STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455572	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgewood Nursing Home	6621 Dan Danciger Rd Fort Worth, TX 76133

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to maintain a safe, functional, sanitary, and comfortable environment for 4 of 5 rooms (Rooms 221, 225, 229, and 231) reviewed for environmental conditions. The facility failed to maintain Rooms 221, 225, 229, and 231 in a safe and sanitary condition. The failure placed residents at risk for infection and decreased quality of life. Findings included: Observation on 10/01/24 at 10:56 AM of room [ROOM NUMBER] revealed a vent cover measuring approximately 10 inches by 10 inches on the ceiling was covered with dark debris. When looking through the vent, it appeared to have thick black dust and debris. room [ROOM NUMBER] had a silver ceiling rail hanging from the ceiling. Observation on 10/01/24 at 11:21 AM of room [ROOM NUMBER] revealed a vent cover measuring approximately 10 inches by 10 inches on the ceiling over resident bed revealed the vent was completely covered with black debris identical to mold, dust and dirt. When looking through the vent, it appeared to have thick black dust and debris. Observation on 10/01/24 at 11:48 AM of room [ROOM NUMBER] revealed a vent cover measuring approximately 10 inches by 10 inches on the ceiling was covered with dark debris inside the vent, and the vent had dark dust outside the vent. Observation on 10/01/24 at 11:49 AM of room [ROOM NUMBER] revealed a vent cover measuring approximately 10 inches by 10 inches on the ceiling was covered with dark debris inside the vent, and the vent had dark dust fairies outside the vent. Interviewed residents revealed they did not have any concerns with the way vents the vents looked; however, they did not recall seeing staff cleaning the vents. (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: 455572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/01/24 at 12:08 PM with Housekeeper C revealed she was aware of the vents in resident Rooms 221, 225, 229 and 231 being dirty. Housekeeper C stated the vents had dark matter on them that looked like mold. Housekeeping C stated she had pointed the vents on another hall to the Maintenance Director about a month ago. She stated she thought since then he would have looked at all the vents in the facility. Housekeeper C stated she had not talked to anyone concerning the vents on Hall 200. Housekeeper C stated she was responsible for alerting the Maintenance Director so that he could clean the vents and not doing so placed the residents at risk of becoming sick or ill. Housekeeper C revealed she had not seen the silver rail measuring approximately 2.5 feet hanging from the ceiling, so she had not reported it to anyone. Housekeeper C stated the way it was hanging placed residents at risk of injury. Housekeeper C stated that she should report it to Maintenance Department to be repaired. Observation and interview on 10/01/24 at 12:26 PM with CNA A in Rooms 221, 225, 229 and 231 revealed she thought the vents had mold on them. CNA A stated she did enter the rooms daily to care for residents, but she never really looked up unless residents complained of being cold. While in room [ROOM NUMBER], a silver ceiling rail measuring approximately 2.5 feet was hanging from the ceiling. CNA A stated it was her responsibility to alert the Maintenance Director if there was a problem in the resident rooms, so they could provide maintenance or repairs. According to CNA A, residents were placed at risk when having dirty vents because they were breathing in what looked like mold which could cause breathing problems and infections. CNA A stated she had not seen the ceiling rail hanging prior to today, but it also placed residents and staff at risk for injury if it fell . Interview on 10/01/24 at 1:46 PM with LVN B revealed she was notified about the vents being dirty by CNA A. She stated she had not had a chance to observe the vents, but anyone that saw the vents dirty would report to the Maintenance Department. She stated anytime housekeeping came to clean the rooms they should be cleaning the vents as well. LVN B stated not doing so could place residents at risk for respiratory concerns. LVN B stated she had not received any concerns so far concerning breathing problems from Rooms 221, 225, 229 or 231. She stated she was also notified about the silver ceiling rail hanging in room [ROOM NUMBER], but when she went to observe the room the Maintenance Director was already in the room. She stated anyone who entered the room could be injured if the rail fell . She stated any staff that entered the room was responsible for notifying the nurse or Maintenance Department of the rail hanging, so that it could be repaired and to prevent injury. Interview on 10/01/24 at 2:57 PM with the Maintenance Director revealed he was notified of the ceiling vents and the hanging rail in resident rooms on Hall 200. He stated after observation of the vents today he ordered new vents. He stated last year he went through the entire building and cleaned the vents and after observing on 10/01/24 it looked like the vents just had a build-up of dust or dirt. He stated on a monthly basis while checking the light bulbs he did dust the vents and looked over resident rooms to see what all needed to be repaired. He stated it was the responsibility of the housekeepers to notify him of anything they saw in the resident rooms that need to be repaired. The Maintenance Director stated not alerting him of the dirty vents and the hanging rail placed residents at risk of developing allergies and breathing infections. He further stated there was not a risk of resident in room [ROOM NUMBER] being affected by the rail because he fixed it, and it was held on tightly by the end that has holding the rail to the ceiling. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgewood Nursing Home	6621 Dan Danciger Rd Fort Worth, TX 76133

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/01/24 at 3:37 PM with the Administrator revealed she ordered new vents. She stated the vents looked like they were all cleaned with degreaser and the paint was coming off. She stated the staff doing Angel Rounds should be looking over resident rooms and reporting any concerns. She stated some staff were out, and perhaps the people that were covering the Angel Rounds were just focusing on the resident needs. She stated anyone, who saw the vents or the rail hanging, was responsible for reporting it to the nurse, the maintenance department or herself. The Administrator stated leaving the items unattended placed the residents at risk of infection and injury if not addressed. Review of the facility's Housekeeping Standards policy, revised January 2024, reflected: The facility will provide a clean and sanitary living environment for the physical and emotional well being of the resident. The housekeeping program will address itself to the prevention of the spread of disease and infection through proper and effective disinfection procedures. Quality Control Monitoring Program - to establish a means of monitoring the quality of housekeeping services. Work Order System - to establish a means of written communication with all departments regarding discrepancies in quality control. Acquiring the proper chemicals, tools, equipment and supplies - to clean and disinfect

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NAME OF PROVIDER OR SUPPLIER: Wedgewood Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 6621 Dan Danciger Rd, Fort Worth, TX 76133	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 5 residents (Resident #1) reviewed for ADL care. The facility failed to provide Resident #1 assistance with timely incontinence care. This failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection. Findings included: Record review of Resident #1's face sheet, dated 10/01/24, reflected the resident was a [AGE] year-old female, admitted to the facility on [DATE], and readmitted on [DATE]. Resident #1's diagnoses included stroke, hypertension (high blood pressure), peripheral artery disease (disorder that causes abnormal narrowing of the arteries), hemiplegia (loss of the ability to move one entire side of the body), dementia (general decline in ability to perform everyday tasks), seizure disorder (uncontrolled shaking movements), and anxiety disorder (mental disorder of uncontrollable feelings). Record review of Resident #1's admission MDS assessment, dated 06/26/24, reflected Resident #1's BIMS score was 15 indicating her cognition was intact. Resident #1 was coded with frequently incontinent of bowel and bladder. Resident #1 required partial/moderate assistance with toileting, shower/bathing and personal hygiene. Record review of Resident #1's current, undated care plan reflected Resident #1 was incontinent of bowel/bladder related to weakness, and dementia. The care plan reflected: Goal: Resident will remain free from skin breakdown due to incontinence and brief use. Resident will be clean and odor free. Interventions: Incontinent: Check frequently for wetness and soiling, every two hours, and change as needed. Briefs or incontinence products as needed for protection. Apply barrier cream to skin after incontinence episodes. Resident wears extended wear/nighttime briefs at night to assist in preventing interrupted sleep for incontinence care. Assist to toilet as needed. Weekly skin checks and report any changes to physician. Observation and interview on 10/01/24 at 11:21 AM revealed Resident #1 was in bed. The resident stated she had been in her room in bed since the 6:00 AM-2:00 PM shift had started. She stated she ate breakfast and must had gone back to sleep. Resident #1 stated she was wet and was ready to be changed. She stated, I don't like to have this urine on me. Resident #1 stated the last time she was changed was prior to the 6:00 AM-2:00 PM shift, and no one had entered her room to ask her if she needed to be changed since early morning. The resident then activated her call light to request assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/01/24 at 11:50 AM revealed CNA A provided Resident #1 with incontinence care, and CNA A used proper technique throughout the procedure. Resident #1 expressed no discomfort, and no skin breakdown was noted. Resident #1's brief was soaked as well as her bedding. Resident #1 stated she was last changed just before day shift (6:00 AM-2:00 PM) came on duty today, so about 6 hours ago. Resident #1 stated she was a heavy wetter and staff usually had to change her linen when they changed her brief. Interview on 10/01/24 at 12:26 PM with CNA A revealed she was working with Resident #1 during 6:00 AM-2:00 PM shift today. CNA A stated she did rounds before and after breakfast, and Resident #1 stated she was okay. CNA A stated Resident #1 was a heavy wetter. CNA A stated the last time she checked on Resident #1 for incontinence care was around 10:00 AM, and the resident was sleeping at the time. According to CNA A, Resident #1 did not have any irritation and had not complained of her care. She stated Resident #1 was usually up and out of bed and able to alert staff when she had to go to the restroom. CNA A stated Resident #1 was soaked down to the bed when she completed the observed incontinence care. She stated she was surprised there was not a bed pad underneath the resident because she needed to have one. CNA A stated it was her responsibility to complete incontinence care rounds to ensure residents were clean and dry. She stated it was her responsibility to ensure the resident's bed was dry and clean. She stated not ensuring residents were clean and dry could cause residents to have skin damage and irritation. Interview on 10/01/24 at 1:46 PM with LVN B revealed she worked the 6:00 AM-2:00 PM shift Monday-Friday and cared for Resident #1 on her hall. She stated she was not sure why Resident #1 was soaked to the bed today. LVN B stated when Resident #1 was in bed, her call light was within reach, and she could alert staff to help her to the restroom. She stated Resident #1 was usually up and about the facility during the day. She stated she viewed Resident #1 as continent while the resident was up in her wheelchair because she was able to alert staff when she needed to go to the restroom, and staff would then assist her. LVN B stated it was the responsibility of the aide to complete incontinence care rounds every 2 hours and as needed. LVN B stated Resident #1 being wet placed her at risk of skin breakdown, falls if trying to change herself, and urinary tract infection. Interview on 10/01/24 at 3:25 PM with the DON revealed she was alerted to Resident #1 being soaked during an incontinence care observation. The DON stated CNAs were responsible for doing rounds every 2 hours on residents to ensure they were clean and dry. She stated nurses were also responsible for checking on their residents to ensure they are doing okay. She stated leaving Resident #1 wet placed her at risk of skin breakdown, infection, and pressure sores. The DON stated Resident #1 usually only required brief changes during the night hours because she alerted staff for assistance when she needed to go to the restroom during the day. She stated Resident #1 could alert staff when she needed to go to the restroom. Review of the facility's Incontinence Care policy, revised 02/14/20, reflected: Purpose: To outline a procedure for cleansing the perineum and buttocks after an incontinence episode. .Apply clean linen/under pad, brief or other incontinent products as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reposition for comfort with call light in reach and provide additional care as needed as requested by patient. The policy revealed an outlined procedure for cleaning the perineum and buttocks after an incontinence episode. The policy included equipment and procedure to be used during incontinence care. The policy did not address how often to check on residents for incontinence care.