STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676069	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor	4925 Elizabeth St Texarkana, TX 75503

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to ensure the right to be free from abuse was provided for 1 of 11 reviewed for abuse. (Resident #1) The facility failed to ensure Resident #1 was free from abuse when CNA A raised her voice and cussed at her on the morning of 04/02/24 . This failure could place residents at risk for abuse and psychosocial harm. Findings included : Record review of a face sheet dated 04/08/24 revealed Resident #1 was [AGE] years old and was admitted on [DATE] with diagnoses including alcohol induced dementia (dementia caused by long term use of alcohol), personal history of traumatic brain injury, and seizures. Record review of the MDS dated [DATE] revealed Resident #1 was usually understood and usually understood others. The MDS revealed a BIMS score of 8, indicating moderate cognitive impairment. The MDS indicated Resident #1 required supervision to moderate assistance with ADLs . The MDS did not indicate any behaviors. Record review of a care plan last edited 04/04/24 revealed Resident #1 had periods of forgetfulness, sometimes needed things repeated due to her brain injury, and had difficulty following a conversation well, due to her cognition and poor memory. The care plan indicated Resident #1 did not answer open ended questions well due to paranoia. Record review of a handwritten note dated 04/02/24 at 7:18 a.m. indicated, I witnessed (Resident #1) being yelled at by CNA (CNA A). She was so loud and mean. She was passing out breakfast trays saying (Resident #1) sit down that ain't your shit. (Resident #1) stop that. I heard (CNA A) screaming. I was going into the bathroom on the 200 hall. (CNA A) was loud and very ugly. I didn't have (the Administrator's) number or (the DON's) to call. The nurses was in lunch room with others giving breakfast. (CNA A) was very mean. I am glad I was not state. Thanks. There was no signature or any indication of who the author of the note was. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a handwritten statement dated 04/2/24 indicated, While serving breakfast (Resident #1) would not sit down. I asked her to sit down but because she's hard of hearing she didn't hear me. I had to talk loud in order for her to hear me. I never cursed or ugly toward her. The statement was signed by CNA A. Record review of a handwritten statement dated 04/11/24 indicated, On 4-2-2024 @ 7:00 am I witness a CNA on Unit 2 yelling & cursing a resident. CNA was yelling Put that shit down, that's not your shit. I don't know why you have to do all that. Go sit down. I was able to hear the CNA outside the unit. I did not report this to the abuse coordinator as I should have. I did let HR know about the incident. The statement was signed by the Activity Director. Record review of a facility form dated 04/03/2024 indicated CNA A received Customer Service education. The form indicated, Use customer service when talking to residents. No loud voices used inside facility. Always be compassionate and kind. The education was conducted by the Administrator. Record review of an Abuse and Neglect in-service dated 01/04/24 indicated, CNA A and the Activity Director were in-serviced on the Abuse and Neglect policy. During an observation and interview on 04/08/24 at 1:07 p.m., CNA A was working on the 200 Unit. She said she was working on both memory care units. CNA A said she had never cussed at any resident. She said her voice was loud and it carried but she would never talk ugly to a resident. She said she did not know of an incident that could have caused someone to say that she yelled or cussed at Resident #1. She said she did not know who could have said that about her. She said she was very upset about it. She said she had been suspended during the investigation. She said that was the first time she had ever been reported to Administration . During an interview on 04/09/24 at 8:09 a.m., Housekeeper B said someone slipped a note under the Administrator's door saying that CNA A had raised her voice and cussed at Resident #1. She said the Administrator went around to all staff to ask who wrote the note. Housekeeper B said CNA A's voice was loud and did carry. She said she had never heard CNA A cuss or be ugly to any resident. She said CNAs did talk rough to residents. During an interview on 04/09/24 at 8:59 a.m., the Activity Director said she was walking outside of the 200 Memory Care Unit on the morning of 04/02/24. She said it was early morning when she was coming in to work. She said she heard yelling and thought what is going on?. She said she heard CNA A yelling and cursing. Saying, [NAME], this not your shit, I don't know why you always do this. Go sit down. Put it back. She said the yelling was repetitive. She said Resident #1 did not know any better and would not have been unable to say what happened. She said she could hear the CNA through the closed door. She said she was not the staff member that wrote the note that was slipped under the Administrator's door and did not know who did. She said she had never seen or heard the CNA say or do anything like that before. She said staff could use some training on how they talk to people. During an interview on 04/09/24 at 9:10 a.m., Resident #1 denied abuse by staff. She denied that CNA A had yelled or cussed at her. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/24 at 1:25 p.m., the DON said if an incident happened Resident #1 would not be able to tell them what happened. She said if they questioned her she would say what she thought they wanted her to say. She said if anyone asked Resident #1 about CNA A yelling and cussing at her she would just say what she thought they would want her to say. She said Resident #1 denied any abuse to her. She said she did not know who wrote the note on 04/02/24. She said the Administrator was the one that conducted the investigation. She said she would consider the allegations made in the note and by the Activity Director to be abuse . The DON said she would have expected the Activity Director have reported the incident immediately to herself or the Administrator. During an interview on 04/09/24 at 2:03 p.m., the Administrator said she was off on 04/02/24 and found the note in her office when she returned to work on 04/03/24. She said had not determined who wrote the note. She said the Activity Director denied writing the note. She said during the process of investigating who wrote the note the Activity Director told her she had heard CNA A yelling at Resident #1. She said the Activity Director at first denied knowing anything but did finally admit she heard the incident She said she would expect staff to report allegations of abuse to her. She said if she was not available she would expect allegations of abuse to be reported to the charge nurse or DON Review of an undated Abuse facility policy indicated, .Our residents have the right to be free from abuse . This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse .Verbal abuse includes .gestured language including but not limited to, disparaging or derogatory terms directed to or with the patient's/resident's hearing distance, cursing or using obscene language when speaking to or within hearing range of a resident .Examples of verbal abuse include the following .Yelling or cursing at a resident .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment are reported immediately or not later than 2 hours for 1 of 11 residents reviewed for abuse and neglect. (Resident #1) The Activity Director and Business Office Manager failed to report the allegation that CNA A verbally abused Resident #1 to the Administrator immediately or within 2 hours of witnessing the abuse. This failure could place residents at risk for further abuse and neglect. Findings included: Record review of a face sheet dated 04/08/24 revealed Resident #1 was [AGE] years old and was admitted on [DATE] with diagnoses including alcohol induced dementia (dementia caused by long term use of alcohol), personal history of traumatic brain injury, and seizures. Record review of the MDS dated [DATE] revealed Resident #1 was usually understood and usually understood others. The MDS revealed a BIMS score of 8, indicating moderate cognitive impairment. The MDS indicated Resident #1 required supervision to moderate assistance with ADLs. Record review of a care plan last edited 04/04/24 revealed Resident #1 had periods of forgetfulness, sometimes needed things repeated due to her brain injury, and had difficulty following a conversation well, due to her cognition and poor memory. The care plan indicated Resident #1 did not answer open ended questions well due to paranoia. Record review of a handwritten note dated 04/02/24 at 7:18 a.m. indicated, I witnessed (Resident #1) being yelled at by CNA (CNA A). She was so loud and mean. She was passing out breakfast trays saying (Resident #1) sit down that ain't your shit. (Resident #1) stop that. I heard (CNA A) screaming. I was going into the bathroom on the 200 hall. (CNA A) was loud and very ugly. I didn't have (the Administrator's) number or (the DON's) to call. The nurses was in lunch room with others giving breakfast. (CNA A) was very mean. I am glad I was not state. Thanks. There was no signature or any indication of who the author of the note was. Record review of a handwritten statement dated 04/2/24 indicated, While serving breakfast (Resident #1) would not sit down. I asked her to sit down but because she's hard of hearing she didn't hear me. I had to talk loud in order for her to hear me. I never cursed or ugly toward her. The statement was signed by CNA A. Record review of a facility form dated 04/03/2024 indicated CNA A received Customer Service education. The form indicated, Use customer service when talking to residents. No loud voices used inside facility. Always be compassionate and kind. The education was conducted by the Administrator. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Abuse Statement inside the Activity Director's personnel file indicated, .A facility owner or employee who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person must report the abuse, neglect, or exploitation .By signing below, I acknowledge understanding of the Abuse Statement . The statement was signed by the Activity Director on 07/24/23. Record review of an Abuse and Neglect in-service dated 01/04/24 indicated, CNA A and the Activity Director were in-serviced on the Abuse and Neglect policy. Record review of a facility form indicated the Activity Director received education titled Non Reporting. The form indicated the date as 4 - . The form indicated, It is your responsibility to notify the Abuse Coordinator immediately after suspected abuse. Non reporting is serious and will result in further disciplinary action. The form did not indicate who conducted the education. Record review of an Associate Memorandum dated 04/08/24 indicated the Activity Director received a written warning. The memorandum indicated, .State Subject of code of conduct rule violated .non reporting abuse allegation . The memorandum was signed by the Activity Director and the Administrator. Record review of a handwritten statement dated 04/11/24 indicated, On 4-2-2024 @ 7:00 am I witness a CNA on Unit 2 yelling & cursing a resident. CNA was yelling Put that shit down, that's not your shit. I don't know why you have to do all that. Go sit down. I was able to hear the CNA outside the unit. I did not report this to the abuse coordinator as I should have. I did let HR know about the incident. The statement was signed by the Activity Director. During an interview on 04/09/24 at 8:59 a.m., the Activity Director said she was walking outside of the 200 Unit on the morning of 04/02/24. She said it was early morning when she was coming in to work. She said she heard yelling and thought what is going on?. She said she heard CNA A yelling and cursing. Saying, this not your shit, I don't know why you always do this. Go sit down. Put it back. She said the yelling was repetitive. She said Resident #1 did not know any better and would not have been unable to say what happened. She said she could hear the CNA through the closed door. She said she was not the staff member that wrote the note that was slipped under the Administrator's door and does not know who did. She said she had never seen or heard the CNA say or do anything like that before. She said staff could use some training on how they talk to people. She said she did not report the incident to anyone until after lunch 04/02/24. She said at that time she reported the incident to the Business Office Manager. She said she did not report the incident to the Administrator because she was not at work that day . She said she was written up for not reporting it immediately to the Administrator and she fully understood why she was written up. She said any abuse should have been reported to the Administrator as soon as possible but for sure within 2 hours. During an interview on 04/09/24 at 9:24 a.m., the Business Office Manager said she did not witness the incident on 04/02/24. She said the Activity Director did report it to her. She said the Activity Director told her that she heard CNA A yelling at Resident #1. She said she told her she was outside of the double doors on the 200 Hall. The Business Office Manager said she did not report what the Activity Director told her to the Administrator because she thought the Activity Director was going to . She said the Administrator came to her on 04/03/24 and asked her about the note and her conversation with the Activity Director. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/09/24 at 10:00 a.m., there was a sign hanging on the bulletin board by the time clock that reflected, (the Administrator) is the Abuse/Neglect Coordinator . Any abuse allegations should be reported immediately. The Administrator's telephone number was on the sign behind her name. There was a sign hanging at the nurse's station with the same information. During an interview on 04/09/24 at 1:25 p.m., the DON said she would have expected the Activity Director have reported the incident immediately to herself or the Administrator. She said, our numbers are posted. There was no excuse for herself or the Administrator to have not been notified. She said allegations of abuse not being reported in a timely manner could cause a resident to not receive the care they need or continue to be abused. During an interview on 04/09/24 at 2:03 p.m., the Administrator said she was off on 04/02/24 and found the note in her office when she returned to work on 04/03/24. She said she first became aware of the incident when she found the note. She said during the process of investigating who wrote the note she discovered the Activity Director had witnessed CNA A yelling at Resident #1. She said she would expect staff to report allegations of abuse to her. She said if she was not available she would expect allegations of abuse to be reported to the charge nurse or DON. She said she would have expected the Activity Director to have reported it to her within two hours. She said someone not reporting abuse left the resident in harm's way. She stated, It makes a bad situation for the resident. Review of an undated Abuse facility policy indicated, .Reporting/Responding Component: Abuse Policy Requirement: It is the policy of the facility to respond to all abuse, neglect, misappropriation of property of resident, and mistreatment of residents immediately. Care and attention will be given utmost priority to the resident involved int the incident .A certified NF must ensure that all alleged violations of abuse are reported to the NF administrator and to other officials in accordance with Texas law no later than two hours after the allegation is made .