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	04/23/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside was adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 3 of 5 residents (Resident#43, Resident#79, Resident#92) reviewed for resident call system. The facility failed on 04/21/2026 to ensure the call light system was adequately equipped, the call light string was hanging down from the wall, away from the residents. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for activities of daily living.Findings included:1. Record review of Resident #43's MDs assessment dated [DATE] reflected he was a [AGE] year old male with an admission date of 12/06/2014, diagnoses included Hemiplegia and hemiparesis following cerebral infraction affecting left dominant side (severe paralysis of one side of the body due to brain damage), Cognitive communication deficit (A communication impairment resulting from underlying cognitive issues such as memory, attention, or executive function deficits), and Vascular Dementia (Decline in thinking skills). Resident #43 had a BIMS score of 03 indicating severe cognitive impairment, he needed moderate assistance with shower and toileting hygiene. Review of Resident #43's care plan, revised on 04/28/2025 reflected he had cognitive impairment. Interventions: . Resident #43 needed supervision/assistance with all decision making, Resident #43 had ADLs self-care Performance deficit related to: Hemiplegia, Debility, Impaired Cognition. Interventions: . Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. In an observation and interview on 04/21/2026 10:16 AM with Resident #43 in his room revealed he was lying in his bed, his call light was hanging down from the wall, away from him. Resident #43 stated he could not reach the call light at that time. 2. Record review of Resident # 79's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 11/01/2024. Diagnoses included Depression, and Cognitive communication deficit (A communication impairment resulting from underlying cognitive issues such as memory, attention, or executive function deficits). Resident #79 had a BIMS score of 00 indicating severe cognitive impairment, he was dependent on staff for toileting hygiene and shower. Record review of Resident #79's care plan, revised on 04/22/2025 reflected he had an ADLs self-care Performance deficit and is at risk for not having his needs met in a timely manner. Functional limitations in range of motion. Hemiplegia/Hemiparesis secondary to a stroke. Interventions: ADL assistance required. Provide shower shave, oral care, hair care and nail care per schedule and when needed. In an observation and interview on 04/21/2026 at 10:24 AM with Resident #79 in his room it was revealed he was lying in his bed, his call light was hanging down from the wall, away from the resident. Resident #79 stated he could not reach the call light at that time. 3. Record review of Resident #92's MDS assessment dated [DATE] reflected she was a [AGE] year-old female with an admission date of 02/25/2022, diagnoses included Unspecified Dementia (memory loss), Legal blindness,. Resident #92 had a BIMS score of 03 indicating severe cognitive impairment, she was dependent on facility staff for toileting hygiene and shower. Record review of Resident #92's care plan, revised on 04/11/2022 reflected she was legally blind, Intervention; . Anticipate needs and meet them as able, Care Plan review dated 01/19/2026 (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected Resident #92 had an ADLs self-care Performance deficit and is at risk for not having her needs met in a timely manner. Interventions: Resident #92 was a high fall risk. In an observation and interview on 04/21/2026 11:16 AM with Resident #92 in her room revealed she was lying in her bed, and the call light was hanging down from the wall, away from the resident. Resident #92 stated she could not reach her call light. An interview with RN K 04/22/26 at 11:18 AM revealed she was the charge nurse for Hall north A. RN K stated all employees going into a resident's room were responsible to ensure the call light was always within reach of the resident. RN K stated residents who did not have their call light within reach were not able to let the staff know of their needs and were at risk for falls, injury skin tear, chocking and even death. RN K stated she could not remember the last time she or her staff received in- service on call light devices. An interview on 04/22/2026 at 12:02 PM with CNA L revealed she was working in hall north A that day, she stated all staff were responsible to ensure the call light was always within the reach of the resident. CNA L stated it was very important to have the call lights for the residents to let the staff know of their immediate needs and not having a call light within reach out residents at risk of falls, injury and skin tears. CNA L stated she had received in-service on call lights within a month. Interview on 04/23/2026 at 10:30 AM with the DON revealed all staff were responsible for ensuring the call light was within the reach of the resident before they left the resident's room. DON stated not having the call light within reach of the resident was detrimental to their safety, it could lead to falls, injury, chocking and even cause death because the resident was not able to let the staff know of their needs. She stated the most recent in-service on call light device was offered to the employees within a week. Record review of facility policy subject Call light-use of Applies to all staff, revised on 1/1/2024 reflected:Policy:It is the policy of this home to ensure residents have a call light within reach that they are physically able to access and that they have been instructed on its use.PROCEDURE12.Be sure call lights are placed near the resident, never on the floor or bedside stand .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 7 residents (Resident #1, Resident #9, Resident #22, Resident #48, Resident #57, Resident #79, Resident #87) of 18 residents reviewed for ADLs. The facility failed to ensure Resident #1, Resident #9, Resident #22, Resident #87 had their fingernails trimmed and cleaned on 04/28/2026. Resident #48, Resident #57, Resident #79 had their fingernails trimmed on 04/28/2026. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, skin breakdown, and a decreased quality of life.1. Record Review of Resident #1's Annual MDS assessment dated [DATE] as a [AGE] year-old male with admission date of 2/10/2025 to the facility. His pertinent diagnoses included: Stroke (occurs when blood flow to the brain is blocked causing brain cells to die), Arthritis, paraplegia (loss of function in the lower body), and Contracture of right hand (stiff joints and reduced mobility). His BIMS score was 15, which indicated Resident #1 had intact cognition. Resident #1 needed setup for personal hygiene. Review of Resident #1's Comprehensive Care Plan, revised 4/24/2025 reflected, Category: [Resident #1] has an ADL self-care performance deficit related to Late effect Stroke, right hemiplegia, Debility, incontinent episodes, and cognitive deficits .Interventions: Check nail length and trim and clean on bath day Report any changes to the nurse. In an interview and observation on 04/21/2026 at 11:19 AM with Resident #1 revealed he had long and dirty fingers nails on both hands measuring approximately 0.2 - 0.4 inches in length extending from the tip of his fingers. He stated he would like his nail to be cleaned and trimmed and stated that staff had not offered nailcare to him for last few weeks. He stated he was unable to trim nails himself related to his contracture. In an interview and observation on 04/22/2026 at 10:49 AM, CNA A stated Resident #1 had long, dirty fingernails. CNA A stated CNAs were responsible for providing nail care, including trimming and cleaning fingernails, unless the resident had diabetes. She stated nail care should be provided on shower days and as needed. CNA A stated the risks of long, dirty fingernails included potential skin tears, and infection. 2. Record review of Resident #9's quarterly MDS Assessment, dated 03/11/2026, reflected the Resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Cerebrovascular Accident (CVA) (a medical emergency where blood flow to part of the brain is interrupted or reduced, depriving tissue of oxygen and causing brain cells to die), and muscles weakness. Resident#9 had a BIMS score of 00/15 indicating severe cognitive impairment. His Functional Abilities assessment indicated he was dependent on staff for his personal hygiene. Record review of Resident #9's care plan, dated 01/29/2026, reflected Focus: [Resident#9] is at risk for not having his needs met in a timely manner. Performance deficit is related to: CVA, contracture right hand. Goal: [Resident#9] will improve current level of function in Bed Mobility. and Personal Hygiene, through the review date. Interventions: Personal Hygiene: dependent. Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Observation and interview on 04/21/2026 at 10:59 AM revealed Resident#9 was lying in bed quietly, he had long nails on both hands, they were approximately 0.4cm in length extending from the tip of his fingers. The nails were discolored tan and the underside, and the nail beds had dark brown colored residue. Resident #9 stated he wanted his fingernails trimmed and cleaned. In an observation and interview on 04/21/2026 at 2:32 PM, RN D looked at Resident#9 fingernails and stated, they needed to be trimmed and cleaned. He stated that Nurses and CNAs were responsible for cleaning and trimming residents' fingernails. He stated that for residents with diabetes, Nurses were responsible for trimming fingernails as needed. RN D stated the risks of long, dirty fingernails included increased risk of infection and decreased quality of life. 3. Record review of Resident #22's MDS assessment dated [DATE] reflected he was an [AGE] year-old male with an admission date of 08/29/2025, diagnoses included Unspecified Dementia (memory loss), and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive communication deficit,. He had a BIMS score of 10 indicating moderate cognitive impairment. Resident #22 needed moderate assistance with personal hygiene. Record Review of Resident #22's care plan, revised on 02/18/2026 reflected Resident #22 had an ADLs self-care Performance deficit and was at risk for not having his needs met in a timely manner. Interventions: . provide shower, shave, oral care, hair care and nail care per schedule and when needed. In an interview and observation on 01/21/2026 at 01:50 PM Resident #22 revealed he was sitting in his room, he had and approximately .2 - .4 inches long and dirty fingernails extending from the tip of his fingers on both hands. He had dark residue under several of his fingernails. Resident #22 stated he liked his fingernails trimmed short and cleaned. 4. Record review of Resident #48's MDS assessment dated [DATE] reflected she was a [AGE] year-old female with an admission date of 09/24/2025, diagnoses included paraplegia (loss of function in the lower body), Hypertension (elevated blood pressure), Depression. Resident #48 had a BIMS score of 15 indicating intact cognitive function. Resident #48 was dependent on facility staff for toileting hygiene and showers. Record Review of Resident #48's care plan, revised on 10/01/2025 reflected Resident #48 had an ADLs self-care Performance deficit and was at risk for not having her needs met in a timely manner.In an observation and interview with Resident #48 on 04/21/2026 11:29 AM revealed she was lying in her bed. Resident #48 had approximately .2 - .4 inches long fingernails extending from the tip of her fingers on both hands. Resident #48 stated she likes her fingernails trimmed and the staff had not offered to trim it recently. 5. Record review of Resident #57's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 06/09/2023, diagnosis of Vascular Dementia (Decline in thinking skills). Resident #57 had a BIMS score of 02 indicating severe cognitive impairment, he needed supervision with personal hygiene. Record Review of Resident #57's care plan, revised on 04/24/2025 reflected he had an ADLs self-care Performance deficit and is at risk for not having his needs being met in a timely manner. In an observation and interview on 04/21/2026 at 11:49 AM with Resident #57 revealed he was sitting in the TV room, Resident #57 had approximately .2 - .4 inches long fingernails extending from the tip of his fingers on both hands, he stated he would like his fingernails trimmed. 6. Record review of Resident # 79's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 11/01/2024. Diagnosis of Cognitive communication deficit (A communication impairment resulting from underlying cognitive issues such as memory, attention, or executive function deficits),. Resident #79 had a BIMS score of 00 indicating severe cognitive impairment, he was dependent on staff for toileting hygiene and shower. Record review of Resident #79's care plan, revised on 04/22/2025 reflected he had an ADLs self-care Performance deficit and is at risk for not having his needs met in a timely manner. Functional limitations in range of motion. Hemiplegia/Hemiparesis secondary to a stroke. Interventions: ADL assistance required. Provide shower shave, oral care, hair care and nail care per schedule and when needed. In an observation and interview on 04/21/2026 at 10:24 AM with Resident #79 in his room revealed he had approximately .25-.50 inches long fingernails extending from the tip of his fingers on both hands, he stated he would like his fingernails trimmed. 7. Record review of Resident #87's MDS assessment dated [DATE] reflected she was an [AGE] year-old female with an admission date of 09/26/2024, diagnoses included Intracerebral Hemorrhage (Bleeding into the brain), Hypertension ((Elevated blood pressure), Cognitive communication deficit (A communication impairment resulting from underlying cognitive issues such as memory, attention, or executive function deficits). Resident #87 had a BIMS score of 15 indicating intact cognitive function, he needed supervision with shower. Record review of Resident #87's care plan, reviewed on 04/29/2025 reflected he had an ADLs self-care Performance deficit and is at risk for not having her needs met in a timely manner., review on 07/30/2025 reflected she had impaired visual function. Interventions: . Anticipate needs and meet them as able. In an observation and interview on 04/21/2026 at 10:30 AM with Resident #87 in her room revealed she had approximately .2 - .4 inches long and dirty fingernails extending from the tip of his fingers on both hands, some of her fingernails had dark residue under it. Resident #87 stated she (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would like her fingernails cleaned and trimmed. In an interview on 04/22/2026 at 11:00 AM LVN B stated that Nurses and CNAs were responsible for clipping residents' fingernails. He stated that for residents with diabetes, Nurses were responsible for trimming fingernails She stated that the expectation was CNAs provide ADL care to residents on shower days and as needed. LVN B stated the risks of long, dirty fingernails included skin tears and increased risk of infection. She stated they would document refusal of care on the progress note, if needed. An interview with RN K 04/22/2026 at 11:18 AM revealed she was the charge nurse for Hall north A. RN K stated all the nursing staff were responsible to ensure the resident's fingernails were cleaned and trimmed, nurses were responsible to trim the fingernails if the resident was diagnosed with diabetes. RN K stated she was responsible for ensuring the CNAs were doing their job, she stated she could not remember when the last time she received in- service on fingernail care. RN K stated not trimming and cleaning the fingernails put residents at risk for infections and skin tears. She stated she expected her staff to reattempt the fingernail care if a resident refused care, and to let the charge nurse know. An interview on 04/22/2026 at 12:02 PM with CNA L revealed she was working on hall north A that day, she stated CNAs were responsible to do the fingernail care for all residents except the residents who were diagnosed with diabetes. She stated the residents who had not had their fingernails cleaned and trimmed were at risk of infections, hurting themselves or others and skin tears. She stated she would reattempt the fingernail care if a resident refused care and let the charge nurse know. She stated she received in-service on fingernail care a week ago. In an interview on 04/23/2026 10:38 AM with the DON stated that the CNAs and the nurses were responsible for keeping the resident's fingernails clean and trimmed. The DON stated nurses were responsible for trimming fingernails for diabetic residents. She stated that her expectation was fingernails care to be provided as needed. She added that if a resident refused care, CNAs should report any refusals to charge nurses. The DON stated that not cleaning and trimming resident's fingernails could lead to the risk for skin tears and infection risk. She stated that as a DON of the facility, she ensured quality of life was maintained in residents by daily rounding and checking 24-hour nursing reports. Record review of the facility's Nail Care policy, dated 01/01/25, reflected nail care was necessary To provide for personal hygiene and prevent infection.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store food in accordance with professional standards for the facility's only kitchen observed for food service safety . The facility failed to ensure food items in the kitchen were appropriately covered on 04/21/2026. This failure could affect residents by placing them at risk for food-borne illness and food contamination. Findings included: Observation of the facility's dry storage on 04/21/2026 at 10:18 AM revealed about 3/4th Packet of tortillas left open exposed to air in a cardboard box. Observation of facility's walk-in refrigerator on 04/21/2026 at 10:22 AM revealed a cardboard box with about 5-6 heads of lettuce open to cold air. In an interview on 04/22/2026 at 1:30 PM with the Dietary Manager revealed stated that her expectation was that all food items in the kitchen be covered at all times. She stated that everyone working in the kitchen, including cooks, dietary aides, and herself, was responsible for ensuring food items were properly covered. She stated that the risk of not appropriately covering food items included crossˆcontamination of food and decreased food quality. She further stated that, as the Dietary Manager, she provided frequent inˆservices to all kitchen staff on appropriate food storage practices. In an interview on 04/22/2026 at 1:47 PM, [NAME] C stated that everyone working in the kitchen was responsible for ensuring that food items were properly covered at all times and not exposed to air. She stated that failure to cover food items could result in crossˆcontamination and could cause residents to become sick. He stated that if the food items were left uncovered, the should be promptly discarded. Record review of facility policy titled, Food Storage: Cold revised October 2019 reflected, It is the center policy to ensure all .frozen and refrigerated food will be appropriately stored in accordance with guidelines of FDA (Food and Drug Administration) Food Code.The Dining Services Director/Cook (s) insures that all food items are store properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination . Record review of facility policy titled, Food Storage: Dry goods revised October 2019 reflected, It is the center policy to ensure all dry goods will be appropriately stored in accordance with guidelines of FDA Food Code. Record Review of FDA Food Code 2022 reflected, . Annex 7: Model Forms, Guides, and Other Aids. Protection from Contamination . 15. Food separated and protected .This item should be marked OUT of compliance when .food is not packaged or covered during storage (unless in the process of cooling); .

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident # 9) reviewed for resident rights. The facility failed to ensure Resident # 9 was assisted with eating in a dignified manner on 04/22/26, CNA I stood while feeding the resident. This failure could place residents at risk for decreased quality of life, quality of care, and self-esteem. Record review of Resident #9's quarterly MDS Assessment, dated 03/11/26, reflected the Resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Cerebrovascular Accident (CVA) (a medical emergency where blood flow to part of the brain is interrupted or reduced, depriving tissue of oxygen and causing brain cells to die), and muscles weakness. Resident#9 had a BIMS score of 00/15 indicating severe cognitive impairment. His Functional Abilities eating: Setup or clean-up assistance. Record review of Resident #9's care plan, dated 01/29/26, reflected Focus: [Resident#9] is at risk for not having his needs met in a timely manner. Performance deficit is related to: CVA, contracture right hand. Goal: [Resident#9] will improve current level of function in Bed Mobility. and Personal Hygiene, through the review date. Interventions: Eating: set up. During an observation on 04/22/26 at 08:54 AM, Resident #9 was in bed with the head of the bed elevated, and CNA I was standing while assisting Resident #9 with his meal. Resident #9 was unable to state how he felt about staff standing during his meal. During an interview on 04/22/26 at 08:59 AM, CNA I stated she was supposed to sit next to Resident #9 while assisting with his meal today. She said she should have gotten a chair and sat while assisting because standing could make a resident uncomfortable, and lead to loss of dignity. During an interview on 04/23/26 at 11:31 AM, the DON said that all staff were responsible for ensuring resident's dignity was maintained and all staff was trained on resident rights. She said when a resident required assistance with meals, the staff should be seated to prevent the residents from being uncomfortable. Record review of a facility policy titled Resident Rights date 02/23/2016 indicated, .11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish and follow a written policy on permitting residents to return to the facility after being hospitalized for 1 resident (Resident #38) of 5 residents reviewed for transfer/discharge. The facility did not allow Resident #38 to return to the facility after evaluation and treatment at hospital ER (Emergency Room) on 04/21/26. This deficient practice could place residents at risk of being discharged and not allowed to return to the facility causing a disruption in their care and services and potential decline in health.Record review of Resident #38's discharge MDS, dated [DATE], revealed Resident#38 was an [AGE] year-old female who was admitted to the facility on [DATE] with the diagnoses including hypertension (elevated blood pressure), Asthma, Chronic Obstructive Pulmonary Disease (chronic, obstructive lung diseases with shared symptoms [shortness of breath, wheezing, cough]), and Respiratory Failure (a critical condition where the lungs cannot get enough oxygen into the blood [Type I] or cannot remove enough carbon dioxide [Type II]) .Resident #38 had a BIMS score of 03/15, which indicates that she had severe cognitive impairment. Functional ability on the MDS dated [DATE] Resident #38 was coded between 6 and 3 meaning independent to partial/moderate assistant . Functional ability on discharge for Resident #38 was not coded. Record review of Resident #38's care plan, dated 03/02/26, revealed Focus: [Resident#38] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Performance deficit is related to chronic COPD and physical debility. Goal [Resident#38] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Performance deficit is related to chronic COPD and physical debility. Interventions: ADL Assistance required Bed Mobility: independent Transfers: supervisionEating: independent Toileting: partial Ambulation: 10 ft supervision rest not attempted due to medical condition Wheelchair: independent Dressing: upper body dressing: independent lower body dressing: partial Personal Hygiene: set up Bathing: partial.Focus: [Resident#38] has the potential for falls related to chronic COPD. Goal: [Resident#38] will not sustain a fall related injury by utilizing fall precautions through next review date. Intervention: Educate [Resident#38]/family/caregivers about safety reminders and what to do if a fall occurs. Encourage socialization and activity attendance as tolerated. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Fall Risk Screening upon admission and quarterly to identify risk factors. Place the resident's call light is within reach and encourage the resident to use it for assistance as needed.Focus: Discharge Plans, LTC: [Resident#38] is in the facility for long-term care placement as a result of a continued need for the services of skilled nursing staff as evidenced by an inability to provide selfcare and discharge planning is not needed. Either the family or [Resident #38] has requested that questions regarding return to the community only be asked on comprehensive assessments. Goal: [Resident#38] and families wishes will be honored through next review date. Interventions: Observe for change in conditions that may affect long-term care goals and notify the physician and responsible party as needed. Encourage and allow [Resident#38] or family to discuss feelings and concerns regarding long-term care placement.Focus: Hospice/Terminal Prognosis: [Resident#38] has a terminal illness and is receiving hospice or palliative care. During the end-of-life process weight loss, skin breakdown, dehydration, fecal impaction, and the gradual or rapid loss of the ability to move may be unavoidable. Contact [Agency name] Hospice for any change of condition, incident/accidents. Goal: Dignity will be maintained and the resident will be kept comfortable and pain free within one hour of interventions through the next review. Intervention: Coordinate with hospice to ensure Helen's spiritual, emotional, intellectual, physical and social needs are met. Assist with ADLs and provide comfort measures as needed. Encourage participation to the extent the resident wishes to participate. Record review of Resident #38's progress notes written by RN D on 04/21/2026 at 7:00 (continued on next page)

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	455572	A. Building B. Wing	04/23/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	PM revealed resident [Family member] out to visit, they were upset about resident injuries from her fall refused to talk with hospice nurse, RN D try to talk with them, they stated were calling 911 and the police [company] came to transfer resident to hospital of family choice resident refuse to sign a AMA form resident took all resident personal belongings and stated she would not be back DON updated Dr. [primary care provider] tele health [name] (provide telehealth services, primarily specializing in mental health, therapy, and, in some cases, virtual urgent care) call update given resident was in no distress before discharge. Record review of Resident #38's EMR on 04/23/26 revealed there was no documentation of a facility physician or designee had contacted Resident#38/family member nor had the facility call the Ombudsman the help Resident#38 find a placement or help with the process of discharge. Record review of hospital record for Resident#38 revealed on 04/22/26 at 12:17 AM [hospital RN name] called Resident#38 family member, and they were trying to come get her. Called facility talk to RN G, Resident#38 left AMA per RN G and will not be accepted back at that facility. Record review of Facility AMA form revealed on 04/21/26 at 6:55 PM Resident#38 family member was presented with the AMA form, and they refused to sign it, and the form was signed by two facility staff nurses. During an interview on 04/22/26 at 10:29 AM The Administrator stated Resident #38 was taken from the facility by a family member AMA, and that was a form of discharge per facility policy, and there should be the whole process of readmission for the Resident to come back to the facility. The Administrator stated the facility did not practice Residents dumping. The administrator stated the case manager in the hospital ER did not inquire about the Resident#38 transfer to hospital that was AMA and tried to send the Resident back to the facility. He stated there was a business marketing staff from another facility that contacted the facility for Resident#38 record to admit her to their facility on 04/22/26. During a telephone interview on 04/22/26 at 10:02 AM Resident#38 family member stated they were notified on 04/21/26 of Resident#38 fall and injury, but when they came to visit Resident#38 they found she had an injury over her right eye, a swollen lips and the recommendation from the Doctor were give Tylenol and monitor the Resident. Resident#38 family member stated they only called 911 to take the Resident to ER for a head CT scan to make sure she did not have any deep injury or bone fracture from the fall she sustained the same day (04/21/26). Resident#38 family members stated the facility staff gave them a paper indicating they took her AMA but they refused to sign it, because the resident was taken by ambulance to ER. They stated they took some of the resident clothes. They stated they followed the Resident to ER, and from there they went home. They stated the ER staff contacted them and asked them to come pick up the resident because the facility will not take her back. They stated they called hospice case manger and asked her to help find a placement for Resident#38, and they could not take care of her at home. They stated Resident#38 used to live at home, at the start of this year (2026) went to hospital, and from hospital she was admitted to nursing home on [DATE], because her mental status was declining and needed nursing home care. During a telephone interview on 04/23/26 at 08:57 AM The [Agency name] hospice case manager stated, she was contacted on 04/22/26 by Resident#38 family member to find a placement for her, because she was in hospital ER and the facility would not take her back since the family member called 911 sent her to hospital ER. She stated she was in the process of sending referrals to get Resident#38 accepted to another facility. During an interview on 04/23/26 at 11:39 AM the DON stated since Resident#38 family member took her from the facility AMA it was a form of discharge. When asked if the facility followed its policies related to resident discharge, and who made the decision to discharge the resident without a notice, she refused to answer and referred this surveyor to the facility Administrator. In a follow up interview with the Administrator on 04/23/26 at 11:45 AM, the Administrator insisted that AMA was a form of discharge and the facility was willing to readmit the Resident. Attempted interview over the phone on 04/23/26 at 2:15 PM with RN G no response, called twice and left a voice message with call back number. Record review of the facility policy titled Against Medical Advice - Including Release Form revised on 01/01/2024 reflected: POLICY :It is the policy of this home that residents leaving Against (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Medical Advice will be allowed to discharge from home at their own risk.PROCEDURENotify the physician and the Director of Nursing Service that the resident or responsible party desires a discharge, which would be against medical advice.Ask the physician or designee to explain to the resident, the consequences of leaving the home against medical advice.If the resident leaves the home without permission, or without signing a release or does not return to the home after being out on pass, documentation to that effect must be made in the resident's clinical software. The Physician, Administrator And The Director Of Nursing Service Must Be Notified Immediately. In The Absence Of The Attending Physician, Contact The Alternate Physician Or Medical Director.Medications are not to be sent with the resident unless the physician approves. A telephone order to this effect must be entered into the resident's clinical software.Have the resident or the responsible party complete and sign the Release Against Medical Advice form in DUPLICATE. Refusal to sign Against Medical Advise Form is to be documented and validated by witness.One copy is given to the resident and the original is to be placed in the medical record. DOCUMENTATIONDate, EXACT time resident left home and who was accompanying resident.Notification of the physician and Director of Nursing Service.Condition of the resident and vital signs if possible, including mental status.What circumstances surrounded the incident of the resident leaving the home.If medications are released and the resident/responsible party refuses to sign the AMA form, list all medications and the amount in the nurse's notes.Any discussions with resident about leaving the home, medications and treatments, which may lead to negative outcome to resident status.If resident/responsible party refuses to sign AMA form document accordingly in the clinical software.Signature and title. Note: When appropriate, Adult Protective Services (APS) may need to be notified for follow-up after resident discharges AMA. Record review of the facility policy titled Transfer and Discharge (including AMA) with the review date 09/01/23 reflected:?Policy Statement: This facility complies with federal regulations to permit each resident to remain in the facility, and not transfer or discharge unless the following criteria is met:Fundamental Information1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the service provided by the facility.3. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident.4. The health of individuals in the facility would otherwise be endangered.5. Respite residents are discharged based upon the agreed length of stay and plan of care6. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare orMedicaid) a stay at the facility; or8. Discharge Against Medical Advise (AMA)-a. The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. The physician/P.A. or NP should be notified and encouraged to speak with the resident.b. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present.c. Notify Adult Protection Services, or other entity, as appropriate if self-neglect is suspected. Document accordingly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (100/200 hall nurses' cart) of 5 medication nurse cart reviewed for pharmacy services in that: The facility failed to ensure LVN F removed medications in unsecure containers from the 100/200 Hall nurses' cart This failure could affect residents resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications, and place residents at risk of not having the medication available due to possible drug diversion.Observation on 04/22/26 at 1:19 PM, of Nurses' Cart Hall 100/200, with LVN F revealed the blister pack for Resident #29's Temazepam 15 mg cap (controlled medication used for pain) had 2 blisters seal broken with pills still inside the broken blisters. One of the blisters had a tape over. Interview on 04/22/26 at 1:19 PM, LVN F stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blisters pack seals were broken, and she was not aware of who might have damaged the blisters. She stated it was not acceptable to tap over the broken seal. She stated the risk would be potential for drug diversion. She stated the nurses and med aides were responsible for checking the medication blister packs for broken seals during the count of narcotics, and during the change of shift. She stated when a broken seal was observed, she would waist the pill with another nurse. Interview on 04/23/26 at 8:56 AM, the DON stated she expected if a blister pack medication seal was broken the pill would be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. She stated taping over the broken blister with medication inside was unacceptable. The DON stated the risk would be potential for drug diversion and infection control issues. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADONs were supposed to check the carts daily. The DON stated the pharmacy consultant checked the carts monthly and she stated ADONs were supposed to do random checks of the medication carts for monitoring. Record review of the facility's policy titled Storage of Medications, dated 01/20/2021, revealed in part . 8. Medication Carts are routinely inspected for discontinued, Outdated, defected or deteriorated medications with worn, illegible, or missing labels. These medications are removed and destroyed in accordance with the facility policy .

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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** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 of 6 residents (Resident #9) observed for infection control. The facility failed to ensure CNA E performed hand hygiene, and proper use of gloves, while providing incontinent care to Resident #9 on 04/22/2026. These failures could place residents at risk for development of infection.Record review of Resident #9's quarterly MDS Assessment, dated 03/11/26, reflected the Resident was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of muscles weakness. Resident#9 had a BIMS score of 00/15 indicating severe cognitive impairment. Further review revealed bladder continence indwelling catheter, and bowel continence frequently incontinent. Record review of Resident #9's care plan, dated 01/29/26, reflected Focus: [Resident#9] has a urinary catheter and is at risk for urinary tract infections and injury. Urinary catheter related to chronic bladder outlet obstruction. Goal: [Resident#9] will be/remain free from catheter-related trauma and complications through next review date. Interventions: Catheter care:. Monitor for and report to the physician any signs or symptoms of a urinary tract infection such as pelvic pain, burning with urination, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, urinary frequency, foul smelling urine, fever, chills, altered mental status, changes in behavior, or changes in eating patterns. Observation on 04/22/26 at 1:30 PM, reflected CNA E and CNA H entered Resident #9's room and washed their hands, put on gown, and gloves. Both CNAs uncovered Resident#9. There was a bedside table dropped with towel and had on the top: box of gloves, a bottle of hands sanitizer, plastic bag with loose clean wipes. CNA E positioned at the right side of the bed unfastened Resident#9 brief, then proceeded to clean the Resident. CNA E cleaned Resident#9's front area starting across his pubic area, and both groin area using one wipe per stroke. CNA E sanitized her gloved hands (Sanitized her hands with gloves on). CNA E cleaned Resident#9 indwelling catheter tubing starting from the insertion site out using one wipe at a time. CNA E with the help of CNA H turned Resident#9 to his right side. CNA E sanitized her gloved hands, cleaned Resident#9 buttocks area, folded the brief and push it under Resident#9. The brief was dirty from resident body sweat. CNA E sanitized her gloved hands, got a clean brief put it under Resident#9. Both CNAs turned Resident#9 on to his back. CNA H removed the dirty brief put it in the trash can. CNA H changed gloves with hands hygiene. CNA E finished putting the brief on Resident#9. Both CNAs pulled the Resident up in the bed and covered him. Both CNAs removed their gowns and gloves, completed hands hygiene and exited the room. In an interview on 04/22/26 at 1:47 PM, CNA E stated she was supposed to change her gloves with hand hygiene after she cleaned the resident before applying the clean brief. CNA E stated she was not supposed to sanitize her gloved hands but change gloves with hands hygiene. CNA A stated not following proper hand hygiene and infection control policy could lead to cross contamination and development of infection for residents. In an interview on 04/23/26 at 11:31 AM, The DON stated during care the staff was to use hand sanitizer or wash hands if they were physically soiled. The DON stated the staff was expected to change gloves with hands hygiene, and not to sanitize gloved hands. She stated during incontinent care the staff was supposed to change gloves and use hand sanitizer when taking off the dirty brief before applying the clean one. The DON stated proper hands hygiene and following proper infection control policy was to be followed to prevent the development of infections for residents and staff. Review of the facility policy dated 11/12/2017 and titled Hand Hygiene reflected, Staff involved in direct resident contact will perform proper hand hygiene procedure to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene indicated and will be performed under condition listed.before applying and after removing personal protective equipment (PPE), including gloves. When, during resident care, moving from a contaminated body site to a clean body site. When in doubt. The use of gloves does not replace hand washing. Wash hands after removing gloves.