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	02/25/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46062 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 memory care units reviewed for adequate supervision to prevent accidents. The facility failed to ensure the Residents in the Unit 1 Memory Care were supervised while CNA A left the memory care unit on a bathroom break on 2/24/25 for at least six minutes observed by state surveyor. This failure could place residents at an increased risk for injury. Findings included: 1. Record review of Resident #1's face sheet dated 2/25/25 revealed she was [AGE] years old and admitted to the facility initially on 7/16/15 and readmitted [DATE]. Resident #1 had diagnoses including cerebrovascular disease (affecting blood flow to the brain and causes brain damage), muscle weakness, lack of coordination, Parkinson's disease (nerve cell damage of central nervous system that affects movement), History of right arm fracture, abnormalities of gait and mobility, need for assistance with personal care, mood disorder, and agnosia (loss of ability to identify objects or people). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was sometimes understood and rarely/never understood others . Resident #1 was unable to complete the BIMS because she was rarely/never understood. The MDS indicated Resident #1 had inattention and disorganized thinking continuously. Resident #1 had a history of falls. Record review of Resident #1's undated Care Plan Report indicated she had cognitive loss/dementia (thinking and social thinking symptoms that interfere with daily functioning) due to a prior CVA (stroke), she had short attention span and had no personal boundaries when it came to other residents and staff; she had behavioral symptoms and had the potential to act inappropriately at times due to Pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder, however, she did not require medication, and she chews on her shirts; she was at risk for falls due to impaired physical function, medication use, impaired cognition and Parkinson's disease with an intervention to increase staff supervision with intensity based on resident need; and she was an elopement risk due to wandering with no meaningful purpose, impaired cognition so she would reside on the secure unit. (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: 676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Edgewood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #2's face sheet dated 2/25/25 revealed she was [AGE] years old and admitted to the facility initially on 8/19/22 and readmitted [DATE]. Resident #2 had diagnoses including senile degeneration of brain (age related decline in cognitive abilities), abnormalities of gait and mobility, lack of coordination, dizziness, dementia, and bipolar disorder (associated with episodes of mood swings ranging from persistent sadness to extreme excitement). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she was understood and usually understood others. Resident #2 had a BIMS score of 5, which indicated she had severe cognitive impairment. The MDS indicated Resident #2 had physical behavioral symptoms directed toward others one to three days. Resident #2 had a history of falls. Record review of Resident #2's undated Care Plan Report indicated she had behavioral symptoms with a diagnosis of bipolar disorder and had socially inappropriately/disruptive behavioral symptoms as evidenced by Resident #2 was witnessed slapping another resident on the unit, she could be combative when asked to do ADLs and she would hit staff and head butt at times; Resident #2 was at risk for falling related to unsteady gait, use of walker, medication use, history of falls, and impaired cognition with an intervention to provide supervision with walking on the secured unit; Resident #2 had a self-care deficit related to dementia and could become combative with staff at times, she would pack her belongings onto her rollator and wander the unit at times; Resident #2 had a potential for elopement and remained on the secured unit and wandered the halls and had to be redirected. Record review of Resident #2's Fall Risk assessment dated [DATE] indicated she scored a 23; a score of 10 or higher represented a high risk for falls. 3. Record review of Resident #3's face sheet dated 2/24/25 revealed she was [AGE] years old and admitted to the facility initially on 4/30/24 and readmitted [DATE]. Resident #3 had diagnoses including lung cancer, brain cancer, abnormalities of gait and mobility, muscle weakness, age-related physical debility, and repeated falls. Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was sometimes understood and sometimes understood others. She had a BIMS score of 12, which indicated she had moderate cognitive impairment. The MDS indicated Resident #3 had history of falls. Record review of Resident #3's undated Care Plan Report indicated she had the potential for elopement, and she had a history of self-propelling out the front door after a visitor and staff brought her back in immediately and she now resided on the memory care unit; she had impaired decision making and poor safety awareness related to memory loss and brain cancer; she had had a history and was at risk for falls due to medications and decline in physical function and impaired cognition due metastatic brain cancer with interventions including anticipate needs and respond promptly to request and increased staff supervision with intensity based on resident's need. (continued on next page)

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/24/25 beginning at 2:38 PM, state surveyor entered the Unit 1 memory care unit. Resident #1 was ambulating in the hallway, and she came immediately to the state surveyor upon entering the unit. Resident #1 had what appeared to be blood around one tooth on her top left side of her mouth and lip. Resident #1 had non-understandable mumbling. There were four residents sitting in the dining room to the right of the Unit 1 entrance door. As state surveyor walked down the hallway, Resident #2 was in the living room on the left side of the hallway, standing in front of the water dispenser and putting water onto a white folded cloth item. Resident #3 self-propelled herself from the dining room into the hallway and would hold her right leg up away from the wheelchair. State surveyor walked down the left side of the hallway knocking on closed doors and looking in the rooms for a staff member to the end of the hall and then walked back down hallway on the right side, knocking on closed doors and looking into rooms for a staff member. There was no staff member present in the Unit 1 memory care unit. There were several residents lying in their beds. At 2:44 PM, CNA A entered the Unit 1 memory care unit door and immediately saw Resident #1's mouth and asked her what did you do to your mouth. CNA A then went to get gloves to look in Resident #1's mouth and saw Resident #2 putting water on cloth items and told Resident #2 to not do that. CNA A asked Resident #2 if she wanted a cup and got a cup to put water in and Resident #2 drank the water. CNA A then went to the unit door entrance and called the nurse to come look at Resident #1's mouth. LVN B came in and assessed Resident #1 assisted by CNA A. LVN B held Resident #1's upper lip up and dabbed area with a gauze pad, there were no cuts to her inner lip, the small amount of blood appeared to be coming from the gum line around the one tooth. During an interview on 2/24/25 at 3:00 PM, CNA A said she had just left the unit and ran to the bathroom. CNA A said she told the nurse that she was going to the bathroom, and it was up to the nurse if she was going to come into the unit to supervise the residents. CNA A said she had put Resident #1 into a clean gown and put her in bed just prior to going to the bathroom and her mouth was not like that before she left. CNA A said Resident #1 was up and down and wandered frequently. CNA A said Resident #2 was aggressive to other residents sometimes and was always into something and pointed at Resident #2 going through all the stuff in the living room. CNA A said Resident #3 was a high fall risk. CNA A said it was a big risk to leave the residents in the memory care unit without supervision because of their dementia and some could be aggressive toward other residents. CNA A said residents were left without supervision all the time when she had to take her lunch break (30 minutes) on the 2-10 shift because there was only one aide on each memory care unit. CNA A said she told the nurse when she was going to lunch and the nurse would tell her okay. CNA A said it was then up to the nurse to decide if anyone was going to supervise the residents in the memory unit. CNA A said sometimes the medication aide would come back to the unit to supposedly give her a lunch break, but it was usually when she was passing meal trays and she could not take a break while residents were eating. During an interview on 2/25/25 at 11:19 AM, CNA C said there was normally two staff members on day shift in the memory care units. CNA C said the residents were never left alone because they have two staff on the day shift. CNA C said the residents had to be supervised so residents did not fall or have an altercation. CNA C said if no one was watching the residents on the memory care unit, anything could happen. CNA C said they have had trainings related to not leaving residents alone on the memory care unit. CNA C said the charge nurse would be responsible for ensuring the residents in the unit were not left unsupervised. CNA C said all staff were responsible for ensuring the safety of the residents on the memory care units. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Edgewood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/24/25 at 4:23 PM, LVN D said there was normally one aide on each memory care unit at night. LVN D said when the aide needed to go to the bathroom or take a lunch break, the nurse or another aide normally would go back there (memory care unit). LVN D there had been times the residents on the memory care unit would be left unattended for approximately 5-10 minutes. LVN D said there was a risk that something could happen if there was no staff supervising the residents in the memory care units. LVN D said all the residents in the memory care unit were high risk for falls, and there were residents in the memory care units that were aggressive toward other residents at times. LVN D said the charge nurse would be responsible for ensuring the residents were supervised at all times on the memory care unit. LVN D said she thought they should have two aides at night instead of tying up the nurse because the nurse had a lot to do. During an interview on 2/25/25 at 2:05 PM, RN F said she normally worked the 6 AM to 2 PM shift. RN F said they usually had two staff on each hall, but now they have two staff members on Unit 1 memory care and one staff member on Unit 2 memory care on the 6 AM to 2 PM. RN F said they kept someone back there (memory care units) at all times. RN F said residents on the memory units should not ever be left unsupervised. RN F said they could not leave the residents on the memory care units unsupervised because there was no telling what they would do. RN F said the nurse would be responsible for ensuring the residents on the memory care units were supervised at all times. RN F said the residents on the memory care units could get into stuff, could fall, one resident could injure another if they were left unsupervised. During an interview on 2/25/25 at 2:51 PM, LVN B said she had worked at the facility for two months and normally on 2 PM to 10 PM shift. LVN B said she normally had Unit 1 and 2 memory care units and the left side of hall 3. LVN B said Resident #1 was bleeding and she could not really tell if there was bleeding around her tooth or her lip initially, but when she pulled her lip up there were no cuts or scrapes. LVN B said she thought maybe her gums were bleeding. LVN B said once she wiped the blood off with the gauze, there was not any cuts or anything. LVN B said there was one aide on each memory care unit on the 2 PM to 10 PM shift since she had been working there. LVN B said the aide had to go to lunch between 6 PM to 630 PM when either the medication aide or the nurse was in the memory care units. LVN B said sometimes the aides would tell her they were going to the bathroom, but she really did not really hear anything from the aides if they needed to go to the bathroom. LVN B said the aides would notify her if they needed to leave the unit. LVN B said if the aide notified her that they needed to leave the unit, it was usually something quick and they were in and out, but she would go to the unit to supervise the residents. LVN B said she did not know CNA A had left the unit yesterday (2/24/25) and the aide didn't tell her she had left the unit. LVN B said she saw state surveyor through the door window of the unit walking down the hallway on 2/24/25 and then she saw CNA A come out of the bathroom. LVN B said she did not know how long she had been in the bathroom. LVN B said the residents on the memory care unit should never been left unsupervised. LVN B said the residents could fall, hurt themselves, get into a fight or become combative with each other. LVN B the resident could get hurt if not supervised at all times. LVN B said the charge nurse was responsible for ensuring the memory care unit was supervised at all times. LVN B said all staff were responsible for ensuring the residents on the memory care unit were safe, but as the charge nurse, she was responsible. LVN B said residents had not been left unsupervised to her knowledge prior to yesterday (2/24/25). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Edgewood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25 at 3:24 PM, the ADON, who had been the DON until 2/1/25, said the memory care unit should never been left unsupervised. The ADON said they had two staff members on Unit 1 memory care unit and one staff member on Unit 2 memory care unit on 6 AM to 2 PM shift. The ADON said all other shifts had one staff member on each memory care unit and the nurse or medication aide go back there (memory care unit) to supervise while staff took their breaks. The ADON said most of the residents on the memory care units were wanderers and they could get hurt, and no one would know it until they came back if they were left unsupervised. The ADON said the aides should be letting the nurse or herself know that they need to leave the unit and the aide should not leave the unit until someone was available to come back to supervise the residents on the memory care unit. The ADON said there should never be any risk to the residents. During an interview on 2/25/24 at 3:53 PM, the ADM said the aides should be waiting until someone could come to relieve them for breaks as per their protocol. The ADM said the residents in the memory care unit should never be left unattended or unsupervised. The ADM said the nursing staff that did the scheduling, and the charge nurse was responsible to ensure the residents were supervised. The ADM said the residents could have an injury that was not witnessed, could impact them physically or mentally, or cause more harm or injuries without them being supervised. During an interview on 2/25/25 at 4:10 PM, the DON said she took over as the DON as of 2/1/25. The DON said Resident #1 bit and chewed on her clothes, but due to there was no staff supervising the residents, they would not be able to determine what caused the bleeding around Resident #1's tooth. The DON said residents on the memory care unit should not be left unsupervised. The DON said they have poor safety awareness, have behaviors, most need maximal assistance, and that was why they were back there (memory care unit) to be constantly supervised. The DON said they could hurt themselves, get into something they were not supposed to, wander into another room, fall, and the list just goes on and anything could happen. The DON said the charge nurse was responsible for ensuring the residents were supervised on the memory care units. The DON said the aide should not have left the memory care unit until someone came to relieve her. The DON said everyone was responsible for ensuring the safety of the residents on the memory care units. The DON said the memory care residents should never be left unattended or unsupervised. Record review of the facility's policy titled Safety and Supervision of Residents, dated revised on 6/2020 indicated . Our facility strives to make the environment as free from accident hazards as possible . Resident safety and supervision and assistance to prevent accidents were facility-wide priorities . employees shall be trained and in-serviced on potential accident hazards and how to identify and report accident hazards and try to prevent avoidable accidents . Our resident-oriented approach to safety addresses safety and accident hazards for individual residents . implementing interventions to reduce accident risks and hazards shall include the following . a. communicating specific interventions to all relevant staff . b. assigning responsibility for carrying out interventions . c. providing training, as necessary . Resident supervision was a core component of the systems approach to safety . the type and frequency of resident supervision was determined by the individual resident's assessed needs and identified hazards in the environment .