

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  05/15/2024
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</b></p> <p>Based on observation, interviews, and record review, the facility failed to ensure residents reviewed received reasonable accommodation of needs for 1 of 19 residents (Resident #42) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #42 had a call light within reach.</p> <p>This failure could place residents at risk of injury that could lead to possible falls, major injuries, hospitalization , and unmet needs.</p> <p>Findings include:</p> <p>Record review of an undated face sheet indicated Resident #42 was an [AGE] year-old male admitted on [DATE] with diagnoses of Pressure Ulcer of Sacral Region (A sacral wound is a pressure ulcer that appears in the sacral region of the body), Protein-Calorie Malnutrition (occurs when a child doesn't eat enough protein and energy measured by calorie) to meet nutritional needs), Urinary Tract Infection (An illness in any part of the urinary tract, the system of organs that makes urine).</p> <p>Record review of the annual MDS dated [DATE] indicated Resident #42 was understood and understood others. The MDS revealed Resident #42's BIMS (Brief Interview for Mental Status) score was a 15 indicating intact cognition. The MDS indicated Resident #42 was dependent for most of his ADLs except eating.</p> <p>Record review of a care plan dated 10/13/2023 revealed Resident #42 was dependent for all of his ADLs except eating. Revealed a problem area initiated 12/14/2022 shows that Resident #42 was provided a touch system call device.</p> <p>During an interview and observation on 5/13/24 at 9:30 a.m., Resident #42 was observed lying in bed with a touch pad call device laying on the floor next to his bed which was in the high position. Resident #42 was asked if his call light worked, and he responded no it did not. Surveyor tested call light by pushing the touch pad. Surveyor observed the light on above the door outside Resident #42's room. Surveyor spoke to Resident #42 and said that his light was working. Resident #42 said he did not know it was working as it was broken and no one told him it was Then working. He said he could not reach his touch pad on the floor as he could not get out of bed on his own and the bed is way too high to reach the floor.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/14/24 at 9:14 a.m. with the DON, she said she would ensure that staff knew to clip Resident #42's push button to his pillow and Resident #42 knew his call device was working.</p> <p>During an interview on 5/14/24 at 1:20 p.m., with the Administrator said residents could be placed at risk for not being able to ask for help if they were unable to indicate they needed staff assistance.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44128</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 5 Halls reviewed for environment. (200 Hall Memory Care Unit)</p> <p>The facility failed to silence a loud, continuous alarm from a malfunctioning call light system on the 200 Hall Memory Care Unit.</p> <p>This failure placed residents at risk of an uncomfortable environment and a decrease in quality of life and self-worth.</p> <p>Findings included:</p> <p>During an observation on 05/13/24 at 9:46 a.m., there were 5 residents present in dining room on 200 Hall Memory Care Unit. There was a very loud, continuous alarm sounding.</p> <p>During an observation on 05/13/24 at 12:39 p.m., lunch was being served to residents on the 200 Hall Memory Care Unit. There was a very loud, continuous alarm sounding.</p> <p>During an observation on 05/13/24 at 2:52 p.m., residents were present on the 200 Hall Memory Care Unit. There was a very loud, continuous alarm sounding.</p> <p>During an observation on 05/14/24 at 7:00 a.m., there was a very loud, continuous alarm sounding on the 200 Hall Memory Care Unit. During an observation of a medication administration with RE D, the alarm was loud and made it difficult to hear the nurse while reviewing the medications with her.</p> <p>During an observation and interview on 05/14/24 at 8:17 a.m., there was a very loud, continuous alarm sounding on the 200 Hall Memory Care Unit. RN D said she did not know how long the call light had been alarming on the 200 Hall Memory Care Unit. She said at least since the morning of 5/13/24. She said she did not know why it was not working. She said it was coming from room [ROOM NUMBER] and they could not turn it off. She said maintenance was aware.</p> <p>During an interview on 05/14/24 at 8:23 a.m., the ADON said there was something wrong with the wiring of the call light system. She said the alarm on the 200 Hall Memory Care unit began alarming some time on 05/12/24. She said the company was supposed to come on 5/13/24 but called to say they could not make it.</p> <p>During an interview on 05/14/24 at 8:33 a.m., the Maintenance Supervisor said the call light system was having a wiring issue. He said room [ROOM NUMBER] had been alarming since 5/10/24. He said the sound could be disabled if the fuse was removed, but taking the fuse out disabled the entire system. He said he talked to the fire equipment company on Thursday, 5/9/24 because he had already began having problems with the system. He said the company had said they would be at the facility on Monday, 5/13/24 for repairs and they did not show up. He said they were expected by noon on 5/14/24.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/14/24 at 3:00 p.m., the DON said the call light was not alarming over the weekend of 5/11/24 and 5/12/24. She said they began having problems with the call light the previous week and had been trying to get the company to come out. She said she did not know why maintenance had not silenced the continuous alarm sounding on the 200 Memory Care Unit on 5/13/24. She said she had just been worried about getting the company out to fix the alarm. She said they were supposed to be at the facility on 5/13/24. She said bells had been provided to all residents that had non-functioning call lights.</p> <p>During an interview on 05/14/24 at 3:43 p.m., the Administrator said she agreed that the continuous call light alarming on the 200 Hall Memory Care Unit on 5/13/24 and the morning of 05/14/24 was loud. She said if it were in her home, it would drive her crazy. She said the Maintenance Supervisor did not know what to do. She said it could have been fixed on 5/13/24 if he had known how to correct the problem. She said he left the alarm on, so it did not cause any other issues. She said they had been trying to get the company out to fix the call lights since Friday, 05/10/24.</p> <p>During an interview on 05/15/24 at 9:18 a.m., RN D said she had passed medications on the 200 Hall Memory Care Unit on 5/13/24 and 5/14/24. She said she did hear the continuous, loud alarm and she said it was very annoying.</p> <p>Record review of a Maintenance Request Log dated 04/01/24 - 05/13/24 did not indicate any request for call light alarm repair.</p> <p>Record review of Resident Roster dated 05/13/24 indicated there were 9 residents on the 200 Hall Memory Care Unit.</p> <p>Review of an undated Quality of Life - Homelike Environment facility policy indicated, .Residents are provided with a safe, comfortable, and homelike environment .comfortable noise levels .The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include .chair and bed alarms .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46062</p> <p>Based on observation, interview, and record review, the facility has failed to ensure that the resident environment remains as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 3 of 8 residents reviewed for accidents. (Residents #15, Resident #19, and Resident #201)</p> <ol style="list-style-type: none"> <li>The facility failed to ensure CNA A and the DON performed a safe mechanical lift transfer for Resident #15.</li> <li>The facility failed to ensure CNA B and CNA C performed a safe mechanical lift transfer for Resident #19.</li> <li>The facility failed to keep Resident #201's smoking materials locked up at the nurse's station.</li> </ol> <p>This failure could place residents at risk of injury from accident and hazards.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #15's face sheet dated 5/14/24 indicated she was [AGE] years old and admitted to the facility on [DATE] with diagnoses including muscle weakness, abnormalities of gait and mobility, lack of coordination, morbid severe obesity (being over 100 pounds over ideal body weight or having a body mass index over 35), and dementia (progressive loss of intellectual functioning with impairment of memory, thinking, and behaviors).</li> <li>Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated she was understood and understood others. The MDS indicated a Resident #15 had a BIMS of 9, which indicated she had moderate cognitive impairment. The MDS indicated Resident #15 used a wheelchair for mobility. The MDS indicated Resident #15 was dependent on staff for chair to bed/bed to chair transfers.</li> <li>Record review of Resident #15's undated care plan revealed she had a problem area of ADL functional status/rehabilitation potential with an approach stating she needed maximum assistance with transfers with the mechanical lift and two staff.</li> <li>Record review of Resident #15's weight dated 5/01/24 revealed she weighed 285 pounds.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 5/14/24 beginning at 9:14 AM, CNA A, assisted by the DON, used a mechanical lift to transfer Resident #15 from her bed to the resident's wheelchair. CNA A positioned the mechanical lift over Resident #15 with the mechanical lift legs in the narrow position under the resident's bed. There did not appear to be any obstructions under Resident #19's bed. CNA A and the DON attached the lift pad to the mechanical lift. CNA A then raised Resident #15 up above the resident's bed with the mechanical lift legs in the narrow position. CNA A then pulled the mechanical lift with Resident #15 suspended in the air back away from the resident's bed and turned the mechanical lift with the lift legs still in the narrow position to her right and started pushing the mechanical lift toward Resident #15's wheelchair that was located at the end of her bed. The DON then reached under CNA A's arms during the moving of Resident #15 and moved the mechanical lift leg spreader lever to the wide position and CNA A continued to then position Resident #15 over her wheelchair. CNA A assisted by the DON then lowered Resident #15 into her wheelchair and positioned her for comfort.</p> <p>During an interview on 5/14/24 at 9:45 AM, Resident #15 said she had not ever been injured during a mechanical lift. Resident #15 said there was always two staff members and she felt safe during the mechanical lift transfers.</p> <p>2. Record review of Resident #19's face sheet dated 5/14/24 indicated he was [AGE] years old and admitted to the facility on [DATE] with diagnoses including morbid severe obesity, heart failure, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit, and mild cognitive impairment.</p> <p>Record review of Resident #19's annual MDS dated [DATE] indicated he was understood and understood others. The MDS indicated a Resident #19 had a BIMS of 9, which indicated he had moderate cognitive impairment. The MDS indicated Resident #19 had verbal behavioral symptoms directed toward others 1-3 days. The MDS indicated Resident #19 used a wheelchair for mobility. The MDS indicated Resident #19 was dependent on staff for chair to bed/bed to chair transfers.</p> <p>Record review of Resident #19's undated care plan revealed he had a problem area of ADL functional status/rehabilitation potential with an approach stating he would be transferred using the mechanical lift with assist of two staff.</p> <p>Record review of Resident #19's weight dated 5/15/24 revealed he weighed 328 pounds.</p> <p>During an observation on 5/14/24 beginning at 10:09 AM, CNA B and CNA C used a mechanical lift to transfer Resident #19 from his bed to the resident's wheelchair. Resident #19's bed was located against the wall closest to the door and his wheelchair was positioned against the wall closest to the window on the opposite side of the room. CNA B positioned the mechanical lift over Resident #19 with the mechanical lift legs in the narrow position under the resident's bed. There did not appear to be any obstructions under Resident #19's bed. CNA C attached the lift pad to the mechanical lift. CNA B then raised Resident #19 up above the resident's bed with the mechanical lift legs in the narrow position. CNA B then pulled the mechanical lift, with Resident #19 suspended in the air, back away from the resident's bed and as CNA B started turning the mechanical lift toward the right, CNA B moved the mechanical lift leg spreader lever to the wide position and then continued to push the mechanical lift and Resident #19 across the room and positioned Resident #19 over his wheelchair, assisted by CNA C. CNA B then locked the mechanical lift wheels and then lowered Resident #19 to his wheelchair and positioned him for comfort, while being assisted by CNA C.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/14/24 at 10:50 AM, Resident #19 said he had not ever been injured during a mechanical lift. Resident #19 said there was always two staff members and he felt safe during the mechanical lift transfers.</p> <p>During an interview on 5/14/24 at 11:05 AM, CNA B said she had worked at the facility since February of 2024 and normally worked the 6 AM to 2 PM shift. CNA B said she had received training related to the mechanical lift. CNA B said there should always be two staff members when performing a mechanical lift. CNA B said the mechanical lift should be positioned over the resident with the mechanical lift legs in the narrow position while under the bed with the breaks applied. CNA B said after attaching the lift pad, the resident would be raised up off the bed with a spotter watching. CNA B said then she would pull the mechanical lift from under the bed frame with the resident in the lifted position and when the mechanical lift legs were clear from the bed, then she would spread the legs of mechanical lift. CNA B said then she would move the resident over their wheelchair, then she would apply the brakes and lower resident into the chair with the assistance of another staff member. CNA B said the purpose of spreading the legs of the mechanical lift was to keep the balance of the mechanical lift. CNA B said when the mechanical lift legs were under the bed, there may not have been enough room under the bed and that was why she did not spread the mechanical lift legs prior to lifting/moving Resident #19. CNA B said if the mechanical lift legs were not spread to the wide position, the mechanical lift could sway and/or tip over and resident could hit the floor and hurt themselves.</p> <p>During an interview on 5/15/24 at 8:32 AM, CNA C said she had worked at the facility since 2006 and usually worked the 6 AM to 2 PM shift. CNA C said she had received training related to the mechanical lift. CNA C said there had to be two staff members present when performing a mechanical lift for safety. CNA C said the mechanical lift would be positioned over the resident with the mechanical lift legs in the narrow position under bed. CNA C said then the lift pad would be attached to the mechanical lift and ensuring it was secured. CNA C said the mechanical lift wheels should be locked, then lift the resident up off the bed. CNA C said then when the mechanical lift was pulled out from under the bed, then spread the legs, and both staff members should guide the resident over to their chair, then lock the lift wheels, and then lower the resident into the chair. CNA C said spreading the mechanical lift legs made it balanced. CNA C said the mechanical lift could tilt over and the resident could fall if the lift legs were not spread to the wide position. CNA C said the mechanical lift legs were not opened to the wide position when they transferred Resident #19 until he was almost to his wheelchair that was on the opposite side of the room. CNA C said Resident #19 could have tilted and fell over.</p> <p>During an interview on 5/15/24 at 8:47 AM, CNA A said she had worked at the facility for fifteen years and normally worked the 6 AM to 2 PM shift. CNA A said she had received training related to the mechanical lift. CNA A said there should always be two staff members present during mechanical lift transfers. CNA A said you should position the mechanical lift over the resident with the mechanical lift legs under the resident's bed, then attach the lift pad to the mechanical lift, lock the wheels of the lift, and then raise the resident up. CNA A said as the mechanical lift legs were pulled out from under the bed with the resident lifted, then open the left legs to the wide position, and then move the resident to over the wheelchair, and then lower the resident into the chair with wheels locked. CNA A said the purpose of having the mechanical lift legs spread to the wide position was to ensure the mechanical lift was balanced and would not tip over, for safety of the resident. CNA A said the legs of the mechanical lift should have been opened to the wide position prior to moving Resident #15 toward her wheelchair during her mechanical lift transfer. CNA A said the resident could have tilted over and fell .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/15/24 at 8:57 AM, the DON said the legs of the mechanical lift should be spread in the wide position during the lift process, but the residents' beds were making it difficult to open the legs while under the beds, so she had told her staff to only leave the mechanical lift legs closed in the narrow position while over the bed. The DON said staff should open the mechanical lift legs to the wide position as soon as the lift clears the bars under the bed, before turning/moving the lift. The DON said she did open the legs of the mechanical lift to the wide position during Resident #15's mechanical lift transfer because CNA A had not opened them before she turned the lift and was moving toward the resident's wheelchair. The DON said it was very important to ensure the mechanical lift legs were opened to the wide position to ensure the stability of the lift during resident transfers, so the mechanical lift did not tip over, because it could really injure a resident.</p> <p>During an interview on 5/15/24 at 10:07 AM, the [NAME] President of Clinical said the mechanical lift legs should be spread open to the wide position, if the bed allowed, during mechanical lift transfers. The [NAME] President of Clinical said if the bed did not allow for the mechanical lift legs to be opened to the wide position under the bed, then the legs should be opened as soon as the lift cleared the bed, prior to moving the mechanical lift with the resident lifted. The [NAME] President of Clinical said they had already in-serviced the CNAs to open the legs of the mechanical lift as soon as clearing the bed, if they were not able to open the legs under the bed prior to lifting the resident or moving/turning the lift. The [NAME] President of Clinical said the legs should be opened to the wide position to ensure the mechanical lift did not tip over and the resident's weight had to be balanced, because they did not want any mechanical lift injuries to the residents.</p> <p>Record review of the facility's Staff Education/Orientation Standards of Practice form titled Competency-Hoyer Lift/Transfer dated 11/09/23, revealed CNA A was checked off by the DON as having met the competency of Hoyer Lift/Transfer, which included . before positioning the legs of the patient lift under a bed, make sure that the area is clear of any obstructions . with the legs of the base open and locked .</p> <p>Record review of the facility's Staff Education/Orientation Standards of Practice form titled Competency-Hoyer Lift/Transfer dated 2/06/24, revealed CNA B was checked off by the DON and the ADON as having met the competency of Hoyer Lift/Transfer, which included . before positioning the legs of the patient lift under a bed, make sure that the area is clear of any obstructions . with the legs of the base open and locked .</p> <p>Record review of the facility's Staff Education/Orientation Standards of Practice form titled Competency-Hoyer Lift/Transfer dated 11/16/23, revealed CNA C was checked off by the DON as having met the competency of Hoyer Lift/Transfer, which included . before positioning the legs of the patient lift under a bed, make sure that the area is clear of any obstructions . with the legs of the base open and locked .</p> <p>3. 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).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Admission MDS 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.</p> <p>Record review of a care plan dated 4/12/24 revealed a problem initiated on 4/17/24 that Resident #201 will remain compliant with the smoking policy and remain free from smoking related injury.</p> <p>During an interview and observation on 5/13/24 at 9:17 a.m., Resident #201 said that she kept her cigarettes in her room. She said she did not keep a lighter in her room. She said that she always had her cigarettes because smoking was the only thing that makes her happy and it was what she liked to do. She said she would go out to smoke during smoking hours with staff, but she kept her cigarettes with her. Surveyor observed an open box of cigarettes on Resident #201's bedside table. There was a lighter inside the box.</p> <p>During an interview on 5/14/24 at 1:20 p.m., with the Administrator she said facility policy state d that residents must keep their cigarettes and lighters at the nurse's station. She said the nurses pass out smoking materials during smoking hours and were supposed to collect their smoking materials afterwards. She said she expected facility staff to confiscate cigarettes and lighters and place them locked away at the nurse's station. She said residents can be placed at risk for burns if they decide to use their lighters unsupervised.</p> <p>During an interview on 5/15/24 at 9:14 a.m. with the DON she said facility policy stated that residents were not allowed to keep their smoking materials. She said this included lighters and cigarettes. She said that it was everyone's responsibility to ensure that residents did not have lighters and cigarettes in their room. She said that yesterday, after she was informed residents had cigarettes, she went and confiscated smoking materials from resident #201. She said residents were placed at risk for harm by having their lighter as they could light it near oxygen tanks and cause an accident.</p> <p>Record review of the facility's policy titled Hoyer Lift Transfer dated August 17, 2023, revealed . the procedure was to help lift residents using a manual lifting device . two nursing assistants were required to perform the procedure . The policy did not address the opening the legs of the mechanical lift to the widest width during transfers.</p> <p>Record review of Patient Lifts by the U.S. Food and Drug Administration, Patient Lifts   FDA was accessed on 05/16/24 indicated . the FDA has compiled a list of best practices that, when followed, can help mitigate the risks associated with patient lifts . users should . keep the base (legs) of the patient lift at maximum open position and situate the lift to provide stability .</p> <p>Record review of Best Practices for Using Patient Lifts by the U.S. Food and Drug Administration (FDA), Best Practices For Using Patient Lifts (fda.gov) was accessed on 5/16/24 indicated . patient lifts were designed to lift and transfer patients from one place to another . found improper use of patient lifts have lead to patient falls . resulted in head traumas, fractures, deaths . can mitigate risks by doing the following . receive training and understand how to operate the lift . keep the base (legs) of the patient lift in the maximum open position .</p> <p>(continued on next page)</p>

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

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a facility policy titled Smoking Policy dated 1/1/2015 indicated . Policy: This Facility permits smoking in a designated area outside of the facility, subject to certain requirements and restrictions set forth below .1.All residents who smoke will be screened using the Safe Smoking Evaluation form upon admission, quarterly and with a significant change in condition to determine any special smoking needs. Resident specific smoking needs will be addressed in the resident's plan of care .7. All residents who smoke will have all their smoking materials stored in a secure area at the nurse's station or other location designated by the facility. The facility considers the use of electronic cigarettes, regardless of the nicotine level, to be smoking material .Smoking and smoking paraphernalia are not allowed in the residents' rooms under any circumstances .</p> <p>45643</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128</b></p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety.</p> <ol style="list-style-type: none"> <li>The facility failed to remove carbon build-up from 2 baking sheets and 1 skillet.</li> <li>The facility failed to ensure that male kitchen staff properly wore facial hair covers while in the kitchen.</li> <li>The facility failed to ensure the scoop for the sugar bin was properly stored.</li> <li>The facility failed to ensure that all food items had been properly dated and labeled in Freezer #1, Freezer #2 and Refrigerator #1.</li> </ol> <p>These failures could place residents at risk of foodborne illness and food contamination.</p> <p>Findings include:</p> <p>During an observation on [DATE] at 8:27 a.m., the Dietary Manager was present in the kitchen with no facial hair cover. He had a beard and a mustache.</p> <p>During an observation on [DATE] at 8:29 a.m., there was carbon build up on 2 baking sheets and 1 skillet. [NAME] G was present in the meal preparation of the kitchen. He had on a facial hair cover below his mouth. His mustache and the upper portions of his beard were exposed.</p> <p>During an observation on [DATE] at 8:31 a.m., inside the pantry, there was a scoop in the sugar bin. There was sugar in the bin.</p> <p>During an observation on [DATE] at 8:32 a.m., inside Freezer #1, there was a bin containing 10 to 20 packages of frozen light brown, round food items with no date or label.</p> <p>During an observation on [DATE] at 8:33 a.m., inside Freezer #2, there were 8 bags of a round yellow vegetable with no label. There were 5 bags of light brown stick shaped food items with no label. There was one bag of green and white vegetables with no label. There were four bags of breaded food items with no label. There were 2 bags of an unknown leafy green vegetable with no label. There was a blue bag of large beige food items with no date or label.</p> <p>During an observation and interview on [DATE] at 8:39 a.m., there was one bag of a red vegetable and a bag of green vegetable with no label. [NAME] G said it was everyone's responsibility to date and label all foods in the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 2:07 p.m., the Dietary Manager said he had been putting his pans in degreaser. He said he guessed not as much as he needed to. He said pans not being clean might lead to a resident getting sick. He said normally all male staff had their facial hair covered when they entered the kitchen. He said on [DATE] he had just come out of the restroom and that was why he did not have a facial hair cover on. He said facial hair not being covered could lead to hair getting into food and cause contamination. He said scoops were supposed to be cleaned and stored on the side of each dry good container. He said on [DATE] he was getting ready to wash the sugar bucket and had not removed the scoop. He said scoops being left inside the dry goods container could lead to contamination. He said it was everyone's responsibility to date and label foods as they were stored in the kitchen. He said it was his responsibility to make sure that all foods were dated and labeled. He said food not being dated could lead to out-of-date food being used and could make someone sick. He said you might not know what kind of food was in an unlabeled package and it could lead to serving the wrong thing.</p> <p>During an interview on [DATE] at 3:43 p.m., the Administrator said the cooks in the kitchen were responsible for keeping the pans clean. She said she would have expected the cooking equipment to have been kept clean and not to have carbon buildup. She said the buildup could get into the food and possibly cause a food borne illness. She said she saw [NAME] G in the kitchen on [DATE] with his facial hair not fully covered. She said, Who wants to eat hair in their food?. She said it is just unsanitary. She said she would expect scoops to be stored properly. She said if the scoop was dirty, it could cause a food borne illness. She said the Dietary Manager needed to make sure foods were dated and labeled. She said if food items were not dated or labeled properly it could cause residents to get expired food or could cause them to mistakenly eat something they were not supposed to eat and could cause them to be sick.</p> <p>Review of a Food Storage facility policy dated [DATE], indicated, .To ensure all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes .Dry storage rooms .Provide scoops for items stored in bins, such as sugar, flour, rice, and other items. Store scoops covered in a protected area near food containers .Use the first-in, first out (FIFO) rotation method. Date packages and place new items behind existing supplies, so the older items are used first .Refrigerators .Date, label and tightly seal all refrigerated foods .</p> <p>Review of an Employee Sanitation facility policy dated [DATE], indicated, .The Nutrition &amp; Foodservice employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness .Employee Cleanliness Requirements .Hairnets, headbands, caps, beard coverings or effective hair restrains must be worn to keep hair from food and food-contact surfaces .</p> <p>Review of a General Kitchen Sanitation facility policy dated [DATE], indicated, .The facility recognizes that food-borne illness has the potential to harm elderly and frail resident. All Nutrition &amp; Foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness .keep food-contact surfaces free of cooking equipment free of encrusted grease deposits and other accumulated soil .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of a 2022 Food Code for the U.S. Food and Drug Administration indicated, XXX,d+[DATE] Hair restraints .food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food .Annex 4. Establish First-In-First Out (FIFO) Procedures. Product rotation is important for both quality and safety reasons. First-In-First-Out (FIFO) means that the first bath of product prepared and placed in storage should be the first one sold or used. Date marking food as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS (temperature control storage) foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirement .</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure all patient care equipment was in safe operating condition for 1 of 16 residents (Resident #27) reviewed for safe, functional equipment.</p> <p>The facility failed to ensure Resident #27's wheelchair had a functioning right brake.</p> <p>This failure could result in resident falls and injury while using their wheelchairs.</p> <p>Findings included:</p> <p>Record review of face sheet dated 05/14/24 indicated Resident #27 was [AGE] years old and was admitted to the facility on [DATE] with diagnoses including repeated falls, unspecified lack of coordination, and abnormalities of gait and mobility.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated a BIMS was not conducted due to Resident #27 being rarely/never understood. The MDS indicated Resident #27 had two or more falls since admission to the facility.</p> <p>Record review of a care plan last revised on 03/18/24 indicated Resident #27 had a history of falls. There were interventions to call hospice for new chair due to anti-rollback no longer functioning. Replace when arrives. Cont to encourage use for safety .staff to attempt to lock w/c (wheelchair) when resident has impulse to stand and walk around unit before she sits down . The care plan indicated Resident #27 was at risk for fall due to wheelchair use and unsteady gait, altered mental status and history of falls with an intervention to encourage staff to attempt to lock wheelchair when resident had the impulse to stand and walk around unit before she sat back down.</p> <p>During an interview on 05/13/24 at 11:19 a.m., a family member of Resident #27 said the resident's wheelchair would not lock properly. She said hospice had sent over a new wheelchair several times because that the wheelchair would not lock properly. The family member said the facility kept sending the wheelchairs back because they did not have an anti-tipping device on them. The family member said she did not know why the anti-tipping device not being on the new chair was an issue since Resident #27's anti-tipping device was broken.</p> <p>During an observation on 05/13/24 at 12:07 p.m., Resident #27 was sitting in her wheelchair in the dining room of the 100 Hall Memory Care Unit. The wheelchair was in the locked position on both sides. The wheelchair moved slightly on the right side when an attempt was made to move the wheelchair. The right side did not completely lock the wheel.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/14/24 at 10:07 a.m., Resident #27's hospice nurse said Resident #27 had issues with her wheelchair. She said nursing staff had requested a new wheelchair because her wheelchair was not locking. She said hospice had sent several out, but they were refused by staff because there was no anti-tipping device. She said hospice did not provide the anti-tipping devices. She said 3 weeks ago she made the DON aware of the situation and provided her a picture of the broken anti-tipping device on the resident's wheelchair. She said the DON told her that was the first she had heard of the device being broken and she would have it fixed. She said she had witnessed Resident #27 scooting her wheelchair around while the brakes were in locked position. She said she did not reach down to make sure the brakes were all the way engaged. She said Resident #27 had several falls, but none were from the wheelchair that she was aware of.</p> <p>During an observation and interview on 05/14/24 at 10:26 a.m., CNA C said the anti-tipping device on Resident #27's wheelchair had been fixed. She said she did not know when it had been repaired. She said the right sided brake still did not work properly. She said even though the left brake worked Resident #27 could still move her wheelchair even with both brakes locked. She said the right brake did not lock the right wheel. She said she felt if both sides would lock the resident would be unable to move the wheelchair. The right side was in locked position but was not preventing the right wheel from turning. She said the right brake had not been working for at least 3 weeks and Resident #27 had been able to move the wheelchair even when the brakes were engaged for a while now.</p> <p>During an interview on 05/14/24 on 10:28 a.m., CNA E said the anti-tipping device was now working on Resident 27's wheelchair. She said even though the left brake locked, the right brake did not lock all the way. She said, She is a strong lady. She said the resident was able to still move the wheelchair. She said she was unaware of any falls the resident may have had from her wheelchair.</p> <p>During an interview on 05/14/24 at 10:44 a.m., Physical Therapy Assistant F said the anti-tipping device was working after the Maintenance Supervisor did repairs. She said he repaired the brakes also. She said the right brake was engaged all the way, but she did not know what to do to make it keep the wheel from moving.</p> <p>During an interview on 05/14/24 at 3:00 p.m., the DON said she was not notified of the brake not working on Resident 27's wheelchair on 5/13/24. She said she thought the resident was just scooting the wheelchair with it locked and did not realize the right sided lock was not locking the wheel. She said the brake not locking could cause the chair to spin if she stood up and cause her to fall.</p> <p>During an interview on 05/14/24 at 3:43 p.m., the Administrator said that she had been unaware of the brake not locking on Resident #27's wheelchair. She said the brakes not working properly could cause the resident to fall. She said Resident #27 was always moving.</p> <p>During an interview on 05/15/24 at 9:18 a.m., RN D she said she had only been aware of the brakes on Resident #27's wheelchair not working for just a few days. She said they had been having issues in getting a new wheelchair from hospice. She said she knew they had sent at least one to the facility. She said, that's been awhile now. She said the new wheelchair was refused because it did not have the anti-tipping device on it.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an undated Proper Functioning of Equipment facility policy indicated, .The facility shall ensure equipment is properly maintained and safe for use by resident .Facility staff should report any unsafe equipment concerns to maintenance and the administrator to ensure a proper response and timely correction of the issue. Any equipment deemed unsafe should be pulled from use until it can be repaired or replaced. Any equipment with minor repair issues that can be used safely until repair or replacement, may be used at the direction of the administrator.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45643</p> <p>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.</p> <p>The facility failed to ensure Resident #201 had a functioning call light.</p> <p>This failure could place residents at risk of injury that could lead to possible falls, major injuries, hospitalization, and unmet needs.</p> <p>Findings include:</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		