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	04/23/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42820 Based on interview and record review, the facility failed to maintain clinical records that were complete and accurate for one (Resident #1) of five residents reviewed for clinical records. The facility failed to ensure Resident #1's clinical record was complete and accurate when the resident experienced a change in condition on 02/02/25. LVN A did not accurately and completely document Resident #1's blood sugar monitoring, medication administration, and contact with the NP or EMS. These failures could place residents whose records are maintained by the facility at risk for delays and errors in their care and treatment. Findings include: Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Type 1 Diabetes, (body does not use insulin effectively or does not produce enough insulin), Major Depressive Disorder, End Stage Renal Disease, (kidneys can no longer function adequately to meet the body's needs), Dependence on Renal Dialysis, Chronic Respiratory Failure with Hypoxia (a condition where there is not enough oxygen in the tissues of your body), Congestive Heart Failure (heart can no longer pump blood well enough to meet the body's needs), dysphagia (difficulty swallowing) Record review of Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 01/30/25, reflected a Brief Interview of Mental Status (BIMS) score of 8, indicating he had moderate cognitive impairment. Record review of Resident #1's progress note, dated 02/13/25, reflected on 02/02/25 he had been transferred via EMS to the hospital after having hypoglycemia (low blood sugar). Record review of Resident #1's progress note, dated 02/13/25, reflected on 02/02/25 the resident had five blood glucose monitoring tests that indicated hypoglycemia (low blood sugar). The time was not documented for five of five of the blood glucose monitoring test. (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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note, dated 02/13/25, reflected on 02/02/25 the resident had been administered three medications. The time was not documented for medication administration for three of three medications (Baqsimi Nasal Powder 3 MG/Dose-2 doses; Ipratropium-Albuterol Inhalation Solution 3 MG/3 ML). Record review of Resident #1's progress note, dated 02/13/25, reflected on 02/02/25 LVN A had contacted the Nurse Practitioner (NP) three times. The time was not documented for three of three NP contacts. Record review of Resident #1's nurses note, dated 02/13/25, reflected on 02/02/25 LVN A had called Emergency Medical Services (EMS) to transport the resident to the hospital. The time was not documented for when EMS was called or when EMS arrived. Interview on 04/22/25 at 2:00 PM with Medication Aide (MA), she stated when she gave a medication, she was required to document the date, time, drug, and dose. She stated if she did not document the medications she gave, the next shift would not know what medications the resident had received and could possibly double dose the resident. Interview on 04/22/25 at 2:35 PM with LVN B, she stated that timing events in the medical record was important to show what occurred with the resident and not documenting medications given could result in a resident receiving the wrong dose of medication. She stated when giving a medication she should document the patient, drug, date, time, and route. Interview on 04/22/25 at 3:15 PM with Licensed Vocational Nurse (LVN) A, she stated complete documentation of a medication should contain the drug, the dose, the route, and the time. She stated, If we don't document the care we give, it can cause a lot of problems and the next shift won't know what happened with the resident. She stated she usually documented all care at the end of the shift, and she did not know why she did not document care and medications on 02/02/25. Interview on 04/23/25 at 12:00 PM with the Administrator, he stated it was his expectation significant events would be documented appropriately and relayed to leadership. He stated every nurse should document and timeline the events that occurred to provide clear understanding of what took place with the resident's care. Interview on 04/23/25 at 3:20 PM with the Assistant Director of Nurses (ADON). The ADON reviewed Resident #1 progress note for 02/02/25 dated 02/13/25. She stated a nurse should document any change of condition, medications given with time administered, to chronologically tell story of what took place. She stated it was her expectation documentation of care provided, should be documented no later than the end of shift by the nurse who provided the care. She stated failure to properly document could cause delay in care and interfere with overall care. Record review of the facility's policy titled Clinical Document Guideline dated 01/01/2025, reflected the following: The patient's clinical record provides a record of the health status, including observations, measurements, history and prognosis and serves as the primary document describing healthcare services provided to the patient. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record is used by healthcare team to record, preserve and communicate the patient's progress and current treatment. 1. Clinical document entries should be objective, factual information and communication that pertain to the care of the patient i.e. patient centered 2. Clinical document entries should not be used to voice complaints, free of subjective assumptions and interdepartmental grievances 3. Clinical document entries should contain the month, day, year and time the narrative is written 4. Entries are signed by the person writing the narrative and include the first initial, last name and title or credentials of the author. 5. Each healthcare team member must document his or her own clinical record entries 6. Initialed entries on clinical documents should have corresponding full signature identification of the initials on the same form or signature legend. 7. Initials are used to authenticate entries on flow sheets, medication record or treatment records. Documentation on flow sheets, medication and treatment records are completed daily or based on the physician orders. 8. Documentation entries on a clinical document should be in in chronological order. 9. Duplicate and repetitive routine entries supported by other clinical documents such as flow sheets and route standards of care should be avoided. i.e. as a routine practice charting meal intake on food acceptance records and in nurse progress notes 10. Documentation by exception is acceptable (clinical entry is made upon occurrence) in some clinical areas i.e. side effect monitoring, behaviors are a few examples. 11. Documentation may be performed via a daily predetermined pathway, flow sheet and documentation system. Types of Clinical Record Entries Late Entry When it is necessary to complete a late or out of sequence entry due to a missed narrative, omitted information from a previous entry or additional pertinent information that occurred during the shift of work use the following process: Identify the entry as late entry Enter the current date and time Identify or refer to the date and incident for which the late entry is written. Clarification Entry (continued on next page)

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