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	01/31/2025

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 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** 43791 Based on observation, interview, and record review, the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 5 residents (Residents #10) reviewed for ADL care. The facility failed to ensure Resident #10's fingernails were kept trimmed. These failures could place the residents at risk of infections or injuries. Findings included: Record review of Resident #10's undated Admission Record reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included myopathy (muscle weakness and involuntary muscle movement), reflux, unsteadiness on feet, and failure to thrive. Record review of Resident #10's annual MDS Assessment, dated 12/16/24, reflected a BIMS score of 6 indicating severe cognitive impairment. Her Functional Abilities assessment indicated she required assistance for her personal hygiene. Record review of Resident #10's care plan, dated 11/14/24, reflected she had an ADL Self-care deficit with an intervention of extensive assistance for personal hygiene. Observation and interview on 1/14/25 at 10:14 AM revealed Resident #10 was lying in bed quietly, her fingernails were all uneven lengths, several were jagged or broken, and there was a black substance under them. Resident #10 stated she wanted her fingernails trimmed but the girl that usually did it had not been there in a while. She stated she had broken some of the nails because they get caught in her bedding. She stated she did not like her nails looking like that. Observation on 1/15/25 at 1:36 PM revealed Resident #10's fingernails had not been trimmed. Interview on 1/15/25 at 1:48 PM CNA-C stated nail care could be done by the CNAs if the resident did not have diabetes, in which case the nurse would have to do it. If the CNAs notice a resident needed nail care during bathing, they notified the nurse. Record review of the facility's Nail Care policy, dated 02/10/20, reflected: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Precaution should be used when trimming nails of residents with diabetes and should be done by a licensed nurse of physician. 1. Assemble equipment 2. Knock on door and request entrance 3. Introduce self, explain procedure and provide privacy 4. Wash hands 5. Fill basin with warm water and alternate soaking hands 6. Carefully brush nails with nailbrush to remove dirt or clean with orange stick 7. Dry hands 8. Gently push cuticles back with orange stick Discard orange sticks after use 9. Trim nails and file for smoothness, as needed 10. Apply moisturizing lotion to hands 11. Reposition for comfort with call light in reach 12. Wash hands 13. Return equipment to designated area and clean/dispose as indicated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 3 residents (Resident #25) reviewed for contracture management The facility failed to provide equipment/services for Resident #25's right hand contracture (a permanent tightening of the muscles). This failure could place residents at risk for a decline in range of motion, decreased mobility, worsening of contractures, and a decline in physical capabilities. Findings included: Record review of Resident #25's MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included aphasia (language disorder that affects a person's ability to communicate), hemiplegia (muscle weakness or partial paralysis on one side of the body). The MDS further reflected Resident #25 has memory problems. Record review of Resident #25's care plan revised on 08/15/24 reflected the resident had ADL self-care performance deficit related to functional limitations in range of motion, decreased mobility, and hemiplegia secondary to a stroke. Interventions included therapy to screen, evaluate, and treat as needed. Observation on 01/14/25 at 2:53 PM of Resident #25 revealed he was in his room sitting in his wheelchair. The resident was noted with a contracture to his right hand and there was no device in place. Resident #25 was not able to speak but appeared to shake his head when asked yes/no questions. Observation on 01/15/25 at 12:46 PM of Resident #25 revealed he was in his room eating lunch. The resident's right hand was contracted, and there was no contracture management device in place his right hand. Interview on 01/16/25 at 9:25 AM with CNA I revealed Resident #25 did have a splint for his hand contracture and either therapy or the nurse were responsible for applying it. CNA I said the resident did not have it the past two days because it was probably in the laundry as it would frequently get soiled. CNA I further stated if the splint was being laundered, the resident should have a rolled washcloth placed in the contracted hand until the splint was returned. Interview on 01/16/25 at 9:01 AM with LVN H revealed Resident #25 did have a splint for his contracted right hand and either therapy or the nurses were responsible for applying the splint . LVN H said she was not aware the resident did not have the splint in his hand the past two days and did not recall the last time she saw him with it. LVN H further stated she did not recall Resident #25 having an order for a splint for his contracture. LVN H said if the resident did not wear the splint for his contracture it could cause the contracture to tighten. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/15/25 at 3:12 PM with the Occupational Therapist revealed she began working at the facility September 2024 and Resident #25 had a palm guard that was being used for his contracted right hand. She stated she was not aware who had initiated the palm guard for the resident's contracture. The Occupational Therapist said it had been about two weeks since she had been able to locate the palm guard and did not know if it had been taken to the laundry to get washed . The Occupational Therapist said there should be an order in place for the palm guard to remind staff to be consistent in applying the palm guard. The Occupational Therapist further stated the palm guard was used to maintain gross motor movement and prevent further limitation in range of motion. Interview on 01/16/25 at 2:02 PM with ADON B revealed Resident #25 normally had a palm guard in place for his contracture and it was usually placed in his right hand by therapy or the nurse. ADON B said she was not sure why the resident was not wearing it the past two days. She said if the palm guard had been taken to the laundry, staff should replace it with a rolled washcloth until the palm guard was brought back from laundry. ADON B further stated not having anything in place in Resident #25's contracture could cause skin breakdown in his hand, advancement of the contracture, and pain from stiffness. ADON B also said there should have been an order for the palm guard, and she would need to clarify why there was not one already in place . Record review of the facility's policy titled Splinting revised January 2020 reflected the following: Policy Splinting is used to protect joints and surrounding soft tissue. This can be accomplished by maintaining joints at position of rest, preventing positions that contribute to contracture and/or deformity, protecting the system of arches within the hand and increasing and maintaining ROM in the joint. Requirements: Physician's order and Occupational Therapist Evaluation

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observations, interviews, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 3 residents (Resident #67) reviewed for enteral feeding. 1. RN G failed to contact the physician and obtain orders before using a de-clogger (a device designed to clear obstructed feeding tubes) to unclog Resident #67's g-tube (Gastrostomy tube, tube inserted through the belly that brings nutrition directly to the stomach) on [DATE]. The facility had de-clogger tools onsite, even though they did not train nurses on their use, and it was not an approved method for de-clogging a g-tube. 2. The facility failed to follow physician orders for Resident 67's enteral feeding tube to be flushed with 100 ml of water every 2 hours. An Immediate Jeopardy was identified on [DATE] at 8:42 AM. The IJ template was provided to the facility on [DATE] at 9:00 AM. While the Immediate Jeopardy was removed on [DATE] at 3:30 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a severity level of immediate threat, due to the facility's continuation of in-servicing and monitoring the plan of removal. This failure placed residents at risk for serious injury and serious harm such as injury to the gastrointestinal tract such as ulceration, bleeding, and perforation. Findings included: 1. Record review of Resident #67's Admission Record dated [DATE] reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment dated [DATE] reflected his diagnoses included cerebral artery (supplies blood to the brain), aphasia (language disorder) following cerebral infarction (stroke), tracheostomy status (procedure to help air and oxygen reach the lungs), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphasia (swallowing difficulties) following cerebral infarction, respiratory failure, and renal failure. Resident #67's BIMS score was not complete. The MDS further revealed Section K - Swallowing/Nutritional Status indicated the resident's nutritional approach was a feeding tube. Record review of Resident #67's care plan revised date [DATE] reflected: Feeding Tube: Resident requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Goal: Resident will maintain adequate nutritional and hydration status as evidenced by weight being stable, no signs or symptoms of malnutrition, or dehydration through review date. Interventions: Administer tube feeding and water flushes as ordered. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #67's physician orders dated [DATE] reflected an order for Enteral Feed Order every shift Intermittent Pump Enteral Feeding: Formula Glucerna 1.5 Amount: Rate: 65 cc Frequency: Total mls/22 hours. Record review of Resident #67's physician orders dated [DATE] reflected an order for Enteral Feed Order every 4 hours flush 200 mls of water to run concurrently with enteral feeding. D/C Date - [DATE]. Record review of Resident #67's physician orders dated [DATE] reflected an order for Enteral Feed Order every 2 hours flush 100 mls of water to run concurrently with enteral feeding. Observation on [DATE] at 11:02 AM revealed Resident #67 lying in bed. He could not answer questions. Resident #67 was connected to his feeding pump, and the feeding rate was set at 65 mL/hr. and the water flush rate was set at 200 mL every 4 hours. The formula bag was dated [DATE] at a rate 65 mL/hr. The water bag was dated [DATE]. Observation on [DATE] at 9:30 AM revealed Resident #67 lying in bed with his feeding pump connected. The feeding rate was set at 65 mL per hour, and the water flush rate was set at 200 mL every 4 hours. Interview on [DATE] at 1:32 PM with RN F revealed she was the nurse assigned to Resident #67. RN F stated Resident #67 had a g-tube, she stated the night shift placed a new formula and water bag. RN F reviewed Resident #67's physician orders and stated the resident had an order to flush 100 mls of water every 2 hours. Observed RN F entered Resident #67's room and observed the resident's feeding pump. She stated the feeding pump rate was incorrect, it was set at 200 mls of water every 4 hours. Observed RN F adjust the feeding pump to 100 ml of water flush every 2 hours. She stated when she came in for her shift (6 AM -2 PM) she completed her rounds and checked on residents feeding pumps. RN F stated she might have missed it. She stated the potential risk of not providing Resident #67 with the correct timed flushes could lead to the g-tube clogging. Interview on [DATE] at 2:29 PM ADON B stated Resident #67's water flushes were changed from 200 ml every 4 hours to 100 mls every 2 hours in the month of [DATE]. She stated she was made aware Resident #67's feeding pump was not accurate; however, there were times that Resident #67's FM had concerns regarding the amount of water the resident received. She stated water flushes were changed upon Resident #67's family member request. She stated Resident #67's family member had been educated on why that amount of water was given to the resident. She stated it was believed Resident #67's FM might have changed the water flushes amount. However, it was expected for the nurses to follow physician orders and if the family did not agree, the nurses should notify the doctor and obtain orders. She stated the potential risk would be the g-tube clogging. Interview on [DATE] at 11:37 AM with NP revealed Resident #67 had issues with g-tube clogging. She stated she was aware of Resident #67's water flushing orders. She stated the orders were changed back in [DATE] to increase the frequency of the water flushes to prevent the g-tube to clog. She stated she was unaware that the resident was receiving water flushes every 4 hours. She stated the water flushes were changed to every 2 hours specifically to prevent the g-tube to clog. She stated her expectations were for the nurses to follow physician orders. She stated the potential risk would be the g-tube to clog. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:25 PM with RNC revealed her expectations were for the nurses to follow physician orders regarding water flushes. She stated she was unaware Resident #67 had any issues with his g-tube clogging. She stated water flushes were needed to prevent the g-tube from clogging. 2. Record review of Resident #67's progress notes dated [DATE] at 06:31 AM by RN G reflected Unable to administer AM medications due g-tube being clogged. Multiple attempts made by x 3 nurses to unclog g-tube. De-clogger tool and coke used. Attempts were unsuccessful. Physician contacted awaiting response. [FM] is aware and present at the bedside. Record review of Resident #67's progress notes dated [DATE] at 09:50 by RN F reflected The night nurse reported that the patient's g-tube is clogged, initial attempt to unclog the tube was unsuccessful, NP was notified. Order received from NP to try to unclog it first with [Don], if unsuccessful then send pt to ER. The [Don] was notified and assisted in successfully unclogging the tube. Bowel sounds were present, and the patient had a bowel moment this morning. NP was notified, got an order to resume his feeding. Observation and interview on [DATE] at 9:30 AM revealed Resident #67 lying in bed with his feeding pump connected and he had a trach. Resident #67's family member was in the room visiting, she stated she had no concerns regarding the care the resident was receiving at the facility. Resident #67's family member stated in [DATE] unknown of the exact dates, the resident was having issues with his g-tube clogging. She stated she could not recall much of the events; however, the facility staff made several attempts to unclog the g-tube and when unsuccessful the resident was transported to the hospital. She stated she recalled the nurses using a de-clogger but did not recall much of what happened or how it was used. Interview on [DATE] at 2:22 PM with RN F stated in the month of [DATE], Resident #67 had issues with g-tube clogging. She stated she could not recall the exact dates; however, one morning she arrived for her 6 AM-2 PM shift and the night nurse informed her that Resident #67's g-tube was clogged, and she could not provide him with his medications. She stated she was unsure if a de-clogger was used. She stated if a nurse used a de-clogger, the nurse must obtain a physician order. She stated she was unsure if a physician order was obtained. Interview on [DATE] at 2:29 PM with ADON A stated Resident #67 had his g-tube replaced once since being admitted to the facility. She stated since Resident #67's g-tube had been changed there had not been any issues. She stated when a g-tube clogs the nurses use methods like pulling back residual, use warm water, cranberry juice, or use coke to break it down. She stated it was up to the nurse's discretion on what method to use and if nothing was successful the resident should go to the hospital. She stated de-cloggers should not be used because it was not part of their training and was unaware if any de-clogger had been used. She stated she was unsure if they had any de-clogger tool in the facility. However, if a nurse knows how to use a de-clogger and felt comfortable using that method it would be up to the nurse's judgment. She stated nurses should obtain physician orders before using a de-clogger. Observation on [DATE] at 4:07 PM with Central Supply Tech of supply room located in the North Station revealed one 16 Fr. 39.5 cm de-clogger tool and on the South Station supply room revealed four 16 Fr. 39. 5cm de-clogger tool. Central Supply Tech stated she was unsure why the facility had de-cloggers. She stated she just orders them, she stated she was not a nurse and was unsure why the de-cloggers were used for. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 4:21 PM with RN J stated he had worked with Resident #67 before; he stated he had not had any issues with Resident #67's g-tube clogging. He stated a couple of weeks ago, unknown of the exact date, Resident #67's g-tube clogged. He stated he went to Resident #67's room to assist and help unclog the g-tube. He stated they tried different methods and a de-clogger was used. Then stated he was unsure if a de-clogger was used and was unsure if the nurse was able to unclog the g-tube. RN J stated he could not recall the nurses who were assigned to Resident #67 and was unsure if the physician was notified. RN J stated he had not used a de-clogger before and had not been in-serviced on how to use one. Interview by phone on [DATE] at 8:08 AM with the Medical Director revealed he was aware of Resident #67's g-tube having multiple issues with clogging. The Medical Director stated each facility used different methods to unclog a g-tube. He stated he did not recall any staff notifying him or him giving any orders for the use of a de-clogger. He stated he was not sure what a de-clogger was. The Medical Director stated if the facility nurses had proper training on how to use a de-clogger and if the tool/device was FDA approved he did not have any issues with the nurses using it. He stated he was not familiar with the device to know of any possible risk, he stated there could be risk, but he did not know what the probability of it would be. The Medical Director stated the use of coke had been used at hospitals in the ERs because the carbonation helped with unclogging g-tubes. He stated he had no issues with nurses using that method. The Medical Director stated he did not necessarily need to be called all the time when situations happened. Interview on [DATE] at 8:52 AM with ADON B revealed when a resident's g-tube clogs it was the expectation for the nurse to notify the doctor, attempt to unclog it by using methods like flushing with warm water, milk it down (hold the tube on the top and push down), and if nothing was working send the resident out to the emergency room . She stated they have used a de-clogger in the past usually after talking to the doctor if they cannot clear the line. She stated on her station they have not used any de-cloggers and was unaware if de-cloggers had been used in the South station. She stated it was up to the doctor's discretion if de-cloggers were to be used. She stated if a de-clogger was used it should be documented and had obtained a physician order. She stated a de-clogger was not part of their training and not part of the nurses check off. Interview on [DATE] at 11:37 AM with NP revealed Resident #67 had issues with his g-tube clogging. She stated it was not normal for his g-tube to clog. She stated in [DATE], unknown of exact date, the resident was sent out to the ER twice. The first time was because the g-tube was partially dislodged. She stated the hospital should have changed the g-tube bud did not. She stated the resident returned to the facility and the g-tube clogged. She stated she was notified, and she recommended to try to unclog it first in house and if unsuccessful send the resident to the hospital; however, the nurse was able to successfully unclog the g-tube. She stated she was unaware a de-clogger and coke was used. She stated her expectations were for the nurses to use methods like using a 10 ml syringe to push back pressure, or to use water. She stated she would not recommend using a de-clogger and had never been a point in time where they would use a de-clogger. She stated maybe there was a misunderstanding when she said de-clog in house that maybe the nurses thought to use any method to unclog it. The NP stated the risk of using a de-clogger could cause injury or if the de-clogger was long enough to perforate something. She stated nurses should be trained to use a de-clogger and should obtain orders if a de-clogger was being used. The NP stated, unknown of the exact date, Resident #67 went to the hospital again because his g-tube clogged again, his g-tube was changed, and it had been working fine since then. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 1:26 PM with RN G stated in [DATE], unknown of the exact date, she was going to give Resident #67's morning medications; however, the g-tube was clogged. She stated she tried to flush it with warm water to try to de-clog it but did not work, she then used a de-clogger and it was effective. She stated RN F was in the room present and tried to assist with unclogging the g-tube. She stated she was the one who used the de-clogger to unclog the g-tube. She stated she did not contact the physician and did not obtain orders prior to using the de-clogger. She stated she was unsure if the other nurses present contacted the doctor or NP. She stated she had used a de-clogger in the hospital setting, was comfortable using a de-clogger and she knew how to use it. She stated it was the first time using a de-clogger at the facility. She stated she should have contacted the doctor first and obtained orders before using a de-clogger. She stated the risk of using a de-clogger would be puncturing the tube if not careful or harming the tube more itself. Interview on [DATE] at 2:25 PM with RNC revealed her expectation for when a g-tube clogs was the nurses were expected to follow policy and procedure for g-tube care. If there were any issues, the nurses should contact the doctor and obtain orders. She stated the nurses should not be using a de-clogger because the facility did not have any policy for a de-clogger, and they could not ensure the nurses had been trained on how to use one. She stated she was unsure why the facility had any de-cloggers in the facility. She stated the only policy the facility had if any complications occur the nurses, were to notify the physician or any abnormalities. Record review of the facility's Following Physician Orders policy, dated [DATE] reflected the following: The policy provide guidance on receiving and following physician orders. . For consulting physician/practitioner orders received via telephone, the nurse will: a. Document the order on the physician order form, notating the time, date, name and title of the person providing the order, and the signature and title of the person receiving the order. b. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record. c. Carry out and implement physician orders. Record review of the facility's Clinical Practice Guideline: Care of Tube Feed Resident policy, review date [DATE] reflected the following: Resident will remain free of complications related to use of a feeding tube. Tube feeding care should be consistent with the current standards of practice and overall therapeutic goals of the resident and delivered in an ethical manner. Prevention of gastrointestinal complications: Provide formula at prescribed rate using appropriate delivery method . (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Notify physician of any abnormalities. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 8:30 AM. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 9:00 AM. The facility's Plan of Removal was accepted on [DATE] at 2:15 PM XXX[DATE] @ 8:42 Immediate Jeopardy Called F-693 The facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feedings. IJ F693 Plan of Removal Immediate Actions taken I. Resident specific On [DATE] resident was immediately assessed BY ADON head to toe without any noted signs or symptoms of injury. On [DATE] the 2 other g-tube residents with g-tubes were immediately assessed By ADON LVN head to toe without any noted signs or symptoms of injury. II. System changes On [DATE] all g-tube de-clogger devices were immediate removed from the facility at the time they were identified during the annual survey as this is not part of our policy. On [DATE] all g-tube de-cloggers were brought to the DON office by Central supply for immediate destruction. On [DATE] Central supply and ADON's were immediately instructed to not order any g-tube de-cloggers moving forward no matter who requested them. And to notify the Administrator if asked. On [DATE] Director of Nurses was terminated for failure to participate in this investigation. On [DATE] Facility policy was updated by VP of clinical services to include problem solving to prevent g-tube clogging. III. Education On [DATE] all licensed nurses were immediately in-serviced by ADON on the facility policy is not to use g-tube de-cloggers and on the facility policy on care of the tube fed resident (prevention of gastrointestinal complications, prevention of mechanical complications, prevention of dignity issues, observations and reporting) (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] all licensed nurses were immediately in-serviced by ADON on following physicians orders for administering flushes. This in-service included validating the pump was programmed to match the physician's order at the beginning of their shift. On [DATE] all nurses were in-serviced by ADON on the updated facility policy for care of the tube fed resident (which includes the notification of the physician anytime a g-tube is clogged). All staff that did not attend the in-service's will be in-serviced on all education completed by ADON prior to their next scheduled shift. IV. Monitoring Nursing supply orders will be pulled weekly x 1 month to ensure de-cloggers are not being ordered. DON/Designee will do random checks weekly x 4 weeks to ensure auto flush pumps are programmed to match the flush ordered by the physician. DON and Administrator will review nursing orders monthly at the facility QAPI meeting to ensure continued compliance. Monitoring of the Immediate Jeopardy continued: Record review on [DATE] at 9:20 AM of Resident #67's MAR indicated he had no medications via g-tube scheduled until bedtime. Interview on [DATE] at 9:25 AM a family member of Resident #67 was bedside, the family member stated they were bedside the majority of the day. The family member described how the nurse administers the resident's medications via the g-tube. They described the medications being in separate cups, the nurse administers one cup at a time followed by some water. The medications were allowed to go in on their own, they never used the syringe to force the medications in. Observation on [DATE] at 9:25 AM of Resident #67's feeding pump indicated he was receiving Glucerna at 65 ml/hr and a 100 ml water flush was scheduled every two hours. Record review on [DATE] at 9:30 AM of Resident #67's nursing notes indicated no issues with his g-tube clogging since [DATE]. Record review on [DATE] at 9:50 AM of Resident #70's MAR reflected she was not scheduled to receive any medications via g-tube until the next morning. Record review on [DATE] at 9:53 AM of Resident #70's nursing notes reflected there had been no issues with her g-tube clogging since [DATE]. Observation on [DATE] at 9:55 AM of Resident #70's feeding pump reflected her Glucerna was infusing at 50 ml/hr and a 125 ml water flush was scheduled every 4 hours. Record review on [DATE] at 10:00 AM of Resident #58's MAR revealed she was not scheduled to receive any medications via her g-tube until bedtime. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review on [DATE] at 10:03 AM of Resident #58's nursing notes reflected there were no issues with her g-tube clogging since [DATE]. Observation on [DATE] at 10:05 AM of Resident #58's feeding pump reflected she was receiving Glucerna at 55 ml/hr with a 75 ml water flush every four hours. Attempts to interview RN G were made via phone on [DATE] at 11:10 AM and 1:40 PM in an attempt to what size and length of de-clogger to use on Resident #67's g-tube. Interview on [DATE] at 11:20 AM with the ADON revealed she did not know how long de-cloggers had been in the facility, they were just always here. Interview on [DATE] at 11:33 AM with the Central Supply Tech revealed she had been in the position since around [DATE] and the de-cloggers were in stock at that time. Several were expired so she ordered more to replace them. The last time she ordered a de-clogger was on [DATE]. She stated on [DATE] all the de-cloggers were turned over to the Administrator. She was advised not to re-order them and to notify the DON if she was asked by anyone to order one. Interview on [DATE] at 11:40 AM with the RNC revealed the previous DON had refused to assist the investigation into de-clogger use, so she was termed. The RNC stated as far as she could determine the previous DON had ordered them to be kept on hand. The DON had stated she trained staff on the use of de-cloggers, but the RNC was unable to locate any training material, no in-services, or anything to indicate de-clogging training had been done with staff. The RNC stated on [DATE] all nursing staff were in-serviced by herself and the ADONs that de-cloggers were not to be used on clogged g-tubes. The nurse was to contact the physician for orders to send the resident to the hospital to have the g-tube replaced or de-clogged. Interview on [DATE] at 12:22 PM with LVN K revealed she had been in-serviced by the ADON on g-tubes. She stated she was not allowed to use the de-clogger, but she had never used one before. She stated she was to call the physician for orders to send the resident to the hospital. If the physician ordered it, they could try to milk or massage the tube to unclog it. Interview on [DATE] at 12:25 PM with LVN H revealed she had been recently in-serviced on g-tubes. She was to call the physician for orders to send them to the hospital. The physician could order them to attempt to unclog the tube by massaging or milking the tube. If the interventions were unsuccessful the resident was to go to the hospital. Interview on [DATE] at 12:30 PM with RN F revealed she had recently been in-serviced on g-tubes. If the resident's g-tube was clogged they were not to use the de-clogger, they were to call the physician for orders to send the resident to the hospital. The physician could order them to attempt to unclog the tube using water on the pump like a bolus or massaging it. Interview on [DATE] at 12:39 PM with LVN L revealed she had been in-serviced on g-tubes recently. She stated it was made clear that de-cloggers were not to be used, and they had been removed from the facility. They were to call the physician for orders to send the resident to the hospital for replacement of the g-tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 1:55 PM with RN-J revealed he had been in-serviced on g-tubes. He stated if the tube was clogged, he was to call the physician for orders to send them to the hospital, or to try massaging the tube to unclog it. Phone interview on [DATE] at 2:00 PM with LVN M revealed she had been in-serviced on g-tubes. She stated it was made clear that de-cloggers were not allowed to be used, and they had been removed from the facility. She stated she had never used a de-clogger and had never been trained on them. She stated she was to call the physician for orders. Interview on [DATE] at 2:24 PM with RN N revealed she had been in-serviced on g-tubes recently. She stated de-cloggers had been removed from the facility. She stated she had used the de-clogger in the past, but she had not been trained at this facility. She stated she knew how to use them from past experience. She stated she was now supposed to call the physician for orders to send the resident to the hospital. Interview on [DATE] at 2:28 PM with LVN O revealed he had been in-serviced on g-tubes recently. He stated if the tube is clogged, he can try to massage it first, and if that didn't work he would call the physician for orders to send the resident out. Telephone interview on [DATE] at 3:10 PM with RN Q revealed she had been in-serviced on g-tubes. She stated if the tube was clogged, she was to call the physician for orders. The physician could order the resident sent out, or to try milking the tube before sending the resident out. She stated de-cloggers were not to be used. Record review of the facility's monitoring tool Weekly Monitoring of G-tube Flush reflected it had been completed weekly since [DATE]. Record review of the facility's Ad Hoc QAA meeting, held on [DATE], reflected physician orders, g-tubes orders had been reviewed. Discussion of g-tube de-clogging process was held. All de-clogging tools were removed, and all nurses were to be educated on the new process. An Immediate Jeopardy was identified on [DATE] at 8:42 AM. While the Immediate Jeopardy was removed on [DATE] at 3:30 PM, the facility remained out of compliance at a scope of isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy, due to the facility's continuation of in-servicing and monitoring the plan of removal.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 6 residents (Resident #67) reviewed for respiratory care. The facility failed to ensure there was a physician order for Resident #67's tracheostomy care, suction tubing, and emergency trach kit. This failure could place residents with a tracheostomy requiring tracheostomy care at risk for respiratory distress, hospitalization s, and a decline in their quality of life. Findings included: Record review of Resident #67's Admission Record dated 01/16/25 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment dated [DATE] reflected his diagnoses included cerebral artery (supplies blood to the bran), aphasia (language disorder) following cerebral infarction (stroke), tracheostomy status (procedure to help air and oxygen reach the lungs), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphagia (swallowing difficulties) following cerebral infarction, respiratory failure, and renal failure. Resident #67's BIMS score was not complete. The MDS further revealed Section O - Special Treatments, Procedures, and Programs indicated resident received oxygen therapy and tracheostomy care. Record review of Resident #67's care plan revised date 10/11/24 reflected: Tracheostomy: Resident has a tracheostomy and is at risk for potential complications such as weight loss, increased secretions, congestion, infection, and respiratory distress. Goal: Resident will have clear airways with adequate ventilation through the next review date. Interventions: Provide oxygen, humidity, tracheostomy care, and tubing changes as indicated by physician's orders. Record review of Resident #67's January MAR revealed O2 @ 3 LPM via Trach. Notify MD if SpO2 falls below 90% while using O2. Perform resp . assess if O2 applied. every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA (lungs cannot effectively transfer oxygen from the air to the bloodstream, resulting in low blood oxygen levels). Start date 01/14/25. There were no physician orders for Trach care or Suction or Emergency supplies. Observation on 01/14/25 at 11:02 AM revealed Resident #67 lying in bed. The resident had a tracheostomy and feeding tube. The resident was not able to answer questions. An emergency kit was at the resident's bedside. Resident #67's family member was in the room visiting. The Family Member stated Resident #67 had a stroke and admitted to the facility with a trach. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/15/25 at 1:32 PM RN F stated she was the nurse assigned to Resident #67. She stated Resident #67 admitted to the facility with a trach. She stated she provided trach care every morning and as needed to Resident #67. She stated she completed suctioning and changes the cannula every day. RN F reviewed Resident #67's physician orders and stated the resident did not have any trach care orders. She stated a couple of weeks ago, unknown of the exact date, Resident #67 had gone to the hospital. She stated the orders might have been deleted. RN F stated the admitting nurse should have put in orders and if the orders were missing the admitting nurse should have contacted the doctor. She stated she was unaware Resident #67 did not have any trach care orders. She stated the potential risk of not having any physician orders would make it appear that they were not providing any care to Resident #67. Record review of Resident #67's January MAR as of 01/15/25 1400 [2:00 PM] reflected the following: Suction Q shift & PRN. Report abnormal secretions to MD every shift related to TRACHEOSTOMY STATUS. Verify the following emergency supplies are at the bedside (above the HOB): Ambu bag Obturator Water-soluble lubricant, Trach in the size ordered, Trach in a size below and size above (preferably), E-cylinder at the bedside for emergency O2 use. every shift for Presence of Trach Interview on 01/15/25 at 2:29 PM with ADON A revealed she was the ADON assigned to the North Station where Resident #67 resided. She stated she was unsure why Resident #67's trach care orders were not showing. She stated she could assure that Resident #67 had trach care physician orders and did not understand how they could disappear from the system. She stated it was the responsibility of the admitting nurse to put in orders. She stated during morning stand up the DON and the ADONs audit physician orders upon return from the hospital. She stated she was unsure if the physician orders were put in the system. However, she had seen the orders prior to today (01/15/25). ADON A stated Resident #67 had been receiving trach care every shift and PRN . She stated there was no potential risk if they did not have any physician orders due to the resident continued to receive care. Interview on 01/16/25 at 2:17 PM with RNC revealed her expectations were for the nurses to obtain physician orders and put them in the system. She stated Resident #67 should have had orders for trach care. She stated she was unaware Resident #67 did not have any physician orders. She stated it was the responsibility of the DON and the ADON to ensure physician orders were obtained. She stated the potential risk of not having physician orders could lead to resident trach care not getting done. Record review of the facility's Respiratory Care Services: Tracheostomy Care policy, review date 2020, reflected the following: To aseptically clean a tracheostomy site and trach tube free from mucous buildup, maintaining tube patency, reducing risk of infection and maintaining skin integrity at the stoma site. Tracheostomy care should be provided every 8 to 12 hours or as indicated by order of physician. 1. Verify physician's order, including: procedure to be done, frequency, physician's signature (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Following Physician Orders policy, dated 09/28/21, reflected the following: The policy provide guidance on receiving and following physician orders. .For consulting physician/practitioner orders received via telephone, the nurse will: a. Document the order on the physician order form, notating the time, date, name and title of the person providing the order, and the signature and title of the person receiving the order. b. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record. c. Carry out and implement physician orders.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 44140 Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 or 2 meals (lunch) reviewed for food meeting residents' needs. The facility failed to prepare and serve pureed mash potatoes as a pudding consistency for residents who required pureed diets during the lunch meal on 01/15/25. This deficient practice could affect residents and place them at risk of not receiving meals that meet their needs Findings included: Record review of Week-At-A-Glance Texas 4 Week 4 menu revealed the menu for the lunch service was . Boiled Potato . Observation on 01/15/25 at 11:16 AM of the Dietary Manager pureed mashed potatoes with a hand whisk, was observed removing the potato skins and then proceeded to place it on the steam table. The Dietary Manager did not check the consistency or ensure it was all blended to have a pudding consistency. Observation of the test tray on 01/15/25 beginning at 12:55 PM with the Dietary Manager, the test tray included the regular textured menu items and the pureed menu items. Pureed mashed potatoes did not have a smooth/pudding consistency. The mashed potatoes had chunks of potato not fully mashed. The Dietary Manager stated when she prepared the mashed potatoes, it appeared it was smooth. She stated she used a whisk instead of the blender. She stated she thought it had the correct consistency. She stated the risk if everything was not completely pureed, was the resident could choke. Follow-up interview on 01/15/25 at 3:43 PM with the Dietary Manager revealed her expectation was for pureed food to have a smooth/ pudding consistency. She stated when she was preparing the mashed potatoes, she thought it was smooth until she tried the test tray, and it was not. She stated the mashed potatoes had lumps in it. She stated she normally oversees her staff complete the puree meals; however, she was the one who prepared the mashed potatoes. She stated the potential harm to residents was the possibility chocking. Record review of the facility's current, undated Pureed Recipe Book General Guidelines policy reflected: When processing foods to obtain a pureed consistency, it is important to know that we want a moist mashed potato consistency. If the product is too dry it may cause difficulty in swallowing too moist may cause aspiration or at the very least be too runny on the plate and give a poor appearance.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 44140 Based on interview and record review, the facility with more than 120 beds, failed to employ a qualified social worker on a full-time basis for one of one Social Worker reviewed for qualifications. The facility, licensed for more than 120 beds, had not employed a full-time, qualified Social Worker since 09/26/24. This deficient practice could result in residents' social service needs not being met. Findings included: Record review of the facility's license revealed the facility had a licensed capacity of 128 residents. Record review of the facility's Department Heads list revealed no Social Worker. Record review of the Social Worker's electronic file revealed she was hired on 03/01/24 and was terminated 09/25/24. During the confidential resident group interview 10 of the 10 residents in attendance revealed the facility had not had a social worker in months. Residents stated they were being told that the facility was actively looking for a social worker. Record review of Resident Council Meeting for the months of October 2024 revealed Social Services: Resident mentioned that we need a staff member. Interview on 01/16/25 at 12:29 PM with HR revealed the facility had not had a Social Worker since the end of September. She stated the facility was actively looking for a new Social Worker. She stated as of today (01/16/25) they hired someone but they had not started yet, she stated she was going to provide the hiring paperwork. She stated the previous Administrator, who was no longer employed, had SW license and the MDS Coordinators would assist with any social service's needs. Interview on 01/16/25 at 2:36 PM with the Administrator revealed he had been employed since 01/13/25. He stated interviews were completed yesterday (01/15/25) and he made an offer, and the offer was accepted. He stated the facility had been without a Social Worker for about 60 days. The Administrator stated the DON, Medical Records, MDS, and ADONs were following up with resident social service's needs. He stated a social worker was needed to advocate resident's rights, be part of the care plan team and make sure psychosocial needs were being met. The Administrator stated the facility did not have a policy for social services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observations and interviews the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two resident (Residents #5 and #60) of five residents reviewed for infection control. MA D failed to sanitize a re-useable blood pressure cuff between uses on Resident #5 and Resident #60. This failure could place the residents at risk of exposure to infections. Findings included: Record review of Resident #5's undated Admission Record reflected he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included kidney disease, diabetes, high blood pressure, and heart failure. Record review of Resident #5's quarterly MDS assessment, dated 11/20/24, reflected a BIMS score of 12 indicating he was cognitively intact. His Functional Assessment indicated he required assistance with all of his ADLs. Record review of Resident #5's care plan, dated 11/04/24, reflected he had an ADL self-care deficit, high blood pressure with interventions of administering medications and monitoring his vital signs. Record review of Resident #60's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included complete paralysis, mild cognitive impairment, and personal care assistance. Record review of Resident #60's quarterly MDS, dated [DATE], reflected a BIMS score of 14 indicating he was cognitively intact. His Functional Assessment indicated he required assistance with all of his ADLs. Record review of Resident #60's care plan, dated 12/02/24, reflected he had an ADL self-care deficit requiring total assistance with his ADLs. Observation on 01/15/25 at 7:32 AM revealed MA D checked Resident #60's blood pressure with a re-useable blood pressure cuff and returned it to her cart without sanitizing it. Observation on 01/15/25 at 7:45 AM revealed MA D checked Resident #5's blood pressure with the same re-useable blood pressure cuff used on Resident #60. MA D failed to sanitize the cuff prior to or after using it on Resident #5. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/15/25 at 12:32 PM with MA D revealed she was unaware she had not sanitized the blood pressure cuff between uses on the residents. She stated she had sanitizing cloths in her cart but she forgot to use them. She stated the risk of not sanitizing between resident uses could be spreading an infection from one resident to another. Interview on 01/16/25 at 2:27 PM with the RNC revealed re-useable medical equipment only had to be sanitized between residents if it was visibly soiled. When asked the risks of not sanitizing equipment between use the RNC shrugged her shoulders and did not provide an answer. She stated staff follow the facility policies. Record review of the facility's Blood Pressure-Obtaining policy, dated 01/01/24, reflected: .5. Closing steps: a. Clean and store re-useable items and discard disposables

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to assure full visual privacy for four (Residents #3, #46, #47, and #61) of twelve residents reviewed for privacy curtains. The facility failed to provide privacy curtains that assured each resident had full visual privacy. This failure could cause anxiety to residents during personal care. Findings included: Observation and interview on 01/14/25 at 10:10 AM revealed Resident #3 had a privacy curtain between the beds that was hanging by 4 hangers, the rest of the curtain hung down to the floor. Resident #3 stated she did not like not having privacy during incontinent care and the staff never bothered pulling that curtain. She stated anyone could walk in and see her when she was exposed. Record review of Resident #3's undated Admission Record reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included emphysema, dementia, and muscle weakness. Record review of Resident #3's quarterly MDS, dated [DATE], reflected a BIMS score of 9, indicating she had moderate cognitive impairment, Her Functional Status indicated she required assistance with all her ADLs. Record review of Resident #3's care plan, dated 12/04/24, reflected she had cognitive impairment, impaired visual function, and a communication deficit. Observation and interview on 01/14/25 at 10:14 AM revealed Resident #47 had no privacy curtain at the foot of his bed. Resident #47 stated it bothered him to not have the curtain. He stated it had not been in place since he was moved to the room, and he had asked staff for a curtain or to move him to a room that had more privacy. Record review of Resident #47's EHR reflected he had been moved to his current room on 09/06/24. Record review of Resident #47's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke, diabetes, and weakness. Record review of Resident #47's quarterly MDS, dated [DATE], reflected a BIMS score of 12 indicating he was moderately cognitively impaired. His Functional Status indicated he needed set-up assistance with his ADLs. Record review of Resident #47's care plan, dated 12/19/24, reflected he had a communication impairment, he was incontinent of bowel and bladder, and had a self-care deficit. (continued on next page)

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	01/31/2025

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 01/14/25 at 10:21 AM revealed Resident #61 had no privacy curtain between the beds. Resident #61 stated it did not bother him now that he did not have a roommate, but when he had one, it was uncomfortable. Record review of Rfesident #61's undated Admission Reocrd reflected he was a [AGE] year-old male admitted to the facility on [DATE] wu=ith disgises which included stroke, anxiety, aand cataracts. Record review of resident #61's quarterly MDS, dated [DATE] reflecctrd A BIMS score of 14 indicating he was cognitively intact. His Functional Status indicated he requierd partial assistance with his ADLs. Record review of Resident #61's care plan, dated 11/05/24 reflected he had a cognitive impairment, impaired communication, and an ADL self-care deficit. Observation and interview on 01/14/25 at 10:55 AM revealed Resident #46 did not have a privacy curtain at the foot of the bed and no track for hanging a curtain was present. Resident #46 stated it had been that way since being moved into the room. Record review of Resident #46's undated Admission Record reflected he was admitted to the facility on [DATE] with diagnoses of chronic kidney disease diabetes, and muscle weakness. Record review of Resident #46's quarterly MDS, dated [DATE], reflected a BIMS score of 15 indicating he was cognitively intact. His Functional Status indicated he was independent with his ADLs. Record review of Resident #46's care plan, dated 1/12/25 reflected he had an ADL self-care deficit, depression and was a smoker. Observations on 01/15/25 and 01/16/25 of the resident rooms revealed privacy curtains had not been addressed. Interview on 01/16/25 at 10:45 AM with ADON A revealed housekeeping was responsible for changing and cleaning the privacy curtains. Maintenance would hang damaged curtains if needed. Interview on 01/16/25 at 12:35 PM with CNA E revealed each resident should have a privacy curtain. She was unaware Resident #46 did not have a curtain in place. She stated privacy curtains were needed for privacy. Interview on 01/16/25 at 12:38 PM RN F revealed she was the nurse assigned for Resident #46 and was not aware he did not have a privacy curtain. She stated Resident #46 did not have the tracks for a privacy curtain . She stated it was the responsibility of housekeeping staff and maintenance staff to change and put up privacy curtains. Interview on 01/16/25 at 1:19 PM with the Housekeeping Supervisor revealed her staff were responsible for changing out privacy curtains when they were soiled. If the curtains needed to be re-hung because the hangers were damaged, maintenance was responsible for making the repairs. The Housekeeping Supervisor stated all curtains were checked monthly by her; the last check was on 01/13/25. She was unaware Resident #3's curtain was only hanging by four hooks, but she would address it with maintenance. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/16/25 at 3:20 PM with the Maintenance Supervisor revealed he had been working at the facility for four years and he was not aware of all the curtains that needed to be replaced. He stated housekeeping took them down to be washed when needed but they did not have a surplus of curtains to allow them to be replaced with a clean one while the other was being washed. He stated it was important to have a privacy curtain for each resident to ensure they had privacy. Interview on 01/16/25 at 3:06 PM with the Administrator revealed the facility had no policy addressing resident privacy or privacy curtains. There was only the Resident Rights policy stating the residents had the right to a clean, comfortable, home like environment. 44140