing until 5/11. Record review of facility's incident report showed Resident #1 had an unwitnessed fall on 4/24/24 at 9:20 a. m. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes for 4/24/24 at 9:49 a.m. stated Today resident fell on floor. When CNA staff came to resident room she is on floor. Nurse came to resident room she is on floor, nurse asked her are u ok she said yes, Nurse asked about you head touch the she said no. No injury found during fall assessment her Vital BP 140/86,P84, R-18, O2 SAT. - 97%. Nurse informed DON 9:27 AM, Informed family by phone call on 9:33 am. Resident is fine. Observation on 4/25/24 at 10:59 a.m. revealed Resident #1 had a single sized bed. There were no bed rails on the bed and no fall mat on the floor. Observation of Resident #1's left arm revealed a 1/2 dollar sized round reddish bruise on the middle of her forearm. Interview on 4/25/24 at 10:59 a.m., Resident #1 stated on 4/24/24, a CNA was going to change her and had her up on her left side facing the window and was going to leave the room. She told the CNA not to leave her because she was going to fall, but the CNA said she would be right back. Resident #1 fell and was lying with her face down on the floor. Resident #1 said it hurt so bad and she was scared she may not make it. She said she got a bruise on her arm from the fall and her back was hurting worse than it normally did. Interview on 4/25/24 at 12:02 p.m. with RN A, she stated if she saw a staff member abusing/neglecting a resident, she would tell the DON and the Abuse Coordinator/Administrator. RN A stated fall risk residents had a band on their wrist. RN A stated she would make sure fall risk residents had their call lights in reach and would check on them more frequently. If a resident had fallen, she would do assessments of the resident. If the resident was alright, she would help them up with assistance and continue neuro checks. If the resident was not alright, she would not move them and 911 would be called. The DON, doctor and family would be notified of the fall. Interview on 4/25/24 at 1:54 p.m. with CNA B, she stated if she saw a staff member abusing or neglecting a resident, she would report it to the administrator. She stated they did abuse/neglect trainings almost every week. CNA B said fall risk residents would have a fall mat, bed at the lowest level, she would make sure the resident had the things they needed, and the call light was in reach. CNA B stated if she found a resident that had fallen, she would call out for a nurse and the nurse would complete assessments on the resident. Interview on 4/25/24 at 2:01 p.m., LVN C stated she had just come back to her office when CNA D came in asking her to check Resident #1's wound as the bandage was saturated. LVN C started getting her supplies together when CNA D came back and told her Resident #1 had fallen. LVN C went down to Resident #1's room and found the resident on the floor. She said the resident did not hit her head on the chair next to her bed but was holding onto it for dear life. LVN C said Resident #1 should always have 2 CNAs in the room during care from then on. Interview on 4/25/24 at 2:11 p.m., CNA D stated she changed Resident #1's brief, had her on her side and noticed the bandage on her back was saturated. CNA D went to get LVN C to look at resident #1's wound. CNA D said she did not just leave Resident #1 on her side but had her left leg over her body. CNA D said she only heard Resident #1 tell her to hurry up. CNA D said she went down the hall to get LVN C and when she started to come back, CNA B was at Resident #1's doorway saying she fell . CNA D ran back to LVN C's office and told her Resident #1 had fallen. CNA D said she was talked to by the DON, did trainings with the ADON and LVN C told them there needed to always be two people in resident #1's room from now on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/25/24 at 3:43 p.m., the DON stated her understanding of Resident #1's fall yesterday (4/24/24) was CNA D had either changed or given Resident #1 a bed bath and went to the door to ask someone to get LVN C when the resident rolled off the bed. The DON said the facility did an incident report and gave Resident #1 aid. Record review of the facility's Nursing Policies and Procedures underfor Fall Management, dated 5/5/23, revealed under Definitions: Assistive Devices refers to any item (e.g. fixtures such as handrails, grab bars, and mechanical devices/equipment such as stand-alone or overhead transfer lifts, canes, wheelchairs, and walkers, etc.) that is used by, or in the care of a resident to promote supplement, or enhance the resident's function and/or safety. Also, under Procedures: 5. Qualified staff evaluates patient/resident for injury from a fall, identify and treat for pain related to fall, and determine contributing causes, including ascertaining what the resident was trying to do before he or shell fell , addresses the risk factors for the fall such as the resident's medical conditions (s), facility environment issues, or a staffing issue; and determines interventions to prevent future falls and completes a Fall Investigation Worksheet. Record review of facility's Leadership Policies and Procedures, Section III: Organizational Ethics, Subject: Abuse, Neglect, Exploitation, or Mistreatment Abuse and Neglect Policy under Section III: Organizational Ethics undated, reflected, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Record review of the facility's Nursing Home Resident Rights, undated, revealed residents had the right to a Dignified Existence by be treated with consideration, respect and dignity, recognizing each resident's individuality. Freedom form abuse, neglect, exploitation and misappropriation of property. Quality of life is maintained or improved.