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	05/15/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observations, interviews and record review, the facility failed to ensure resident rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 19 residents (Resident #201) reviewed for resident rights. The facility failed to ensure Resident #201 had a functioning call light. This failure could place residents at risk of injury that could lead to possible falls, major injuries, hospitalization , and unmet needs. Findings include: 1. Record review of an undated face sheet indicated Resident #201 was an [AGE] year-old female admitted on [DATE] with diagnoses of Hypokalemia (a lower-than-normal potassium level in your bloodstream), Impacted Cerumen (When too much earwax builds up it can cause symptoms such as temporary hearing loss), Hypertension (when the pressure in your blood vessels is too high). Record review of the Admission MDS assessment dated [DATE] indicated Resident #201 was understood and understood by others. The MDS revealed Resident #201's BIMs (Brief Interview for Mental Status) score was a 15 indicating intact cognition. The MDS indicated Resident #201 required supervision with bed mobility, transfers, walking, dressing, eating, toileting, personal hygiene, and bathing. Record review of a care plan dated 4/12/24 revealed Resident #201 will be provided a call light for assistance. Revealed a problem initiated on 4/17/24 that Resident #201 was incontinent of bowel and bladder and required assistance with incontinent care. During an interview and observation on 5/13/24 at 9:17 a.m., Resident #201 said her call light did not work. She said she did not have a bell to ring to notify staff she needed help. She said she could not call for help because the push button didn't work, and she did not have a bell to ring. She said if she needed help, she would have to wait for someone to come into her room. She said staff would come into her room throughout the day. Surveyor pushed Resident #201's call light button. Surveyor went outside Resident #201's room and looked for the light above her door. The light did not turn on indicating that the call light system was malfunctioning. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 5/14/24 at 8:31 a.m. Resident #201 said her call light was fixed yesterday afternoon after surveyors left. She said the call light system was working . She said she wasn't sure exactly how long her call light had not been working but she knew it had been at least a week. She said sometime last week she was pushing her button, and she was looking for help from staff because she had to pee. She said no one came until later and she asked about her button. The staff that came later that night said her call light didn't work. She said that this was the first time she knew that her call light didn't work. She said she cannot recall dates of when this occurred. She said that staff also brought in a bell last night for her to ring but the call light was fixed so she never got to use it. It was observed that Resident #201's call light was functioning. During an interview on 5/14/24 at 1:11 p.m. with the Maintenance Supervisor said they just had a problem last Thursday, 5/9/24, with the call light system malfunctioning. He said he had reached out to the company that services the call light system last week. He said they have not been out to the facility yet. He said they would get someone out to the facility today but they said they were short staffed so it could be later in the day. He said they were supposed to come out yesterday but didn't make it out here. He said it was beyond his control to fix the system as there was an issue with the wiring. He said the call lights in 300 hall was non-working. He said however that a few of the rooms were back working as he replaced a fuse on the breaker box today. During an interview on 5/14/24 at 1:20 p.m., with the Administrator said the issue with the call lights started late last week. She said all of 300 hall was down. She said they had issued bells to residents so they could ring and indicate they needed assistance. She said all of the rooms with a non-working call light system should have had bells. She said she did not know why Resident #201 was lacking a bell. She said residents can be placed at risk for not being able to ask for help if they were unable to indicate they needed staff assistance. During an interview on 5/14/24 at 9:14 a.m. with the DON she said she was aware that the facility call light system was having intermittent problems. She said that she was not aware that Resident #201's call light system was non-working. She said she made a trip to a local retail store and bought bells to place in resident's rooms. She said she would have placed a bell in Resident #201's room had she known it was not working. Record review of an undated facility policy titled Call light system indicated Policy: The facility shall maintain a functioning call light system for residents . Procedure: Any failure of the call light system should be reported to maintenance and the administrator, who will triage the issue and determine, based on the situation, what best course of action is needed to repair the system and ensure residents have the ability to call for help until the issue is repaired.