

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Edgewood Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of neglect for 1 (Resident #3) of 3 residents reviewed for neglect. The facility failed to conduct a thorough investigation when a family member of Resident #3 told staff that Resident #3 was found sitting in urine, feces and was dirty on 11/30/25. This failure could place residents at risk of skin breakdown. Findings included: Record review of Resident #3's face sheet, dated 12/10/25, reflected an [AGE] year-old female, who admitted to the facility on [DATE]. Resident #3 had diagnoses of Alzheimer's Disease (progressive brain disorder, the most common cause of dementia, characterized by gradual memory loss, thinking problems, and behavioral changes, stemming from brain cell death due to protein buildup (plaques and tangles)), encounter for attention to gastrostomy (medical visit for care of a feeding tube (G-tube)), and adult failure to thrive (syndrome of progressive global decline in physical and cognitive function). Record review of Resident #3's Nursing Home Comprehensive Item set MDS, dated [DATE], reflected Resident #3 did not conduct a brief interview for mental status as she was rarely/never understood. Resident #3's functional abilities implied she was dependent for eating, oral hygiene, toileting hygiene, shower/bathe/ upper/lower body dressing, putting on/taking off footwear and personal hygiene. Resident #3 bladder and bowel revealed Resident #3 was always incontinent. During an interview on 12/10/25 at 10:27 a.m., Resident #3's Resident Representative stated that a family member had went to the facility on [DATE] to visit Resident #3 and when the family member arrived, they found Resident #3 sitting soaked in urine, feces and bed was dirty. Resident #3's Resident Representative stated that the family member had to go get the nurse to ask who the aide was who was supposed to provide care to Resident #3, the nurse did not know where the aide was, but the nurse was able to get another aide to change Resident #3. Resident #3's Resident Representative stated he sent an email to the facility Administrator on 12/02/2025 and the Administrator told him he would report this allegation to the State, and they were going to handle it and they did. Resident #3's Resident Representative stated the Administrator moved Resident #3 to a different hall with permanent staff to provide better continuity of care as the previous hall used a lot of agency staff. Resident #3's Resident Representative stated he has been fine with the care for Resident #3 since the incident. During an interview on 12/10/25 at 11:37 a.m., the Administrator stated that he was informed by Resident #3's family member on 12/02/2025 via email of an allegation of neglect of Resident #3. The email stated that Resident #3 was found by a family member soaked in urine, feces and was dirty and that the family member requested Resident #3 be changed, but the nurse was unable to locate the aide that was assigned to the resident and that this was negligent. The Administrator stated that after he read the email his priority was to go check on Resident #3, had the clinical staff perform a skin assessment to ensure no skin breakdown. Then he reported the allegation to the State and started his investigation. Also, he contacted Resident #3's Resident Representative to inform him that his concerns were being investigated. The Administrator stated that he found that the staff that cared for Resident #3 on 11/30/2025 were agency staff. The Administrator stated he contacted the agency but never received a response. The Administrator stated he tried to contact CNA B who was responsible for Resident #3's care but was unsuccessful. He did instruct the DON to ensure CNA B did not return the facility. The Administrator stated he did not contact the nurse that was on shift or the aide that changed Resident #3. The Administrator acknowledged that to find out how Resident #3 presented the aide who changed her should have been contacted. The Administrator stated that he and the DON conducted the investigation, because he allowed the DON to deal with the clinical staff. Record review of an email from Resident #3 family member to the Administrator dated 12/02/2025 sent at 8:32am revealed on 11/30/2025 at 11:45 a.m. Resident #3's family member walked into Resident #3's room and Resident #3 was soaked with feces and urine, and sheets were dirty. Resident #3's family member informed RN A that Resident #3 needed to be changed and asked RN A who was the aide assigned to Resident #3 and RN A found the aide asleep in her car. The aide that day was agency, this was unacceptable and negligent. During an interview on 12/10/2025 at 3:03 p.m., the DON revealed that she learned about the allegation of neglect from the Administrator who received an email from Resident #3's Resident Representative on 12/02/2025 after morning meeting. The DON stated her role in the investigation was to assign staff to complete Resident #3's skin assessment, get the agency contact information to the Administrator, and to contact the RN A and the CNA B that worked that day to gather facts, but was unsuccessful in contacting RN A and CNA B. The DON stated that she also</p>		