STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676029	A. Building B. Wing	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on observation, interview, and record review, the facility failed to ensure residents had the right to make choices about aspects of his or her life in the facility that are significant to the resident for 2 (Residents #11, and #13) of 14 residents reviewed for resident rights. The facility failed to accommodate Resident #11 and #13's preference for showers instead of a bed bath. This failure placed residents, who need assistance with activities of daily living (ADLs), at risk of not having the right to make choices related to their life in the facility. Findings included: Record review of Resident #13's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses which included, chronic obstructive pulmonary disease and morbid obesity. Record review of Resident #13's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15. She was totally dependent on two staff for bathing. She was five feet one inch tall and weighed 260 pounds. Record review of Resident #13's un-dated Care Plan, indicated the resident had impaired range of motion to both of her upper and lower extremities. She required one staff participation in bathing. The resident was to receive a shower on Tuesdays and Saturdays, per her request. Record review of Resident #13's Skin Assessment - Shower Sheets, indicated: -09/20/22 - the resident received a bed bath and had no documented skin issues. -09/22/22 - the resident received a bed bath and had no documented skin issues. -09/27/22 - the resident received a bed bath and had no documented skin issues. -09/29/22 - the resident received a bed bath and had no documented skin issues. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-09/20/22 - the resident received a bed bath and had no documented skin issues. -10/04/22 - the resident received a bed bath and redness was documented under the resident's right breast and underarm. -10/11/22 - the resident received a bed bath and redness was documented under the resident's right underarm. Record review of Resident #13's electronic medical record for bathing documentation, indicated: -10/15/22 - the resident did not receive a shower. She received a full-body bath. -10/20/22 - the resident did not receive a shower. She received a full-body bath. -10/22/22 - the resident did not receive a shower. She received a full-body bath. -10/27/22 - the resident did not receive a shower. She received a sponge bath. In an observation and interview on 10/26/22 at 1:22 PM, Resident #13 was in her room sitting in her wheelchair. She requested showers, but staff continue to give her a bed bath instead. She said the staff tell her they don't have time, or they will give her a shower, but then they don't. She said it has been about a month since she has had an actual shower and her hair was not clean. The resident's hair was short and curly, some of the curls appeared clumped together from not being shampooed. She said her bath schedule was Tuesdays, Thursdays, and Saturdays on the 2:00 PM - 10:00 PM shift. In an interview on 10/26/22 at 4:04 PM, Resident #14 said she felt bad for her roommate, because Resident #13 has asked for a shower instead of a bed bath, but staff always have some excuse, like they will do it later and then say it's too late to give her one. She said staff don't want to get Resident #13 up with the lift, so they say they don't have enough help. She said she does not know how long it's been since Resident #13 had an actual shower. In an observation and interview on 10/27/22 at 6:38 PM, Resident #13 was in bed. She said she did not get her shower or even a full bed bath this evening. She said she got a little wipe down of her breasts and private area. She said her gown was changed but her hair was still, nasty. The resident's hair appeared greasy, and the curls were stuck together. In an interview on 10/27/22 at 6:40 PM, CNA A, who was working Resident #13's hall, said she was agency staff and did not know which residents on the hall were scheduled for a bath today (10/27/22) on her shift (2:00 PM - 10:00 PM). She said the other aide on the hall, CNA B, was in charge of showers. In an interview on 10/27/22 at 7:00 PM, CNA B said she had been working at the facility about a month; she said she did receive orientation and the shower schedule was posted at the nurses' station. She said realistically she could not get all the showers done on her shift that needed to be done. She said she had been giving residents wipe downs, not bed baths or showers, to save time. She said one resident on the hall got a true bed bath this evening (10/27/22), and the others were wiped down. She said the bathing documentation was in the electronic medical record only, and not on paper shower sheets. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was readmitted to the facility on [DATE] with diagnoses which included, diabetes and morbid obesity. Record review of Resident #11's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15. She was totally dependent on one staff for bathing. She was five feet one inch tall and weighed 253 pounds. Record review of Resident #11's un-dated Care Plan indicated the resident was at risk for an activities of daily living self-care deficit related to morbid obesity. She was to be provided a sponge bath when a full bath or shower could not be tolerated. Record review of Resident #11's Skin Assessment - Shower Sheets, indicated: -09/20/22 - the resident received a bed bath and had no documented skin issues. -09/27/22 - the resident received a bed bath and had no documented skin issues. -10/06/22 - the resident received a bed bath and had no documented skin issues. -10/13/22 - the resident received a bed bath and had redness under her breasts, abdominal fold, and groin. -10/27/22 - the resident received a bed bath and had no documented skin issues. In an interview and observation on 10/28/22 at 10:47 PM, Resident #11 was in bed; she appeared to be well groomed, and her hair had been done. She said she had begged staff for a shower but only received what she would call a spit bath. She said the aides give her excuses of why she cannot receive a shower that included, she can't stand up so they can't do a shower, it would be too hard on their backs, it's too hard to get her into the wheelchair with the lift, they don't have time, and they don't have towels. She said she feels they just don't want to fool with giving her a shower. She said she does not feel there is any oversight for the aides. She said sometimes the aides just use wipes to give her a spit bath, and don't use soap and water. Record review of the Resident Council Minutes dated 08/08/22 indicated the residents reported the aides needed to make sure the residents were getting their showers. Record review of the Resident Council Minutes dated 09/13/22 indicated the residents reported they were only getting showers once a week. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/28/22 at 11:12 AM, the DON said she did not know if there was a reason Resident #13 was only getting bed baths; she said if the resident had good trunk control, she could be showered, but she did not know if that was case for Resident #13. She said she would find out. She said she was not aware staff was just wiping the residents down and not giving them a proper bed bath because the aides documented the residents were provided a bed bath. She said if residents were safe to have a shower, they should have a shower. She said Resident #11 was safe to have a shower. She said she was not sure if the facility had a shower gurney, reclining shower chair, or bariatric shower chair, to ensure the residents who wished to have a shower were accommodated, but she would find out. She said the aides were to document in the electronic medical record and on paper shower sheets. She said the paper shower sheets let the nurses know if the resident had any skin issues. She said the aides had been inconsistent with the documentation on both the electronic medical records and the shower sheets. She said the ADON who was monitoring the showers and bed baths quit about a month ago. She said she tried to monitor but it was hard to keep up because she did not have an ADON, at this time. She said it was important to give the residents a shower if they wanted one because it was the residents' right to have a choice. In an interview on 10/28/22 at 12:40 PM, the DON said the facility did not have any specialized shower equipment for residents with poor trunk control or bariatric residents. Record review of the facility's un-dated Accommodation of Needs policy indicated the resident had the right to reside and receive services in the facility with reasonable accommodation of needs and preferences, except when the health or safety of the individual or other residents would be endangered. The facility will evaluate the resident's needs and make reasonable accommodations to the extent possible.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on interview and record review, the facility failed to immediately notify the resident representative regarding a significant change in the resident's psychosocial status, for one resident (Resident #8) of 14 residents reviewed for changes in condition. The facility did not notify Resident #8's responsible party when she tested positive for COVID-19 and had a room change. This failure could place all the residents residing in the facility at risk of their responsible parties not being aware of room changes and changes in the residents' conditions. Findings included: Record Review of Resident #8's Admission Record dated 10/28/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with a diagnosis of stroke. The resident was not her own responsible party. Record Review of Resident #8's admission MDS dated [DATE] indicated the resident's cognition was not assessed. Record Review of the Grievance Log, indicated on 09/14/22 the facility received multiple complaints, from residents' responsible parties regarding not being notified of room changes. The resolution was for the DON to address the issue and ensure the calls were being completed prior to the room changes taking place. The log indicated on 09/14/22 the grievances were resolved. Record Review of Resident #8's Census Record indicated she changed rooms on 09/23/22. Record Review of a Nursing Note dated 9/28/2022 at 7:14 PM, indicated the resident continued on isolation for COVID. Record Review of Resident #8's Progress Notes from 09/23/22 - 10/29/22 did not indicate any documentation the resident's responsible party was notified of her COVID positive status or room change on 09/23/22. In an interview on 10/24/22 at 3:52 PM, Resident #8's responsible party said she was not made aware of the resident's positive COVID status or room change. She said she arrived at the facility, she was not sure of the date, to find the resident had been moved and was in isolation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/28/22 at 11:30 AM, the DON said an agency staff nurse did not notify Resident #8's responsible party of her COVID positive status, but the responsible party visited the next day and was aware. She said she did not believe the resident had a room change but when looked the in the electronic medical record, the resident did have room change on 09/23/22, when she tested positive for COVID. She said the Admissions Coordinator, or the Social Worker were usually responsible for room change notifications. She said it was important to notify Resident #8's responsible party because the resident was not her own responsible party and the responsible party needed to know about any changes. In an interview on 10/28/22 at 11:57 AM, the Admissions Coordinator said in Resident #8's case, because the resident was COVID positive, it would have been up to the nurse to immediately notify the resident's responsible party of the room change. She said she only assists with notification for planned room changes. Record Review of the facility's un-dated Resident Rights policy indicated it is the policy of this facility to notify the resident, his/her responsible party of changes in the resident's condition and/or status. The nurse supervisor will notify the resident's responsible party when: there is a need to alter the resident's treatment significantly, and there is a change in the resident's room assignment.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on observation, interview and record review, the facility failed to provide a safe environment free from abuse for 4 (Resident #3, #12, #13, and #14) of 14 residents reviewed for abuse. The facility failed to protect and assure the safety of Residents #3, #12, #13, and #14 when verbal abuse was reported on 10/19/22 and 10/20/22. Resident #3 was verbally abused by staff (recorded on video footage) and Residents #12, #13, and #14 said they were verbally abused by CNA E. These failures placed residents, who resided in the facility, at risk of abuse, and mental anguish caused by fear. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 10/24/22. While the IJ was removed on 10/29/22, the facility remained out of compliance at a severity level of actual harm, and a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective actions. Findings included: In an interview, with the DON and Administrator on 10/20/22 at 9:15 AM, the DON said staff found a camera hidden in a Halloween decoration in Resident #3's room. The DON said she received the call from staff on 10/19/22 round 2:00 AM staff regarding the camera. She said the staff texted her a picture of the Halloween decoration and the camera in it. The DON had staff unplug the camera because it was plugged into an un-approved extension cord. The DON said she was not surprised to find the hidden camera in the room, because the resident's family disagreed with an abuse investigation, conducted on 09/15/22, that did not reveal any abuse. The Administrator said Resident #3's family did not contact the facility regarding the camera, and they had not reported any concerns. The Administrator said he was going to have the Social Worker contact Resident #3's family regarding the camera to get to sign an Electronic Monitoring Form, but he did not know if the Social Worker had contacted them yet. The Administrator and DON said they had not heard anything from the family regarding the camera and no abuse or care issues had been reported to them. On 10/20/22 at 10:43 AM, a video was received from Resident #3's responsible party. The video was recorded on 10/19/22 at 1:58 AM, it showed a female staff person (LVN C) taking Resident #3 to his room in his wheelchair. She pulled him backwards into the room in his wheelchair. LVN C, once in the resident's room, she faced the resident and said, there you go, she pointed her right finger at the resident and said, you stop it, then she pulled her right hand in a fist, the fist does not touch the resident, but her left hand came down on something that cannot be seen in frame and a pop was heard, at the same time LVN C was heard again saying, you stop it, the resident told LVN C, fuck you, LVN C turned towards the door and it appeared the resident attempted to continue the altercation, but the images are obscured by the Halloween decoration. LVN C asked the resident, are you fighting me?', then she said angrily, at the door, you stay there and then shuts the door. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 11:08 AM, a video was received from Resident #3's responsible party, it was recorded on 10/16/22 at 12:09 AM, it showed a male staff person (CNA D) enter the resident's room the resident was in bed. CNA D picked up the bed sheet but the resident tugs on the sheet, and CNA D lets go of the sheet. The resident says, get off me, you mother fucker, and throws the sheet at CNA D. CNA D walked to the foot of the resident's bed and told he resident, I'm going to kick your ass. The resident responds but his response could not be understood on the video. In a telephone interview on 10/20/22 at 11:25 AM, Resident #3's responsible party said she had a previous complaint regarding staff treatment of the resident, which she believed to be abuse, that was investigated and found to be unsubstantiated on 09/15/22. She said she disagreed with the findings of the facility's investigation and felt the facility was covering up abuse and/or mistreatment of Resident #3. She said a former employee, Housekeeper F, informed her she believed Resident #3 was being mistreated and told her she should place a camera in his room, because reports to the Administrator and DON of mistreatment were not being acted on. She said Housekeeper F was terminated for telling her about the mistreatment of Resident #3 for not reporting the abuse allegations to the Administrator. She said based on her experience with the facility; she decided to place a hidden camera in the resident's room. She said the resident did not have a roommate and it was not violating any other resident's privacy. She said when she saw the abuse recorded on the camera, she came to the facility to check on Resident #3 but did not alert the facility to the hidden camera. She said the videos showed Resident #3 was being abused by the staff. She said on 10/19/22 around 2:00 AM she could see on the camera that staff discovered the camera was in the room. She said she could see several staff members looking at the camera before it was unplugged. She said, staff from the facility just called her a few minutes ago, she did not know who, to tell her the camera was not approved and that she would need to sign a consent for its use. She said she asked the person that called if they were concerned about what the camera revealed and the person did not answer the question, and just told her she needed to sign the form in order for the camera to be approved. She said she informed the staff she had already removed the camera from the room and took it home. She said no one reached out to her about the camera prior to the phone call today, after the investigator entered the facility. She said there was one additional video that she had not sent yet, but she would send it. She said she wanted to move the resident to another facility but had to wait for his Medicaid to be approved before her facility of choice would accept him. She said she feels stuck because she cannot move him but cannot trust that he won't be harmed at the facility. On 10/20/22 at 12:04 PM, the Administrator and DON were shown the above videos for staff identification purposes. They said both videos showed abuse of Resident #3. They identified LVN C as the staff in the first video and CNA D in the second video. The DON said there had been no reports or concerns regarding the employees' care and treatment of the residents. She said the employees would be notified and suspended pending the outcome of the investigation. On 10/20/22 at 12:38 PM, the third and final video was received from Resident #3's responsible party, it was recorded on 10/13/22 at 7:36 PM, it showed two staff (LVN C and CNA E) providing care to the resident while he was in bed. LVN C was at the head of the resident's bed encouraging him to allow care but he was saying don't do that, CNA E was observed getting some wipes, she joined LVN C at the resident's bedside. The resident could be heard saying, God dammit, at that point, LVN C's left hand went up with her hand open, while she leaned forward and told the resident to stop it, she does not hit the resident, but it appeared to be a gesture like she was going to slap the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 12:45 PM, the Administrator and DON said the third video was LVN C who appeared to raise her hand to Resident #3. They said the other staff was CNA E. Record Review of Resident #3's Admission Record dated 10/20/22 indicated the [AGE] year-old male resident was readmitted to the facility on [DATE] with diagnoses which included dementia and major depressive disorder. Record Review of Resident #3's quarterly MDS dated [DATE] indicated the resident had short and long-term memory problems. He was severely cognitively impaired. He had no behaviors. Record Review of Resident #3's un-dated Care Plan indicated he had behaviors which included, combativeness, physical and verbal aggression with staff. The interventions included to provide physical and verbal cues to alleviate the resident's anxiety and give positive feedback. If the resident resists care, reassure the resident, leave, and return 5-10 minutes later and try again. In an observation on 10/20/22 at 1:34 PM, Resident #3 was propelling himself in his wheelchair. He was not able to answer any direct questions. In an interview on 10/20/22 at 2:44 PM, CNA E watched third video. She said she did not think LVN C was raising her hand to the resident, but she was not paying attention, at the time. She said she thought maybe LVN C was reaching to roll the resident over. She said she had never seen any staff being abusive or mistreating the resident. She said around 10:00 PM yesterday, 10/19/22, the resident's responsible party asked her if she was aware there had been a camera in the room. She said she told her she was not aware. She said the resident's responsible party told her she put the camera in the room because the resident was being abused by the staff. She said she told the resident's responsible party she did not believe that would happen at the facility. She said she did not tell anyone the resident's responsible party reported the resident had been abused. She said LVN C overheard her talking with the resident's responsible party and knew about the allegation. She said she was supposed to inform the Administrator of any abuse allegations; however, she did not report it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/20/22 at 4:21 PM, with the DON present, LVN C said on 10/19/22 Resident #3 was awake around 2:00 AM and staff got him up in his wheelchair and assisted him to the nurses' station for monitoring. She said the resident became combative, threw things off the nurses' station, and tried to hit, kick and bite staff. She said the video showed her pulling him in his room backwards because he was being combative. She said her right hand was in a fist and pulled back because she thought he was going to grab or bite her. She said she did not make physical contact with the resident. She said the slap sound on the video was when she slapped her own leg. She said she did not feel she was being abusive to the resident. She said she was speaking loudly but it was because the resident was hard of hearing. She said she did tell the resident to stay in his room and closed the door, but it was only for approximately 5 minutes until she could get a CNA to assist her to put the resident back to bed. She denied ever threatening or hitting the resident. She said staff discovered the camera after 2:00 AM and let the DON know. She said she did hear CNA E speaking to Resident #3's responsible party but she did not hear the allegation of abuse. She later said that maybe CNA E told her something about the allegation, but she did not remember, and she was busy at the time. She said she would report abuse to the DON, she was not aware the Administrator was the Abuse Coordinator. She said she should not have raised her voice to the resident. She said Resident #3 tried to kick her as she was leaving the room and that was why she asked him if he was trying to fight her. She said she never raised her hand to hit the resident. The DON informed her she was suspended pending the outcome of the investigation and was not to return to the facility until further notice. In a telephone interview on 10/20/22 at 3:35 PM, with the DON present, CNA D said if the resident was too combative, he was supposed to get another CNA to assist him, but he did not feel the resident was being that aggressive on 10/16/22. He said the resident tugged on the sheet and he let go, he said he did not know, at the time, the camera was in the room. He said he did tell the resident he was going to kick his ass because he was under pressure, but he would not have physically hurt the resident because it was not in his heart to do so. He said what he said was abuse. He said he was frustrated and tired of the resident being so mean. He said he had not seen or heard any other staff be mean or aggressive with the resident. He said he apologized dearly for his actions and would never hurt the residents. The DON informed him he could not report to work and was under investigation. In an interview on 10/20/22 at 5:00 PM, the Administrator said staff knew he was the Abuse Coordinator because they had all been in-serviced and it was posted in the facility. He said it was his expectation that staff would notify him immediately of any allegations of abuse or mistreatment. He said the facility would investigate, and notify the police and State Agency. In a telephone interview on 10/20/22 at 5:42 PM, Resident #3's responsible party said on 10/19/22 she spoke to CNA E regarding her abuse concerns and why she installed the camera. She said she asked if she could show CNA E the videos of the abuse, but the CNA told her her eyesight was not good and she did not think she could see the videos. She said she believed CNA E did not wish to see the videos because she would have to report the abuse to the Administrator. She said it further showed how staff wanted to turn a blind eye to reports of abuse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 10/20/22 at 6:07 PM, Former Housekeeper F said she was the housekeeper on Resident #3's hall and she felt staff were not caring for the resident appropriately. She said she believed the staff were not assisting him with meals, were abrupt and discourteous to him. She said she spoke with the Administrator and DON about her concerns, but she believed they were not addressed. She said she spoke to the resident's responsible party regarding her concerns and told her she should put a camera in the resident's room because she believed he was being mistreated by staff. She said when the facility found out she told the resident's responsible party she suspected abuse, the DON called her on 09/10/22, to question her if she knew who the Abuse Coordinator was, and she told her it was the Administrator. She said the Administrator wanted to meet with her in the next day 09/11/22, in his office, but she did not meet with him for fear she would be terminated. She said her last day of employment was 09/11/22. She said the facility's inaction regarding allegations made employees not want to report anything. She said other facility employees knew about things but don't report it. She would not give the investigator the names of the other employees. She said there were employees, still working at the facility, who abused residents. She named CNA E, as an abuser. In an observation on 10/24/22 at 9:30 AM, Resident #3 was propelling himself in his wheelchair. He was smiling and appeared to be in a good mood. He was not able to answer questions appropriately. In an interview on 10/24/22 at 9:43 AM, the Administrator and DON said the videos showed, based on their investigation, verbal abuse, and included intimidation and seclusion. They said they were going to terminate LVN C and CNA D for abuse. They said CNA E would be terminated for not reporting the allegation of abuse to the Administrator. The Administrator and DON said Former Housekeeper F never reported any abuse, neglect, or mistreatment of Resident #3 to them. The Administrator and DON said in-service training was provided orally and written for all staff on all three shifts, after the abuse allegation regarding Resident #3 on 09/15/22. On 10/24/22 at 12:43 PM the Administrator and DON were informed of an Immediate Jeopardy. On 10/25/22 at 3:58 PM Safe Surveys (interviews with residents regarding abuse and/or mistreatment) were received from the Administrator. On 10/25/22 at 4:18 PM the Immediate Jeopardy Plan of Removal was accepted. In an interview on 10/26/22 at 10:04 AM, the Social Worker said Medical Records had completed Safe Surveys with residents on 10/20/22. Record Review of the Safe Surveys, provided by the Administrator, on 10/25/22 at 3:58 PM, did not include any completed by Medical Records. Record Review of the Resident Council Minutes dated 10/17/22 indicated resident said they needed more customer service and respect from the staff. No staff was named and the number of residents who voiced this was not identified. In an interview on 10/26/22 at 10:27 AM, the AD said the Resident Council did bring up, in the meeting on 10/17/22, that they would like staff to be more respectful, but no abuse was alleged. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/26/22 at 11:05 AM, Medical Records said she conducted safe surveys on 10/20/22. She said during the surveys on 10/20/22, Resident #13 said CNA E yelled at her and was pointing her finger at her so close to her she thought the aide was going to hit her, but she did not. She said Resident 13's roommate, Resident #14 said she put on the light again for a different reason, to ask a question, and CNA E yelled at them again and stated, why are you on the light again? What's your problem? I was just in here!. She said Resident #14 was the Resident Council President and told her that they just tried not to bother CNA E after that. She said Resident #14 told Resident #13 they needed to speak up to get it to stop. She said Residents #13 and #14 told her they were verbally abused by CNA E. She said the interviews were between 9:00 AM -11:00 AM on Thursday, 10/20/22. She said she told the Administrator and DON immediately on 10/20/22. She said the residents told her the verbal abuse occurred on Monday, 10/17/22 on the 2:00 PM - 10:00 PM shift. She said, after she reported the allegation of abuse to the Administrator and DON, she interviewed Resident #12 on 10/20/22 between 11:00 AM -12:00 PM and the resident told her CNA E had verbally abused her too by yelling at her. She said once again she immediately informed the Administrator and DON of the verbal abuse allegation on 10/20/22. On 10/26/22 at 12:10 PM the investigator sent the Administrator an email requesting any additional safe surveys and if the facility had any new allegations of abuse. Record Review of Resident #13's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses which included, chronic obstructive pulmonary disease and bipolar disorder (a mental illness). Record Review of Resident #13's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). In an observation and interview on 10/26/22 at 1:22 PM, Resident #13 was in her room in her wheelchair. She said on 10/17/22, her roommate, Resident #14, had the call light and CNA E came in the room and was screaming, upset, that the call light was on. She said CNA E came over to her while she was in her bed and was screaming and pointing her finger so close to her; she was afraid she was going to hit her. She said CNA E was mad that her roommate had turned on the call light. She said she was shocked, she felt threatened and scared by CNA E's outburst. She said she later, the same evening, wanted to just ask a question, she put the call light on, and CNA E came in yelling again and asked why they were on the light again after she had just been in there. She said CNA E verbally abused her on 10/17/22. She said the only person she told, about the abuse, was the Medical Records person on 10/20/22. Record Review of Resident #12's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses of mild cognitive impairment, mild intellectual disabilities, depression and, the need for assistance with personal care. Record Review of Resident #12's quarterly MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS score of 10 (a score of 8-12 indicated moderate cognitive impairment). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 1:46 PM, Resident #12 was in her wheelchair. She said about two or three weeks ago, CNA E came in her room and was going to assist with her incontinent care. She said CNA E started yelling at her, saying the resident could help more with the care. She said she was unable to physically help more, and she started crying. She said she was verbally abused by CNA E and was a little scared of her. She said it was on a weekend, and she told a lady working the 500 Hall, she did not know the lady's name, and the DON was called. She said she told the DON what happened with CNA E. She said the DON told her they would do some additional training with staff. She said she felt like she received the silent treatment from CNA E after she reported her. She said she reported the incident again on 10/20/22 to the Medical Records person. At 10/26/22 at 2:41 PM, there was no response from the Administrator regarding the email sent at 12:10 PM. In an interview on 10/26/22 at 2:58 PM, the Administrator said Medical Records conducted some Safe Surveys on 10/20/22. He said she did not notify him of the verbal abuse allegations reported by Residents #12, #13, and #14. He said staff conducting the Safe Surveys were told to immediately report any allegations of abuse and/or mistreatment to him immediately. He said he would look for the Safe Surveys conducted by Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 PM, the DON said she was not aware of the new allegations regarding CNA E. She said she was not contacted on a weekend regarding an incident between Resident #12 and CNA E. She said she would immediately tell the Administrator of any allegations regarding abuse. She said CNA E was terminated on Monday, 10/24/22 for not reporting Resident #3's responsible party's allegation of abuse to the Administrator. Record Review of Resident #14's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was readmitted to the facility on [DATE] with diagnoses which included mild cognitive impairment and anxiety. Record Review of Resident #14's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 4:04 PM, Resident #14 was in bed in her room. She said she had been the Resident Council President about a month. She said, in the Resident Council Meeting in October 2022 it was discussed how the staff were speaking to the residents, at times. She said the residents perceived some of the staff to be snotty and argumentative, at times, like when a resident needed something the staff acted like they were doing the resident a favor instead of the fact that the staff worked for the residents. She said this was discussed in the council because staffs' attitudes towards the residents were getting worse not better. She said Medical Records came in and asked her, last week on 10/20/22 about her treatment in the facility. She said she told her about an incident on Monday 10/17/22 around 5:00 PM, she requested to be transferred from her wheelchair to bed and provided incontinent care. She said CNA E told her go to room and get in position. She said she followed instructions and waited over an hour and then put the call light on. She said CNA E came into the room yelling and screaming that the resident should not have put the call light on and that she had to just wait her turn for assistance. She said she told CNA E she was going to report her, and CNA E told her to go ahead because she did not have to answer to the resident. She said CNA E was screaming over her and pointing her finger. She said CNA E then went to her roommate's (Resident #13) side of the bed, the roommate was in bed, CNA E was standing over Resident #13, still yelling, and pointing her finger but was directed at her (Resident #14) and not the roommate (Resident #13). She said Resident #13 became afraid CNA E was going to hit her and Resident #13 started crying. She said she told Resident #13 not to cry because CNA E was mad at her (Resident #14). She said CNA E left the room, and Resident #13, who does not cuss, said Holy Shit!. She said about an hour later, the same evening, Resident #13 just wanted to ask a question, so she put the call light on, and CNA E came in the room screaming again. She said CNA E asked them What is your problem why is the call light on again?. She said Resident #13 apologized and said she just wanted to ask the AD something. She said she had been a resident at the facility for 5 years and CNA E had always had a temper. She said CNA E had an attitude like she was invincible because nothing ever happened to her, and she felt like she would not get fired. She said CNA E had always had a bad temper, but it had never been like this before. She said she did not tell anyone about the incident until the Medical Records person asked her about abuse on 10/20/22. She said she was verbally abused and intimidated by CNA E on 10/17/22. In an interview on 10/26/22 at 4:47 PM, the DON and the Clinical Resource RN said Medical Records had the Safe Surveys dated 10/20/22, on her person, for Residents #12, #13, and #14. She said Medical Records reported them verbally to the Administrator on 10/20/22 but did not give him the forms. They said the Administrator and Medical Records were suspended pending the outcome of the investigation. Record Review of Safe Surveys dated 10/20/22, not timed, indicated the question, Do you feel that you have been intentionally injured by a team member? -Resident #12 - verbal abuse -Resident #13 - verbal abuse with violently yelling and afraid CNA E would hit her on Monday (10/17/22) -Resident #14 - verbally abused with attitude - CNA E (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review revealed Medical Records completed the three above Safe Surveys again on 10/20/22, not timed, and all three residents' answers to Do you feel you have been intentionally injured by a team member? were changed to, No. In an interview on 10/27/22 at 10:02 AM, the Clinical Resource RN and DON said the facility began in-services with all staff on the types of abuse, with a written quiz. The DON was made the Abuse Prevention Coordinator. The facility began interview with staff to see if any abuse allegations had been reported to the Administrator that were not acted upon. The facility began a root cause analysis. She said the Safe Surveys conducted on 10/20/22 with Residents #12, #13, and #14 revealed verbal abuse by CNA E. The DON said CNA E worked on 10/21/22, after the allegations of verbal abuse were reported to the Administrator on 10/20/22. She said CNA E did not work after 10/21/22. She said CNA E was terminated on 10/24/22 for not reporting the allegation of abuse made by Resident #3's responsible party, but not related to the allegations of verbal abuse. Record Review of CNA E's time sheet dated 10/27/22 indicated she worked on 10/21/22 from 2:24 PM - 9:48 PM, 7.4 hours. Attempts were made to interview CNA E on 10/28/22 at 5:23 PM, 7:24 PM, and 10/29/22 at 12:19 PM, there was no answer to the phone call and messages, a text was also sent on 10/29/22 at 12:20 PM requesting an interview, no return call was received prior to the exit on 10/29/22 at 1:00 PM. In a telephone interview on 10/27/22 at 5:26 PM, Medical Records said she told the Administrator immediately about each of the allegations of verbal abuse on 10/20/22. She said she told him after each allegation was made. She said the DON was also present, during the discussion with the Administrator. She said the administrator told her to shred Resident #12, #13, #14's Safe Surveys that revealed verbal abuse. She said he told her State was not looking at verbal abuse as being intentionally injured. She said the Administrator, then gave her new forms to complete with the same residents again. She said on 10/26/22, after the investigator asked about the Safe Surveys, she got the three original Safe Surveys for Resident #12, #13, and #14 out of the shred bin to give to the Administrator. She said the Administrator understood on 10/20/22 Residents #12, #13, and #14 had alleged they were verbally abused by CNA E. In an interview on 10/27/22 at 5:41 PM, the DON said she was not involved in the conversation regarding the abuse, as stated above, on 10/20/22. She said she was not aware of abuse being reported on the three residents (Residents #12, #13, and #14) in question. In a telephone interview on 10/27/22 at 5:45 PM, the Administrator said DON was not in the room when Medical Records discussed the verbal abuse allegations. He said Medical Records did notify him on 10/20/22 of the verbal abuse allegations. He said with everything going on the verbal abuse allegations did not cross his mind again. He said yesterday (10/26/22) Medical Records did get the Safe Surveys out of the shred bin, but he did not tell her to shred them. He told her to set them aside in his office. He said he did ask her to conduct new Safe Surveys on Resident #12, #13, and #14 because he did not believe verbal abuse was applicable to the question, Do you feel that you have been intentionally injured by a team member?. He said he was aware of the facility abuse policy and reporting requirements. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety related to the verbal abuse from CNA E and just a combination of things. She said she might need an increase in her anti-anxiety medication. Record Review of the facility's Abuse: Prevention of and Prohibition Against dated October 2022 indicated verbal abuse included the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representative, or within their hearing distance, regardless of their [NAME], ability to comprehend, or disability. Prevention included - all staff, residents and visitors are encouraged to report incidents and grievances without the fear of retribution. Supervising staff to identify and correct any inappropriate or unprofessional behaviors. Identifying, correcting, and intervening in situations in which abuse is more likely to occur. Investigation included - all identified events are reported to the Administrator immediately. After receiving the allegation, during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. Protection included - immediately removing the employee from the care of any resident when an allegation of abuse is reported. Reporting included - all allegations of abuse she be reported immediately to the Administrator. Allegations of abuse will be reported to the appropriate State Agency in the applicable timeframes, as per the policy and applicable regulations. The Administrator and DON were notified of the Immediate Jeopardy on 10/24/22 at 12:43 PM, a Plan of Removal was requested and the Immediate Jeopardy template was provided. The Plan of Removal was accepted on 10/25/22 at 4:18 PM. Review of the Plan of Removal included: Immediate Action: 1. Medical Director / Resident's physician notified of IJ (Immediate Jeopardy) by the Administrator on 10/24/22 at 1:58 PM via phone. 2. In-service with quiz was started on 10-24-22 for employees, educated by Administrator, Clinical Resource, or Director of Nursing. Quiz and Inservice to be completed by all staff by end of day 10-25-22. Agency staff will be required to be in-serviced and quizzed prior to starting their shift on the floor. The in-service will include: a. Types of abuse with definitions, b. Contact and name of Abuse Coordinator and Grievance Coordinator, c. Timeframes for reporting, and the d. Seven components of abuse policy, which are: i. Screening - background checks on employee ii. Training - on hire, with any allegation of ANE, and annually iii. Prevention - identify, correcting, and intervening to ensure safe environment (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	iv. Identification - identifying different types of abuse v. Investigation - complete and through investigative process and documentation of [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse of residents for 4 (Resident #3, #12, #13, and #14) of 14 residents reviewed for abuse. The facility failed to implement a policy and process for immediately investigating, protecting the residents, and reporting allegations of abuse when: 1. Resident #3's responsible party made allegations of abuse to CNA E on 10/19/22 and she did not report it to the Administrator and the facility did not investigate or implement measures to protect the resident from further abuse; and 2. Resident #12, #13, and #14 reported on 10/20/22 that CNA E verbally abused them, and the facility did not investigate or implement measures to protect the residents from further abuse. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 10/24/22. While the IJ was removed on 10/29/22, the facility remained out of compliance at a severity level of actual harm, and a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective actions. Findings included: Record Review of the facility's Abuse: Prevention of and Prohibition Against dated October 2022 indicated verbal abuse included the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representative, or within their hearing distance, regardless of their [NAME], ability to comprehend, or disability. Prevention included - all staff, residents and visitors are encouraged to report incidents and grievances without the fear of retribution. Supervising staff to identify and correct any inappropriate or unprofessional behaviors. Identifying, correcting, and intervening in situations in which abuse is more likely to occur. Investigation included - all identified events are reported to the Administrator immediately. After receiving the allegation, during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. Protection included - immediately removing the employee from the care of any resident when an allegation of abuse is reported. Reporting included - all allegations of abuse she be reported immediately to the Administrator. Allegations of abuse will be reported to the appropriate State Agency in the applicable timeframes, as per the policy and applicable regulations. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview, with the DON and Administrator on 10/20/22 at 9:15 AM, the DON said staff found a camera hidden in a Halloween decoration in Resident #3's room. The DON said she received the call from staff on 10/19/22 round 2:00 AM staff regarding the camera. She said the staff texted her a picture of the Halloween decoration and the camera in it. The DON had staff unplug the camera because it was plugged into an un-approved extension cord. The DON said she was not surprised to find the hidden camera in the room, because the resident's family disagreed with an abuse investigation, conducted on 09/15/22, that did not reveal any abuse. The Administrator said Resident #3's family did not contact the facility regarding the camera, and they had not reported any concerns. The Administrator said he was going to have the Social Worker contact Resident #3's family regarding the camera to get to sign an Electronic Monitoring Form, but he did not know if the Social Worker had contacted them yet. The Administrator and DON said they had not heard anything from the family regarding the camera and no abuse or care issues had been reported to them. On 10/20/22 at 10:43 AM, a video was received from Resident #3's responsible party. The video was recorded on 10/19/22 at 1:58 AM, it showed a female staff person (LVN C) taking Resident #3 to his room in his wheelchair. She pulled him backwards into the room in his wheelchair. LVN C, once in the resident's room, she faced the resident and said, there you go, she pointed her right finger at the resident and said, you stop it, then she pulled her right hand in a fist, the fist does not touch the resident, but her left hand came down on something that cannot be seen in frame and a pop was heard, at the same time LVN C was heard again saying, you stop it, the resident told LVN C, fuck you, LVN C turned towards the door and it appeared the resident attempted to continue the altercation, but the images are obscured by the Halloween decoration. LVN C asked the resident, are you fighting me?', then she said angrily, at the door, you stay there and then shuts the door. On 10/20/22 at 11:08 AM, a video was received from Resident #3's responsible party, it was recorded on 10/16/22 at 12:09 AM, it showed a male staff person (CNA D) enter the resident's room the resident was in bed. CNA D picked up the bed sheet but the resident tugs on the sheet, and CNA D lets go of the sheet. The resident says, get off me, you mother fucker, and throws the sheet at CNA D. CNA D walked to the foot of the resident's bed and told he resident, I'm going to kick your ass. The resident responds but his response could not be understood on the video. (continued on next page)

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	676029	A. Building B. Wing	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 10/20/22 at 11:25 AM, Resident #3's responsible party said she had a previous complaint regarding staff treatment of the resident, which she believed to be abuse, that was investigated and found to be unsubstantiated on 09/15/22. She said she disagreed with the findings of the facility's investigation and felt the facility was covering up abuse and/or mistreatment of Resident #3. She said a former employee, Housekeeper F, informed her she believed Resident #3 was being mistreated and told her she should place a camera in his room, because reports to the Administrator and DON of mistreatment were not being acted on. She said Housekeeper F was terminated for telling her about the mistreatment of Resident #3 for not reporting the abuse allegations to the Administrator. She said based on her experience with the facility; she decided to place a hidden camera in the resident's room. She said the resident did not have a roommate and it was not violating any other resident's privacy. She said when she saw the abuse recorded on the camera, she came to the facility to check on Resident #3 but did not alert the facility to the hidden camera. She said the videos showed Resident #3 was being abused by the staff. She said on 10/19/22 around 2:00 AM she could see on the camera that staff discovered the camera was in the room. She said she could see several staff members looking at the camera before it was unplugged. She said, staff from the facility just called her a few minutes ago, she did not know who, to tell her the camera was not approved and that she would need to sign a consent for its use. She said she asked the person that called if they were concerned about what the camera revealed and the person did not answer the question, and just told her she needed to sign the form in order for the camera to be approved. She said she informed the staff she had already removed the camera from the room and took it home. She said no one reached out to her about the camera prior to the phone call today, after the investigator entered the facility. She said there was one additional video that she had not sent yet, but she would send it. She said she wanted to move the resident to another facility but had to wait for his Medicaid to be approved before her facility of choice would accept him. She said she feels stuck because she cannot move him but cannot trust that he won't be harmed at the facility. On 10/20/22 at 12:04 PM, the Administrator and DON were shown the above videos for staff identification purposes. They said both videos showed abuse of Resident #3. They identified LVN C as the staff in the first video and CNA D in the second video. The DON said there had been no reports or concerns regarding the employees' care and treatment of the residents. She said the employees would be notified and suspended pending the outcome of the investigation. On 10/20/22 at 12:38 PM, the third and final video was received from Resident #3's responsible party, it was recorded on 10/13/22 at 7:36 PM, it showed two staff (LVN C and CNA E) providing care to the resident while he was in bed. LVN C was at the head of the resident's bed encouraging him to allow care but he was saying don't do that, CNA E was observed getting some wipes, she joined LVN C at the resident's bedside. The resident could be heard saying, God dammit, at that point, LVN C's left hand went up with her hand open, while she leaned forward and told the resident to stop it, she does not hit the resident, but it appeared to be a gesture like she was going to slap the resident. On 10/20/22 at 12:45 PM, the Administrator and DON said the third video was LVN C who appeared to raise her hand to Resident #3. They said the other staff was CNA E. Record Review of Resident #3's Admission Record dated 10/20/22 indicated the [AGE] year-old male resident was readmitted to the facility on [DATE] with diagnoses which included dementia and major depressive disorder. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #3's quarterly MDS dated [DATE] indicated the resident had short and long-term memory problems. He was severely cognitively impaired. He had no behaviors. Record Review of Resident #3's un-dated Care Plan indicated he had behaviors which included, combativeness, physical and verbal aggression with staff. The interventions included to provide physical and verbal cues to alleviate the resident's anxiety and give positive feedback. If the resident resists care, reassure the resident, leave, and return 5-10 minutes later and try again. In an observation on 10/20/22 at 1:34 PM, Resident #3 was propelling himself in his wheelchair. He was not able to answer any direct questions. In an interview on 10/20/22 at 2:44 PM, CNA E watched third video. She said she did not think LVN C was raising her hand to the resident, but she was not paying attention, at the time. She said she thought maybe LVN C was reaching to roll the resident over. She said she had never seen any staff being abusive or mistreating the resident. She said around 10:00 PM yesterday, 10/19/22, the resident's responsible party asked her if she was aware there had been a camera in the room. She said she told her she was not aware. She said the resident's responsible party told her she put the camera in the room because the resident was being abused by the staff. She said she told the resident's responsible party she did not believe that would happen at the facility. She said she did not tell anyone the resident's responsible party reported the resident had been abused. She said LVN C overheard her talking with the resident's responsible party and knew about the allegation. She said she was supposed to inform the Administrator of any abuse allegations; however, she did not report it. In an interview on 10/20/22 at 4:21 PM, with the DON present, LVN C said on 10/19/22 Resident #3 was awake around 2:00 AM and staff got him up in his wheelchair and assisted him to the nurses' station for monitoring. She said the resident became combative, threw things off the nurses' station, and tried to hit, kick and bite staff. She said the video showed her pulling him in his room backwards because he was being combative. She said her right hand was in a fist and pulled back because she thought he was going to grab or bite her. She said she did not make physical contact with the resident. She said the slap sound on the video was when she slapped her own leg. She said she did not feel she was being abusive to the resident. She said she was speaking loudly but it was because the resident was hard of hearing. She said she did tell the resident to stay in his room and closed the door, but it was only for approximately 5 minutes until she could get a CNA to assist her to put the resident back to bed. She denied ever threatening or hitting the resident. She said staff discovered the camera after 2:00 AM and let the DON know. She said she did hear CNA E speaking to Resident #3's responsible party but she did not hear the allegation of abuse. She later said that maybe CNA E told her something about the allegation, but she did not remember, and she was busy at the time. She said she would report abuse to the DON, she was not aware the Administrator was the Abuse Coordinator. She said she should not have raised her voice to the resident. She said Resident #3 tried to kick her as she was leaving the room and that was why she asked him if he was trying to fight her. She said she never raised her hand to hit the resident. The DON informed her she was suspended pending the outcome of the investigation and was not to return to the facility until further notice. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 10/20/22 at 3:35 PM, with the DON present, CNA D said if the resident was too combative, he was supposed to get another CNA to assist him, but he did not feel the resident was being that aggressive on 10/16/22. He said the resident tugged on the sheet and he let go, he said he did not know, at the time, the camera was in the room. He said he did tell the resident he was going to kick his ass because he was under pressure, but he would not have physically hurt the resident because it was not in his heart to do so. He said what he said was abuse. He said he was frustrated and tired of the resident being so mean. He said he had not seen or heard any other staff be mean or aggressive with the resident. He said he apologized dearly for his actions and would never hurt the residents. The DON informed him he could not report to work and was under investigation. In an interview on 10/20/22 at 5:00 PM, the Administrator said staff knew he was the Abuse Coordinator because they had all been in-serviced and it was posted in the facility. He said it was his expectation that staff would notify him immediately of any allegations of abuse or mistreatment. He said the facility would investigate, and notify the police and State Agency. In a telephone interview on 10/20/22 at 5:42 PM, Resident #3's responsible party said on 10/19/22 she spoke to CNA E regarding her abuse concerns and why she installed the camera. She said she asked if she could show CNA E the videos of the abuse, but the CNA told her her eyesight was not good and she did not think she could see the videos. She said she believed CNA E did not wish to see the videos because she would have to report the abuse to the Administrator. She said it further showed how staff wanted to turn a blind eye to reports of abuse. In a telephone interview on 10/20/22 at 6:07 PM, Former Housekeeper F said she was the housekeeper on Resident #3's hall and she felt staff were not caring for the resident appropriately. She said she believed the staff were not assisting him with meals, were abrupt and discourteous to him. She said she spoke with the Administrator and DON about her concerns, but she believed they were not addressed. She said she spoke to the resident's responsible party regarding her concerns and told her she should put a camera in the resident's room because she believed he was being mistreated by staff. She said when the facility found out she told the resident's responsible party she suspected abuse, the DON called her on 09/10/22, to question her if she knew who the Abuse Coordinator was, and she told her it was the Administrator. She said the Administrator wanted to meet with her in the next day 09/11/22, in his office, but she did not meet with him for fear she would be terminated. She said her last day of employment was 09/11/22. She said the facility's inaction regarding allegations made employees not want to report anything. She said other facility employees knew about things but don't report it. She would not give the investigator the names of the other employees. She said there were employees, still working at the facility, who abused residents. She named CNA E, as an abuser. In an observation on 10/24/22 at 9:30 AM, Resident #3 was propelling himself in his wheelchair. He was smiling and appeared to be in a good mood. He was not able to answer questions appropriately. In an interview on 10/24/22 at 9:43 AM, the Administrator and DON said the videos showed, based on their investigation, verbal abuse, and included intimidation and seclusion. They said they were going to terminate LVN C and CNA D for abuse. They said CNA E would be terminated for not reporting the allegation of abuse to the Administrator. The Administrator and DON said Former Housekeeper F never reported any abuse, neglect, or mistreatment of Resident #3 to them. The Administrator and DON said in-service training was provided orally and written for all staff on all three shifts, after the abuse allegation regarding Resident #3 on 09/15/22. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/24/22 at 12:43 PM the Administrator and DON were informed of an Immediate Jeopardy. On 10/25/22 at 3:58 PM Safe Surveys (interviews with residents regarding abuse and/or mistreatment) were received from the Administrator. On 10/25/22 at 4:18 PM the Immediate Jeopardy Plan of Removal was accepted. In an interview on 10/26/22 at 10:04 AM, the Social Worker said Medical Records had completed Safe Surveys with residents on 10/20/22. Record Review of the Safe Surveys, provided by the Administrator, on 10/25/22 at 3:58 PM, did not include any completed by Medical Records. Record Review of the Resident Council Minutes dated 10/17/22 indicated resident said they needed more customer service and respect from the staff. No staff was named and the number of residents who voiced this was not identified. In an interview on 10/26/22 at 10:27 AM, the AD said the Resident Council did bring up, in the meeting on 10/17/22, that they would like staff to be more respectful, but no abuse was alleged. In an interview on 10/26/22 at 11:05 AM, Medical Records said she conducted safe surveys on 10/20/22. She said during the surveys on 10/20/22, Resident #13 said CNA E yelled at her and was pointing her finger at her so close to her she thought the aide was going to hit her, but she did not. She said Resident 13's roommate, Resident #14 said she put on the light again for a different reason, to ask a question, and CNA E yelled at them again and stated, why are you on the light again? What's your problem? I was just in here!. She said Resident #14 was the Resident Council President and told her that they just tried not to bother CNA E after that. She said Resident #14 told Resident #13 they needed to speak up to get it to stop. She said Residents #13 and #14 told her they were verbally abused by CNA E. She said the interviews were between 9:00 AM -11:00 AM on Thursday, 10/20/22. She said she told the Administrator and DON immediately on 10/20/22. She said the residents told her the verbal abuse occurred on Monday, 10/17/22 on the 2:00 PM - 10:00 PM shift. She said, after she reported the allegation of abuse to the Administrator and DON, she interviewed Resident #12 on 10/20/22 between 11:00 AM -12:00 PM and the resident told her CNA E had verbally abused her too by yelling at her. She said once again she immediately informed the Administrator and DON of the verbal abuse allegation on 10/20/22. On 10/26/22 at 12:10 PM the investigator sent the Administrator an email requesting any additional safe surveys and if the facility had any new allegations of abuse. Record Review of Resident #13's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses which included, chronic obstructive pulmonary disease and bipolar disorder (a mental illness). Record Review of Resident #13's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 1:22 PM, Resident #13 was in her room in her wheelchair. She said on 10/17/22, her roommate, Resident #14, had the call light and CNA E came in the room and was screaming, upset, that the call light was on. She said CNA E came over to her while she was in her bed and was screaming and pointing her finger so close to her; she was afraid she was going to hit her. She said CNA E was mad that her roommate had turned on the call light. She said she was shocked, she felt threatened and scared by CNA E's outburst. She said she later, the same evening, wanted to just ask a question, she put the call light on, and CNA E came in yelling again and asked why they were on the light again after she had just been in there. She said CNA E verbally abused her on 10/17/22. She said the only person she told, about the abuse, was the Medical Records person on 10/20/22. Record Review of Resident #12's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses of mild cognitive impairment, mild intellectual disabilities, depression and, the need for assistance with personal care. Record Review of Resident #12's quarterly MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS score of 10 (a score of 8-12 indicated moderate cognitive impairment). In an observation and interview on 10/26/22 at 1:46 PM, Resident #12 was in her wheelchair. She said about two or three weeks ago, CNA E came in her room and was going to assist with her incontinent care. She said CNA E started yelling at her, saying the resident could help more with the care. She said she was unable to physically help more, and she started crying. She said she was verbally abused by CNA E and was a little scared of her. She said it was on a weekend, and she told a lady working the 500 Hall, she did not know the lady's name, and the DON was called. She said she told the DON what happened with CNA E. She said the DON told her they would do some additional training with staff. She said she felt like she received the silent treatment from CNA E after she reported her. She said she reported the incident again on 10/20/22 to the Medical Records person. At 10/26/22 at 2:41 PM, there was no response from the Administrator regarding the email sent at 12:10 PM. In an interview on 10/26/22 at 2:58 PM, the Administrator said Medical Records conducted some Safe Surveys on 10/20/22. He said she did not notify him of the verbal abuse allegations reported by Residents #12, #13, and #14. He said staff conducting the Safe Surveys were told to immediately report any allegations of abuse and/or mistreatment to him immediately. He said he would look for the Safe Surveys conducted by Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 PM, the DON said she was not aware of the new allegations regarding CNA E. She said she was not contacted on a weekend regarding an incident between Resident #12 and CNA E. She said she would immediately tell the Administrator of any allegations regarding abuse. She said CNA E was terminated on Monday, 10/24/22 for not reporting Resident #3's responsible party's allegation of abuse to the Administrator. Record Review of Resident #14's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was readmitted to the facility on [DATE] with diagnoses which included mild cognitive impairment and anxiety. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #14's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). In an observation and interview on 10/26/22 at 4:04 PM, Resident #14 was in bed in her room. She said she had been the Resident Council President about a month. She said, in the Resident Council Meeting in October 2022 it was discussed how the staff were speaking to the residents, at times. She said the residents perceived some of the staff to be snotty and argumentative, at times, like when a resident needed something the staff acted like they were doing the resident a favor instead of the fact that the staff worked for the residents. She said this was discussed in the council because staffs' attitudes towards the residents were getting worse not better. She said Medical Records came in and asked her, last week on 10/20/22 about her treatment in the facility. She said she told her about an incident on Monday 10/17/22 around 5:00 PM, she requested to be transferred from her wheelchair to bed and provided incontinent care. She said CNA E told her go to room and get in position. She said she followed instructions and waited over an hour and then put the call light on. She said CNA E came into the room yelling and screaming that the resident should not have put the call light on and that she had to just wait her turn for assistance. She said she told CNA E she was going to report her, and CNA E told her to go ahead because she did not have to answer to the resident. She said CNA E was screaming over her and pointing her finger. She said CNA E then went to her roommate's (Resident #13) side of the bed, the roommate was in bed, CNA E was standing over Resident #13, still yelling, and pointing her finger but was directed at her (Resident #14) and not the roommate (Resident #13). She said Resident #13 became afraid CNA E was going to hit her and Resident #13 started crying. She said she told Resident #13 not to cry because CNA E was mad at her (Resident #14). She said CNA E left the room, and Resident #13, who does not cuss, said Holy Shit!. She said about an hour later, the same evening, Resident #13 just wanted to ask a question, so she put the call light on, and CNA E came in the room screaming again. She said CNA E asked them What is your problem why is the call light on again?. She said Resident #13 apologized and said she just wanted to ask the AD something. She said she had been a resident at the facility for 5 years and CNA E had always had a temper. She said CNA E had an attitude like she was invincible because nothing ever happened to her, and she felt like she would not get fired. She said CNA E had always had a bad temper, but it had never been like this before. She said she did not tell anyone about the incident until the Medical Records person asked her about abuse on 10/20/22. She said she was verbally abused and intimidated by CNA E on 10/17/22. In an interview on 10/26/22 at 4:47 PM, the DON and the Clinical Resource RN said Medical Records had the Safe Surveys dated 10/20/22, on her person, for Residents #12, #13, and #14. She said Medical Records reported them verbally to the Administrator on 10/20/22 but did not give him the forms. They said the Administrator and Medical Records were suspended pending the outcome of the investigation. Record Review of Safe Surveys dated 10/20/22, not timed, indicated the question, Do you feel that you have been intentionally injured by a team member? -Resident #12 - verbal abuse -Resident #13 - verbal abuse with violently yelling and afraid CNA E would hit her on Monday (10/17/22) -Resident #14 - verbally abused with attitude - CNA E (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review revealed Medical Records completed the three above Safe Surveys again on 10/20/22, not timed, and all three residents' answers to Do you feel you have been intentionally injured by a team member? were changed to, No. In an interview on 10/27/22 at 10:02 AM, the Clinical Resource RN and DON said the facility began in-services with all staff on the types of abuse, with a written quiz. The DON was made the Abuse Prevention Coordinator. The facility began interview with staff to see if any abuse allegations had been reported to the Administrator that were not acted upon. The facility began a root cause analysis. She said the Safe Surveys conducted on 10/20/22 with Residents #12, #13, and #14 revealed verbal abuse by CNA E. The DON said CNA E worked on 10/21/22, after the allegations of verbal abuse were reported to the Administrator on 10/20/22. She said CNA E did not work after 10/21/22. She said CNA E was terminated on 10/24/22 for not reporting the allegation of abuse made by Resident #3's responsible party, but not related to the allegations of verbal abuse. Record Review of CNA E's time sheet dated 10/27/22 indicated she worked on 10/21/22 from 2:24 PM - 9:48 PM, 7.4 hours. Attempts were made to interview CNA E on 10/28/22 at 5:23 PM, 7:24 PM, and 10/29/22 at 12:19 PM, there was no answer to the phone call and messages, a text was also sent on 10/29/22 at 12:20 PM requesting an interview, no return call was received prior to the exit on 10/29/22 at 1:00 PM. In a telephone interview on 10/27/22 at 5:26 PM, Medical Records said she told the Administrator immediately about each of the allegations of verbal abuse on 10/20/22. She said she told him after each allegation was made. She said the DON was also present, during the discussion with the Administrator. She said the administrator told her to shred Resident #12, #13, #14's Safe Surveys that revealed verbal abuse. She said he told her State was not looking at verbal abuse as being intentionally injured. She said the Administrator, then gave her new forms to complete with the same residents again. She said on 10/26/22, after the investigator asked about the Safe Surveys, she got the three original Safe Surveys for Resident #12, #13, and #14 out of the shred bin to give to the Administrator. She said the Administrator understood on 10/20/22 Residents #12, #13, and #14 had alleged they were verbally abused by CNA E. In an interview on 10/27/22 at 5:41 PM, the DON said she was not involved in the conversation regarding the abuse, as stated above, on 10/20/22. She said she was not aware of abuse being reported on the three residents (Residents #12, #13, and #14) in question. In a telephone interview on 10/27/22 at 5:45 PM, the Administrator said DON was not in the room when Medical Records discussed the verbal abuse allegations. He said Medical Records did notify him on 10/20/22 of the verbal abuse allegations. He said with everything going on the verbal abuse allegations did not cross his mind again. He said yesterday (10/26/22) Medical Records did get the Safe Surveys out of the shred bin, but he did not tell her to shred them. He told her to set them aside in his office. He said he did ask her to conduct new Safe Surveys on Resident #12, #13, and #14 because he did not believe verbal abuse was applicable to the question, Do you feel that you have been intentionally injured by a team member?. He said he was aware of the facility abuse policy and reporting requirements. (continued on next page)

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	676029	A. Building B. Wing	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety related to the verbal abuse from CNA E and just a combination of things. She said she might need an increase in her anti-anxiety medication. The Interim Administrator, Clinical Resource RN, and DON were notified of the Immediate Jeopardy on 10/27/22 at 4:01 PM, a Plan of Removal was requested and the Immediate Jeopardy template was provided. The Plan of Removal was accepted on 10/28/22 at 2:50 PM. Review of the Plan of Removal included: Immediate Action: 1. Administrator suspended on 10/26/22 pending the outcome of the investigation. 2. Medical Director / Resident's physician notified of IJ by Director of Nursing at 5:25 PM via phone. 3. In-service regarding Abuse: Prevention of and Prohibition Against was started on 10-27-22 for routinely scheduled facility staff, educated by Clinical Resource/designee. Inservice to be completed with routinely scheduled facility staff, by 4:30PM on 10-28-22. Remaining facility staff and agency staff will be required to be in-serviced on this policy upon start of their shift by the Director of Nursing/designee. 4. RN Clinical Resource will conduct education on the facility ANE policy with leadership team: a. Leadership Team: Administrator, Director of Nur [TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse or mistreatment, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, including the State Agency, in accordance with State law through established procedures for 4 (Residents #3, #12, #13, and #14) of 14 residents reviewed for abuse. 1) CNA E failed to report Resident #3's responsible party's allegation of abuse to the Administrator on 10/19/22. 2) The Administrator failed to report Resident #12, #13, and #14's allegations of verbal abuse on 10/20/22 to the State Agency; due to not reporting the residents continued to be exposed to the staff that had verbally abused them. These failures could place all the residents, who resided in the facility, at risk for abuse and mental anguish. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 11/14/22. While the IJ was removed on 11/14/22, the facility remained out of compliance at a severity level of actual harm, and a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective actions. Findings included: In an interview, with the DON and Administrator on 10/20/22 at 9:15 AM, the DON said staff found a camera hidden in a Halloween decoration in Resident #3's room. The DON said she received the call from staff on 10/19/22 round 2:00 AM staff regarding the camera. She said the staff texted her a picture of the Halloween decoration and the camera in it. The DON had staff unplug the camera because it was plugged into an un-approved extension cord. The DON said she was not surprised to find the hidden camera in the room, because the resident's family disagreed with an abuse investigation, conducted on 09/15/22, that did not reveal any abuse. The Administrator said Resident #3's family did not contact the facility regarding the camera, and they had not reported any concerns. The Administrator said he was going to have the Social Worker contact Resident #3's family regarding the camera to get to sign an Electronic Monitoring Form, but he did not know if the Social Worker had contacted them yet. The Administrator and DON said they had not heard anything from the family regarding the camera and no abuse or care issues had been reported to them. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 10:43 AM, a video was received from Resident #3's responsible party. The video was recorded on 10/19/22 at 1:58 AM, it showed a female staff person (LVN C) taking Resident #3 to his room in his wheelchair. She pulled him backwards into the room in his wheelchair. LVN C, once in the resident's room, she faced the resident and said, there you go, she pointed her right finger at the resident and said, you stop it, then she pulled her right hand in a fist, the fist does not touch the resident, but her left hand came down on something that cannot be seen in frame and a pop was heard, at the same time LVN C was heard again saying, you stop it, the resident told LVN C, fuck you, LVN C turned towards the door and it appeared the resident attempted to continue the altercation, but the images are obscured by the Halloween decoration. LVN C asked the resident, are you fighting me?', then she said angrily, at the door, you stay there and then shuts the door. On 10/20/22 at 11:08 AM, a video was received from Resident #3's responsible party, it was recorded on 10/16/22 at 12:09 AM, it showed a male staff person (CNA D) enter the resident's room the resident was in bed. CNA D picked up the bed sheet but the resident tugs on the sheet, and CNA D lets go of the sheet. The resident says, get off me, you mother fucker, and throws the sheet at CNA D. CNA D walked to the foot of the resident's bed and told he resident, I'm going to kick your ass. The resident responds but his response could not be understood on the video. In a telephone interview on 10/20/22 at 11:25 AM, Resident #3's responsible party said she had a previous complaint regarding staff treatment of the resident, which she believed to be abuse, that was investigated and found to be unsubstantiated on 09/15/22. She said she disagreed with the findings of the facility's investigation and felt the facility was covering up abuse and/or mistreatment of Resident #3. She said a former employee, Housekeeper F, informed her she believed Resident #3 was being mistreated and told her she should place a camera in his room, because reports to the Administrator and DON of mistreatment were not being acted on. She said Housekeeper F was terminated for telling her about the mistreatment of Resident #3 for not reporting the abuse allegations to the Administrator. She said based on her experience with the facility; she decided to place a hidden camera in the resident's room. She said the resident did not have a roommate and it was not violating any other resident's privacy. She said when she saw the abuse recorded on the camera, she came to the facility to check on Resident #3 but did not alert the facility to the hidden camera. She said the videos showed Resident #3 was being abused by the staff. She said on 10/19/22 around 2:00 AM she could see on the camera that staff discovered the camera was in the room. She said she could see several staff members looking at the camera before it was unplugged. She said, staff from the facility just called her a few minutes ago, she did not know who, to tell her the camera was not approved and that she would need to sign a consent for its use. She said she asked the person that called if they were concerned about what the camera revealed and the person did not answer the question, and just told her she needed to sign the form in order for the camera to be approved. She said she informed the staff she had already removed the camera from the room and took it home. She said no one reached out to her about the camera prior to the phone call today, after the investigator entered the facility. She said there was one additional video that she had not sent yet, but she would send it. She said she wanted to move the resident to another facility but had to wait for his Medicaid to be approved before her facility of choice would accept him. She said she feels stuck because she cannot move him but cannot trust that he won't be harmed at the facility. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 12:04 PM, the Administrator and DON were shown the above videos for staff identification purposes. They said both videos showed abuse of Resident #3. They identified LVN C as the staff in the first video and CNA D in the second video. The DON said there had been no reports or concerns regarding the employees' care and treatment of the residents. She said the employees would be notified and suspended pending the outcome of the investigation. On 10/20/22 at 12:38 PM, the third and final video was received from Resident #3's responsible party, it was recorded on 10/13/22 at 7:36 PM, it showed two staff (LVN C and CNA E) providing care to the resident while he was in bed. LVN C was at the head of the resident's bed encouraging him to allow care but he was saying don't do that, CNA E was observed getting some wipes, she joined LVN C at the resident's bedside. The resident could be heard saying, God dammit, at that point, LVN C's left hand went up with her hand open, while she leaned forward and told the resident to stop it, she does not hit the resident, but it appeared to be a gesture like she was going to slap the resident. On 10/20/22 at 12:45 PM, the Administrator and DON said the third video was LVN C who appeared to raise her hand to Resident #3. They said the other staff was CNA E. Record Review of Resident #3's Admission Record dated 10/20/22 indicated the [AGE] year-old male resident was readmitted to the facility on [DATE] with diagnoses which included dementia and major depressive disorder. Record Review of Resident #3's quarterly MDS dated [DATE] indicated the resident had short and long-term memory problems. He was severely cognitively impaired. He had no behaviors. Record Review of Resident #3's un-dated Care Plan indicated he had behaviors which included, combativeness, physical and verbal aggression with staff. The interventions included to provide physical and verbal cues to alleviate the resident's anxiety and give positive feedback. If the resident resists care, reassure the resident, leave, and return 5-10 minutes later and try again. In an observation on 10/20/22 at 1:34 PM, Resident #3 was propelling himself in his wheelchair. He was not able to answer any direct questions. In an interview on 10/20/22 at 2:44 PM, CNA E watched third video. She said she did not think LVN C was raising her hand to the resident, but she was not paying attention, at the time. She said she thought maybe LVN C was reaching to roll the resident over. She said she had never seen any staff being abusive or mistreating the resident. She said around 10:00 PM yesterday, 10/19/22, the resident's responsible party asked her if she was aware there had been a camera in the room. She said she told her she was not aware. She said the resident's responsible party told her she put the camera in the room because the resident was being abused by the staff. She said she told the resident's responsible party she did not believe that would happen at the facility. She said she did not tell anyone the resident's responsible party reported the resident had been abused. She said LVN C overheard her talking with the resident's responsible party and knew about the allegation. She said she was supposed to inform the Administrator of any abuse allegations; however, she did not report it. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/20/22 at 4:21 PM, with the DON present, LVN C said on 10/19/22 Resident #3 was awake around 2:00 AM and staff got him up in his wheelchair and assisted him to the nurses' station for monitoring. She said the resident became combative, threw things off the nurses' station, and tried to hit, kick and bite staff. She said the video showed her pulling him in his room backwards because he was being combative. She said her right hand was in a fist and pulled back because she thought he was going to grab or bite her. She said she did not make physical contact with the resident. She said the slap sound on the video was when she slapped her own leg. She said she did not feel she was being abusive to the resident. She said she was speaking loudly but it was because the resident was hard of hearing. She said she did tell the resident to stay in his room and closed the door, but it was only for approximately 5 minutes until she could get a CNA to assist her to put the resident back to bed. She denied ever threatening or hitting the resident. She said staff discovered the camera after 2:00 AM and let the DON know. She said she did hear CNA E speaking to Resident #3's responsible party but she did not hear the allegation of abuse. She later said that maybe CNA E told her something about the allegation, but she did not remember, and she was busy at the time. She said she would report abuse to the DON, she was not aware the Administrator was the Abuse Coordinator. She said she should not have raised her voice to the resident. She said Resident #3 tried to kick her as she was leaving the room and that was why she asked him if he was trying to fight her. She said she never raised her hand to hit the resident. The DON informed her she was suspended pending the outcome of the investigation and was not to return to the facility until further notice. In a telephone interview on 10/20/22 at 3:35 PM, with the DON present, CNA D said if the resident was too combative, he was supposed to get another CNA to assist him, but he did not feel the resident was being that aggressive on 10/16/22. He said the resident tugged on the sheet and he let go, he said he did not know, at the time, the camera was in the room. He said he did tell the resident he was going to kick his ass because he was under pressure, but he would not have physically hurt the resident because it was not in his heart to do so. He said what he said was abuse. He said he was frustrated and tired of the resident being so mean. He said he had not seen or heard any other staff be mean or aggressive with the resident. He said he apologized dearly for his actions and would never hurt the residents. The DON informed him he could not report to work and was under investigation. In an interview on 10/20/22 at 5:00 PM, the Administrator said staff knew he was the Abuse Coordinator because they had all been in-serviced and it was posted in the facility. He said it was his expectation that staff would notify him immediately of any allegations of abuse or mistreatment. He said the facility would investigate, and notify the police and State Agency. In a telephone interview on 10/20/22 at 5:42 PM, Resident #3's responsible party said on 10/19/22 she spoke to CNA E regarding her abuse concerns and why she installed the camera. She said she asked if she could show CNA E the videos of the abuse, but the CNA told her her eyesight was not good and she did not think she could see the videos. She said she believed CNA E did not wish to see the videos because she would have to report the abuse to the Administrator. She said it further showed how staff wanted to turn a blind eye to reports of abuse. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 10/20/22 at 6:07 PM, Former Housekeeper F said she was the housekeeper on Resident #3's hall and she felt staff were not caring for the resident appropriately. She said she believed the staff were not assisting him with meals, were abrupt and discourteous to him. She said she spoke with the Administrator and DON about her concerns, but she believed they were not addressed. She said she spoke to the resident's responsible party regarding her concerns and told her she should put a camera in the resident's room because she believed he was being mistreated by staff. She said when the facility found out she told the resident's responsible party she suspected abuse, the DON called her on 09/10/22, to question her if she knew who the Abuse Coordinator was, and she told her it was the Administrator. She said the Administrator wanted to meet with her in the next day 09/11/22, in his office, but she did not meet with him for fear she would be terminated. She said her last day of employment was 09/11/22. She said the facility's inaction regarding allegations made employees not want to report anything. She said other facility employees knew about things but don't report it. She would not give the investigator the names of the other employees. She said there were employees, still working at the facility, who abused residents. She named CNA E, as an abuser. In an observation on 10/24/22 at 9:30 AM, Resident #3 was propelling himself in his wheelchair. He was smiling and appeared to be in a good mood. He was not able to answer questions appropriately. In an interview on 10/24/22 at 9:43 AM, the Administrator and DON said the videos showed, based on their investigation, verbal abuse, and included intimidation and seclusion. They said they were going to terminate LVN C and CNA D for abuse. They said CNA E would be terminated for not reporting the allegation of abuse to the Administrator. The Administrator and DON said Former Housekeeper F never reported any abuse, neglect, or mistreatment of Resident #3 to them. The Administrator and DON said in-service training was provided orally and written for all staff on all three shifts, after the abuse allegation regarding Resident #3 on 09/15/22. On 10/24/22 at 12:43 PM the Administrator and DON were informed of an Immediate Jeopardy. On 10/25/22 at 3:58 PM Safe Surveys (interviews with residents regarding abuse and/or mistreatment) were received from the Administrator. On 10/25/22 at 4:18 PM the Immediate Jeopardy Plan of Removal was accepted. In an interview on 10/26/22 at 10:04 AM, the Social Worker said Medical Records had completed Safe Surveys with residents on 10/20/22. Record Review of the Safe Surveys, provided by the Administrator, on 10/25/22 at 3:58 PM, did not include any completed by Medical Records. Record Review of the Resident Council Minutes dated 10/17/22 indicated resident said they needed more customer service and respect from the staff. No staff was named and the number of residents who voiced this was not identified. In an interview on 10/26/22 at 10:27 AM, the AD said the Resident Council did bring up, in the meeting on 10/17/22, that they would like staff to be more respectful, but no abuse was alleged. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/26/22 at 11:05 AM, Medical Records said she conducted safe surveys on 10/20/22. She said during the surveys on 10/20/22, Resident #13 said CNA E yelled at her and was pointing her finger at her so close to her she thought the aide was going to hit her, but she did not. She said Resident 13's roommate, Resident #14 said she put on the light again for a different reason, to ask a question, and CNA E yelled at them again and stated, why are you on the light again? What's your problem? I was just in here!. She said Resident #14 was the Resident Council President and told her that they just tried not to bother CNA E after that. She said Resident #14 told Resident #13 they needed to speak up to get it to stop. She said Residents #13 and #14 told her they were verbally abused by CNA E. She said the interviews were between 9:00 AM -11:00 AM on Thursday, 10/20/22. She said she told the Administrator and DON immediately on 10/20/22. She said the residents told her the verbal abuse occurred on Monday, 10/17/22 on the 2:00 PM - 10:00 PM shift. She said, after she reported the allegation of abuse to the Administrator and DON, she interviewed Resident #12 on 10/20/22 between 11:00 AM -12:00 PM and the resident told her CNA E had verbally abused her too by yelling at her. She said once again she immediately informed the Administrator and DON of the verbal abuse allegation on 10/20/22. On 10/26/22 at 12:10 PM the investigator sent the Administrator an email requesting any additional safe surveys and if the facility had any new allegations of abuse. Record Review of Resident #13's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses which included, chronic obstructive pulmonary disease and bipolar disorder (a mental illness). Record Review of Resident #13's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). In an observation and interview on 10/26/22 at 1:22 PM, Resident #13 was in her room in her wheelchair. She said on 10/17/22, her roommate, Resident #14, had the call light and CNA E came in the room and was screaming, upset, that the call light was on. She said CNA E came over to her while she was in her bed and was screaming and pointing her finger so close to her; she was afraid she was going to hit her. She said CNA E was mad that her roommate had turned on the call light. She said she was shocked, she felt threatened and scared by CNA E's outburst. She said she later, the same evening, wanted to just ask a question, she put the call light on, and CNA E came in yelling again and asked why they were on the light again after she had just been in there. She said CNA E verbally abused her on 10/17/22. She said the only person she told, about the abuse, was the Medical Records person on 10/20/22. Record Review of Resident #12's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses of mild cognitive impairment, mild intellectual disabilities, depression and, the need for assistance with personal care. Record Review of Resident #12's quarterly MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS score of 10 (a score of 8-12 indicated moderate cognitive impairment). (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 1:46 PM, Resident #12 was in her wheelchair. She said about two or three weeks ago, CNA E came in her room and was going to assist with her incontinent care. She said CNA E started yelling at her, saying the resident could help more with the care. She said she was unable to physically help more, and she started crying. She said she was verbally abused by CNA E and was a little scared of her. She said it was on a weekend, and she told a lady working the 500 Hall, she did not know the lady's name, and the DON was called. She said she told the DON what happened with CNA E. She said the DON told her they would do some additional training with staff. She said she felt like she received the silent treatment from CNA E after she reported her. She said she reported the incident again on 10/20/22 to the Medical Records person. At 10/26/22 at 2:41 PM, there was no response from the Administrator regarding the email sent at 12:10 PM. In an interview on 10/26/22 at 2:58 PM, the Administrator said Medical Records conducted some Safe Surveys on 10/20/22. He said she did not notify him of the verbal abuse allegations reported by Residents #12, #13, and #14. He said staff conducting the Safe Surveys were told to immediately report any allegations of abuse and/or mistreatment to him immediately. He said he would look for the Safe Surveys conducted by Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 PM, the DON said she was not aware of the new allegations regarding CNA E. She said she was not contacted on a weekend regarding an incident between Resident #12 and CNA E. She said she would immediately tell the Administrator of any allegations regarding abuse. She said CNA E was terminated on Monday, 10/24/22 for not reporting Resident #3's responsible party's allegation of abuse to the Administrator. Record Review of Resident #14's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was readmitted to the facility on [DATE] with diagnoses which included mild cognitive impairment and anxiety. Record Review of Resident #14's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). (continued on next page)

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	676029	A. Building B. Wing	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 4:04 PM, Resident #14 was in bed in her room. She said she had been the Resident Council President about a month. She said, in the Resident Council Meeting in October 2022 it was discussed how the staff were speaking to the residents, at times. She said the residents perceived some of the staff to be snotty and argumentative, at times, like when a resident needed something the staff acted like they were doing the resident a favor instead of the fact that the staff worked for the residents. She said this was discussed in the council because staffs' attitudes towards the residents were getting worse not better. She said Medical Records came in and asked her, last week on 10/20/22 about her treatment in the facility. She said she told her about an incident on Monday 10/17/22 around 5:00 PM, she requested to be transferred from her wheelchair to bed and provided incontinent care. She said CNA E told her go to room and get in position. She said she followed instructions and waited over an hour and then put the call light on. She said CNA E came into the room yelling and screaming that the resident should not have put the call light on and that she had to just wait her turn for assistance. She said she told CNA E she was going to report her, and CNA E told her to go ahead because she did not have to answer to the resident. She said CNA E was screaming over her and pointing her finger. She said CNA E then went to her roommate's (Resident #13) side of the bed, the roommate was in bed, CNA E was standing over Resident #13, still yelling, and pointing her finger but was directed at her (Resident #14) and not the roommate (Resident #13). She said Resident #13 became afraid CNA E was going to hit her and Resident #13 started crying. She said she told Resident #13 not to cry because CNA E was mad at her (Resident #14). She said CNA E left the room, and Resident #13, who does not cuss, said Holy Shit!. She said about an hour later, the same evening, Resident #13 just wanted to ask a question, so she put the call light on, and CNA E came in the room screaming again. She said CNA E asked them What is your problem why is the call light on again?. She said Resident #13 apologized and said she just wanted to ask the AD something. She said she had been a resident at the facility for 5 years and CNA E had always had a temper. She said CNA E had an attitude like she was invincible because nothing ever happened to her, and she felt like she would not get fired. She said CNA E had always had a bad temper, but it had never been like this before. She said she did not tell anyone about the incident until the Medical Records person asked her about abuse on 10/20/22. She said she was verbally abused and intimidated by CNA E on 10/17/22. In an interview on 10/26/22 at 4:47 PM, the DON and the Clinical Resource RN said Medical Records had the Safe Surveys dated 10/20/22, on her person, for Residents #12, #13, and #14. She said Medical Records reported them verbally to the Administrator on 10/20/22 but did not give him the forms. They said the Administrator and Medical Records were suspended pending the outcome of the investigation. Record Review of Safe Surveys dated 10/20/22, not timed, indicated the question, Do you feel that you have been intentionally injured by a team member? -Resident #12 - verbal abuse -Resident #13 - verbal abuse with violently yelling and afraid CNA E would hit her on Monday (10/17/22) -Resident #14 - verbally abused with attitude - CNA E (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review revealed Medical Records completed the three above Safe Surveys again on 10/20/22, not timed, and all three residents' answers to Do you feel you have been intentionally injured by a team member? were changed to, No. In an interview on 10/27/22 at 10:02 AM, the Clinical Resource RN and DON said the facility began in-services with all staff on the types of abuse, with a written quiz. The DON was made the Abuse Prevention Coordinator. The facility began interview with staff to see if any abuse allegations had been reported to the Administrator that were not acted upon. The facility began a root cause analysis. She said the Safe Surveys conducted on 10/20/22 with Residents #12, #13, and #14 revealed verbal abuse by CNA E. The DON said CNA E worked on 10/21/22, after the allegations of verbal abuse were reported to the Administrator on 10/20/22. She said CNA E did not work after 10/21/22. She said CNA E was terminated on 10/24/22 for not reporting the allegation of abuse made by Resident #3's responsible party, but not related to the allegations of verbal abuse. Record Review of CNA E's time sheet dated 10/27/22 indicated she worked on 10/21/22 from 2:24 PM - 9:48 PM, 7.4 hours. Attempts were made to interview CNA E on 10/28/22 at 5:23 PM, 7:24 PM, and 10/29/22 at 12:19 PM, there was no answer to the phone call and messages, a text was also sent on 10/29/22 at 12:20 PM requesting an interview, no return call was received prior to the exit on 10/29/22 at 1:00 PM. In a telephone interview on 10/27/22 at 5:26 PM, Medical Records said she told the Administrator immediately about each of the allegations of verbal abuse on 10/20/22. She said she told him after each allegation was made. She said the DON was also present, during the discussion with the Administrator. She said the administrator told her to shred Resident #12, #13, #14's Safe Surveys that revealed verbal abuse. She said he told her State was not looking at verbal abuse as being intentionally injured. She said the Administrator, then gave her new forms to complete with the same residents again. She said on 10/26/22, after the investigator asked about the Safe Surveys, she got the three original Safe Surveys for Resident #12, #13, and #14 out of the shred bin to give to the Administrator. She said the Administrator understood on 10/20/22 Residents #12, #13, and #14 had alleged they were verbally abused by CNA E. In an interview on 10/27/22 at 5:41 PM, the DON said she was not involved in the conversation regarding the abuse, as stated above, on 10/20/22. She said she was not aware of abuse being reported on the three residents (Residents #12, #13, and #14) in question. In a telephone interview on 10/27/22 at 5:45 PM, the Administrator said DON was not in the room when Medical Records discussed the verbal abuse allegations. He said Medical Records did notify him on 10/20/22 of the verbal abuse allegations. He said with everything going on the verbal abuse allegations did not cross his mind again. He said yesterday (10/26/22) Medical Records did get the Safe Surveys out of the shred bin, but he did not tell her to shred them. He told her to set them aside in his office. He said he did ask her to conduct new Safe Surveys on Resident #12, #13, and #14 because he did not believe verbal abuse was applicable to the question, Do you feel that you have been intentionally injured by a team member?. He said he was aware of the facility abuse policy and reporting requirements. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety related to the verbal abuse from CNA E and just a combination of things. She said she might need an increase in her anti-anxiety medication. Record Review of the facility's Abuse: Prevention of and Prohibition Against dated October 2022 indicated verbal abuse included the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representative, or within their hearing distance, regardless of their [NAME], ability to comprehend, or disability. Prevention included - all staff, residents and visitors are encouraged to report incidents and grievances without the fear of retribution. Supervising staff to identify and correct any inappropriate or unprofessional behaviors. Identifying, correcting, and intervening in situations in which abuse is more likely to occur. Investigation included - all identified events are reported to the Administrator immediately. After receiving the allegation, during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. Protection included - immediately removing the employee from the care of any resident when an allegation of abuse is reported. Reporting included - all allegations of abuse she be reported immediately to the Administrator. Allegations of abuse will be reported to the appropriate State Agency in the applicable timeframes, as per the policy and applicable regulations. The Interim Administrator was notified of the Immediate Jeopardy on 11/14/22 at 10:55 AM, a Plan of Removal was requested and the Immediate Jeopardy template was provided. The Plan of Removal was accepted on 11/14/22 at 12:56 PM. Review of the Plan of Removal included: Immediate Action 1. Administrator suspended on 10/26/22 pending the outcome of the investigation. 2. Medical Director/Resident's physician notified of IJ by Director of Nursing at 5:25 PM via phone. 3. In-service regarding Abuse: Prevention of and Prohibition Against was started on 10-27-22 for routinely scheduled facility staff, educated by Clinical Resource/designee. Inservice to be completed with routinely scheduled facility staff, by 4:30PM on 10-28-22. Remaining facility staff and [NAME] [TRUNCATED]

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on observations, interview and record reviews the facility failed to ensure allegations of abuse were thoroughly investigated, prevent further potential abuse, and mistreatment while the investigation was in process, and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken for 4 (Residents #3, #12, #13, and #14) of 14 residents reviewed for abuse. The facility failed to immediately investigate, protect the residents, and report allegations of abuse when: 1. Resident #3's responsible party made allegations of abuse to CNA E on 10/19/22 and she did not report it to the Administrator and the facility did not investigate or implement measures to protect the resident from further abuse; and 2. Resident #12, #13, and #14 reported on 10/20/22 that CNA E verbally abused them, and the facility did not investigate or implement measures to protect the residents from further abuse. These failures place all the residents, residing in the facility, at risk of abuse and mental anguish. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 10/24/22. While the IJ was removed on 10/29/22, the facility remained out of compliance at a severity level of actual harm, and a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective actions. Findings included: In an interview, with the DON and Administrator on 10/20/22 at 9:15 AM, the DON said staff found a camera hidden in a Halloween decoration in Resident #3's room. The DON said she received the call from staff on 10/19/22 round 2:00 AM staff regarding the camera. She said the staff texted her a picture of the Halloween decoration and the camera in it. The DON had staff unplug the camera because it was plugged into an un-approved extension cord. The DON said she was not surprised to find the hidden camera in the room, because the resident's family disagreed with an abuse investigation, conducted on 09/15/22, that did not reveal any abuse. The Administrator said Resident #3's family did not contact the facility regarding the camera, and they had not reported any concerns. The Administrator said he was going to have the Social Worker contact Resident #3's family regarding the camera to get to sign an Electronic Monitoring Form, but he did not know if the Social Worker had contacted them yet. The Administrator and DON said they had not heard anything from the family regarding the camera and no abuse or care issues had been reported to them. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 10:43 AM, a video was received from Resident #3's responsible party. The video was recorded on 10/19/22 at 1:58 AM, it showed a female staff person (LVN C) taking Resident #3 to his room in his wheelchair. She pulled him backwards into the room in his wheelchair. LVN C, once in the resident's room, she faced the resident and said, there you go, she pointed her right finger at the resident and said, you stop it, then she pulled her right hand in a fist, the fist does not touch the resident, but her left hand came down on something that cannot be seen in frame and a pop was heard, at the same time LVN C was heard again saying, you stop it, the resident told LVN C, fuck you, LVN C turned towards the door and it appeared the resident attempted to continue the altercation, but the images are obscured by the Halloween decoration. LVN C asked the resident, are you fighting me?', then she said angrily, at the door, you stay there and then shuts the door. On 10/20/22 at 11:08 AM, a video was received from Resident #3's responsible party, it was recorded on 10/16/22 at 12:09 AM, it showed a male staff person (CNA D) enter the resident's room the resident was in bed. CNA D picked up the bed sheet but the resident tugs on the sheet, and CNA D lets go of the sheet. The resident says, get off me, you mother fucker, and throws the sheet at CNA D. CNA D walked to the foot of the resident's bed and told he resident, I'm going to kick your ass. The resident responds but his response could not be understood on the video. In a telephone interview on 10/20/22 at 11:25 AM, Resident #3's responsible party said she had a previous complaint regarding staff treatment of the resident, which she believed to be abuse, that was investigated and found to be unsubstantiated on 09/15/22. She said she disagreed with the findings of the facility's investigation and felt the facility was covering up abuse and/or mistreatment of Resident #3. She said a former employee, Housekeeper F, informed her she believed Resident #3 was being mistreated and told her she should place a camera in his room, because reports to the Administrator and DON of mistreatment were not being acted on. She said Housekeeper F was terminated for telling her about the mistreatment of Resident #3 for not reporting the abuse allegations to the Administrator. She said based on her experience with the facility; she decided to place a hidden camera in the resident's room. She said the resident did not have a roommate and it was not violating any other resident's privacy. She said when she saw the abuse recorded on the camera, she came to the facility to check on Resident #3 but did not alert the facility to the hidden camera. She said the videos showed Resident #3 was being abused by the staff. She said on 10/19/22 around 2:00 AM she could see on the camera that staff discovered the camera was in the room. She said she could see several staff members looking at the camera before it was unplugged. She said, staff from the facility just called her a few minutes ago, she did not know who, to tell her the camera was not approved and that she would need to sign a consent for its use. She said she asked the person that called if they were concerned about what the camera revealed and the person did not answer the question, and just told her she needed to sign the form in order for the camera to be approved. She said she informed the staff she had already removed the camera from the room and took it home. She said no one reached out to her about the camera prior to the phone call today, after the investigator entered the facility. She said there was one additional video that she had not sent yet, but she would send it. She said she wanted to move the resident to another facility but had to wait for his Medicaid to be approved before her facility of choice would accept him. She said she feels stuck because she cannot move him but cannot trust that he won't be harmed at the facility. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 12:04 PM, the Administrator and DON were shown the above videos for staff identification purposes. They said both videos showed abuse of Resident #3. They identified LVN C as the staff in the first video and CNA D in the second video. The DON said there had been no reports or concerns regarding the employees' care and treatment of the residents. She said the employees would be notified and suspended pending the outcome of the investigation. On 10/20/22 at 12:38 PM, the third and final video was received from Resident #3's responsible party, it was recorded on 10/13/22 at 7:36 PM, it showed two staff (LVN C and CNA E) providing care to the resident while he was in bed. LVN C was at the head of the resident's bed encouraging him to allow care but he was saying don't do that, CNA E was observed getting some wipes, she joined LVN C at the resident's bedside. The resident could be heard saying, God dammit, at that point, LVN C's left hand went up with her hand open, while she leaned forward and told the resident to stop it, she does not hit the resident, but it appeared to be a gesture like she was going to slap the resident. On 10/20/22 at 12:45 PM, the Administrator and DON said the third video was LVN C who appeared to raise her hand to Resident #3. They said the other staff was CNA E. Record Review of Resident #3's Admission Record dated 10/20/22 indicated the [AGE] year-old male resident was readmitted to the facility on [DATE] with diagnoses which included dementia and major depressive disorder. Record Review of Resident #3's quarterly MDS dated [DATE] indicated the resident had short and long-term memory problems. He was severely cognitively impaired. He had no behaviors. Record Review of Resident #3's un-dated Care Plan indicated he had behaviors which included, combativeness, physical and verbal aggression with staff. The interventions included to provide physical and verbal cues to alleviate the resident's anxiety and give positive feedback. If the resident resists care, reassure the resident, leave, and return 5-10 minutes later and try again. In an observation on 10/20/22 at 1:34 PM, Resident #3 was propelling himself in his wheelchair. He was not able to answer any direct questions. In an interview on 10/20/22 at 2:44 PM, CNA E watched third video. She said she did not think LVN C was raising her hand to the resident, but she was not paying attention, at the time. She said she thought maybe LVN C was reaching to roll the resident over. She said she had never seen any staff being abusive or mistreating the resident. She said around 10:00 PM yesterday, 10/19/22, the resident's responsible party asked her if she was aware there had been a camera in the room. She said she told her she was not aware. She said the resident's responsible party told her she put the camera in the room because the resident was being abused by the staff. She said she told the resident's responsible party she did not believe that would happen at the facility. She said she did not tell anyone the resident's responsible party reported the resident had been abused. She said LVN C overheard her talking with the resident's responsible party and knew about the allegation. She said she was supposed to inform the Administrator of any abuse allegations; however, she did not report it. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/20/22 at 4:21 PM, with the DON present, LVN C said on 10/19/22 Resident #3 was awake around 2:00 AM and staff got him up in his wheelchair and assisted him to the nurses' station for monitoring. She said the resident became combative, threw things off the nurses' station, and tried to hit, kick and bite staff. She said the video showed her pulling him in his room backwards because he was being combative. She said her right hand was in a fist and pulled back because she thought he was going to grab or bite her. She said she did not make physical contact with the resident. She said the slap sound on the video was when she slapped her own leg. She said she did not feel she was being abusive to the resident. She said she was speaking loudly but it was because the resident was hard of hearing. She said she did tell the resident to stay in his room and closed the door, but it was only for approximately 5 minutes until she could get a CNA to assist her to put the resident back to bed. She denied ever threatening or hitting the resident. She said staff discovered the camera after 2:00 AM and let the DON know. She said she did hear CNA E speaking to Resident #3's responsible party but she did not hear the allegation of abuse. She later said that maybe CNA E told her something about the allegation, but she did not remember, and she was busy at the time. She said she would report abuse to the DON, she was not aware the Administrator was the Abuse Coordinator. She said she should not have raised her voice to the resident. She said Resident #3 tried to kick her as she was leaving the room and that was why she asked him if he was trying to fight her. She said she never raised her hand to hit the resident. The DON informed her she was suspended pending the outcome of the investigation and was not to return to the facility until further notice. In a telephone interview on 10/20/22 at 3:35 PM, with the DON present, CNA D said if the resident was too combative, he was supposed to get another CNA to assist him, but he did not feel the resident was being that aggressive on 10/16/22. He said the resident tugged on the sheet and he let go, he said he did not know, at the time, the camera was in the room. He said he did tell the resident he was going to kick his ass because he was under pressure, but he would not have physically hurt the resident because it was not in his heart to do so. He said what he said was abuse. He said he was frustrated and tired of the resident being so mean. He said he had not seen or heard any other staff be mean or aggressive with the resident. He said he apologized dearly for his actions and would never hurt the residents. The DON informed him he could not report to work and was under investigation. In an interview on 10/20/22 at 5:00 PM, the Administrator said staff knew he was the Abuse Coordinator because they had all been in-serviced and it was posted in the facility. He said it was his expectation that staff would notify him immediately of any allegations of abuse or mistreatment. He said the facility would investigate, and notify the police and State Agency. In a telephone interview on 10/20/22 at 5:42 PM, Resident #3's responsible party said on 10/19/22 she spoke to CNA E regarding her abuse concerns and why she installed the camera. She said she asked if she could show CNA E the videos of the abuse, but the CNA told her her eyesight was not good and she did not think she could see the videos. She said she believed CNA E did not wish to see the videos because she would have to report the abuse to the Administrator. She said it further showed how staff wanted to turn a blind eye to reports of abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 10/20/22 at 6:07 PM, Former Housekeeper F said she was the housekeeper on Resident #3's hall and she felt staff were not caring for the resident appropriately. She said she believed the staff were not assisting him with meals, were abrupt and discourteous to him. She said she spoke with the Administrator and DON about her concerns, but she believed they were not addressed. She said she spoke to the resident's responsible party regarding her concerns and told her she should put a camera in the resident's room because she believed he was being mistreated by staff. She said when the facility found out she told the resident's responsible party she suspected abuse, the DON called her on 09/10/22, to question her if she knew who the Abuse Coordinator was, and she told her it was the Administrator. She said the Administrator wanted to meet with her in the next day 09/11/22, in his office, but she did not meet with him for fear she would be terminated. She said her last day of employment was 09/11/22. She said the facility's inaction regarding allegations made employees not want to report anything. She said other facility employees knew about things but don't report it. She would not give the investigator the names of the other employees. She said there were employees, still working at the facility, who abused residents. She named CNA E, as an abuser. In an observation on 10/24/22 at 9:30 AM, Resident #3 was propelling himself in his wheelchair. He was smiling and appeared to be in a good mood. He was not able to answer questions appropriately. In an interview on 10/24/22 at 9:43 AM, the Administrator and DON said the videos showed, based on their investigation, verbal abuse, and included intimidation and seclusion. They said they were going to terminate LVN C and CNA D for abuse. They said CNA E would be terminated for not reporting the allegation of abuse to the Administrator. The Administrator and DON said Former Housekeeper F never reported any abuse, neglect, or mistreatment of Resident #3 to them. The Administrator and DON said in-service training was provided orally and written for all staff on all three shifts, after the abuse allegation regarding Resident #3 on 09/15/22. On 10/24/22 at 12:43 PM the Administrator and DON were informed of an Immediate Jeopardy. On 10/25/22 at 3:58 PM Safe Surveys (interviews with residents regarding abuse and/or mistreatment) were received from the Administrator. On 10/25/22 at 4:18 PM the Immediate Jeopardy Plan of Removal was accepted. In an interview on 10/26/22 at 10:04 AM, the Social Worker said Medical Records had completed Safe Surveys with residents on 10/20/22. Record Review of the Safe Surveys, provided by the Administrator, on 10/25/22 at 3:58 PM, did not include any completed by Medical Records. Record Review of the Resident Council Minutes dated 10/17/22 indicated resident said they needed more customer service and respect from the staff. No staff was named and the number of residents who voiced this was not identified. In an interview on 10/26/22 at 10:27 AM, the AD said the Resident Council did bring up, in the meeting on 10/17/22, that they would like staff to be more respectful, but no abuse was alleged. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/26/22 at 11:05 AM, Medical Records said she conducted safe surveys on 10/20/22. She said during the surveys on 10/20/22, Resident #13 said CNA E yelled at her and was pointing her finger at her so close to her she thought the aide was going to hit her, but she did not. She said Resident 13's roommate, Resident #14 said she put on the light again for a different reason, to ask a question, and CNA E yelled at them again and stated, why are you on the light again? What's your problem? I was just in here!. She said Resident #14 was the Resident Council President and told her that they just tried not to bother CNA E after that. She said Resident #14 told Resident #13 they needed to speak up to get it to stop. She said Residents #13 and #14 told her they were verbally abused by CNA E. She said the interviews were between 9:00 AM -11:00 AM on Thursday, 10/20/22. She said she told the Administrator and DON immediately on 10/20/22. She said the residents told her the verbal abuse occurred on Monday, 10/17/22 on the 2:00 PM - 10:00 PM shift. She said, after she reported the allegation of abuse to the Administrator and DON, she interviewed Resident #12 on 10/20/22 between 11:00 AM -12:00 PM and the resident told her CNA E had verbally abused her too by yelling at her. She said once again she immediately informed the Administrator and DON of the verbal abuse allegation on 10/20/22. On 10/26/22 at 12:10 PM the investigator sent the Administrator an email requesting any additional safe surveys and if the facility had any new allegations of abuse. Record Review of Resident #13's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses which included, chronic obstructive pulmonary disease and bipolar disorder (a mental illness). Record Review of Resident #13's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). In an observation and interview on 10/26/22 at 1:22 PM, Resident #13 was in her room in her wheelchair. She said on 10/17/22, her roommate, Resident #14, had the call light and CNA E came in the room and was screaming, upset, that the call light was on. She said CNA E came over to her while she was in her bed and was screaming and pointing her finger so close to her; she was afraid she was going to hit her. She said CNA E was mad that her roommate had turned on the call light. She said she was shocked, she felt threatened and scared by CNA E's outburst. She said she later, the same evening, wanted to just ask a question, she put the call light on, and CNA E came in yelling again and asked why they were on the light again after she had just been in there. She said CNA E verbally abused her on 10/17/22. She said the only person she told, about the abuse, was the Medical Records person on 10/20/22. Record Review of Resident #12's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses of mild cognitive impairment, mild intellectual disabilities, depression and, the need for assistance with personal care. Record Review of Resident #12's quarterly MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS score of 10 (a score of 8-12 indicated moderate cognitive impairment). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 1:46 PM, Resident #12 was in her wheelchair. She said about two or three weeks ago, CNA E came in her room and was going to assist with her incontinent care. She said CNA E started yelling at her, saying the resident could help more with the care. She said she was unable to physically help more, and she started crying. She said she was verbally abused by CNA E and was a little scared of her. She said it was on a weekend, and she told a lady working the 500 Hall, she did not know the lady's name, and the DON was called. She said she told the DON what happened with CNA E. She said the DON told her they would do some additional training with staff. She said she felt like she received the silent treatment from CNA E after she reported her. She said she reported the incident again on 10/20/22 to the Medical Records person. At 10/26/22 at 2:41 PM, there was no response from the Administrator regarding the email sent at 12:10 PM. In an interview on 10/26/22 at 2:58 PM, the Administrator said Medical Records conducted some Safe Surveys on 10/20/22. He said she did not notify him of the verbal abuse allegations reported by Residents #12, #13, and #14. He said staff conducting the Safe Surveys were told to immediately report any allegations of abuse and/or mistreatment to him immediately. He said he would look for the Safe Surveys conducted by Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 PM, the DON said she was not aware of the new allegations regarding CNA E. She said she was not contacted on a weekend regarding an incident between Resident #12 and CNA E. She said she would immediately tell the Administrator of any allegations regarding abuse. She said CNA E was terminated on Monday, 10/24/22 for not reporting Resident #3's responsible party's allegation of abuse to the Administrator. Record Review of Resident #14's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was readmitted to the facility on [DATE] with diagnoses which included mild cognitive impairment and anxiety. Record Review of Resident #14's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 4:04 PM, Resident #14 was in bed in her room. She said she had been the Resident Council President about a month. She said, in the Resident Council Meeting in October 2022 it was discussed how the staff were speaking to the residents, at times. She said the residents perceived some of the staff to be snotty and argumentative, at times, like when a resident needed something the staff acted like they were doing the resident a favor instead of the fact that the staff worked for the residents. She said this was discussed in the council because staffs' attitudes towards the residents were getting worse not better. She said Medical Records came in and asked her, last week on 10/20/22 about her treatment in the facility. She said she told her about an incident on Monday 10/17/22 around 5:00 PM, she requested to be transferred from her wheelchair to bed and provided incontinent care. She said CNA E told her go to room and get in position. She said she followed instructions and waited over an hour and then put the call light on. She said CNA E came into the room yelling and screaming that the resident should not have put the call light on and that she had to just wait her turn for assistance. She said she told CNA E she was going to report her, and CNA E told her to go ahead because she did not have to answer to the resident. She said CNA E was screaming over her and pointing her finger. She said CNA E then went to her roommate's (Resident #13) side of the bed, the roommate was in bed, CNA E was standing over Resident #13, still yelling, and pointing her finger but was directed at her (Resident #14) and not the roommate (Resident #13). She said Resident #13 became afraid CNA E was going to hit her and Resident #13 started crying. She said she told Resident #13 not to cry because CNA E was mad at her (Resident #14). She said CNA E left the room, and Resident #13, who does not cuss, said Holy Shit!. She said about an hour later, the same evening, Resident #13 just wanted to ask a question, so she put the call light on, and CNA E came in the room screaming again. She said CNA E asked them What is your problem why is the call light on again?. She said Resident #13 apologized and said she just wanted to ask the AD something. She said she had been a resident at the facility for 5 years and CNA E had always had a temper. She said CNA E had an attitude like she was invincible because nothing ever happened to her, and she felt like she would not get fired. She said CNA E had always had a bad temper, but it had never been like this before. She said she did not tell anyone about the incident until the Medical Records person asked her about abuse on 10/20/22. She said she was verbally abused and intimidated by CNA E on 10/17/22. In an interview on 10/26/22 at 4:47 PM, the DON and the Clinical Resource RN said Medical Records had the Safe Surveys dated 10/20/22, on her person, for Residents #12, #13, and #14. She said Medical Records reported them verbally to the Administrator on 10/20/22 but did not give him the forms. They said the Administrator and Medical Records were suspended pending the outcome of the investigation. Record Review of Safe Surveys dated 10/20/22, not timed, indicated the question, Do you feel that you have been intentionally injured by a team member? -Resident #12 - verbal abuse -Resident #13 - verbal abuse with violently yelling and afraid CNA E would hit her on Monday (10/17/22) -Resident #14 - verbally abused with attitude - CNA E (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review revealed Medical Records completed the three above Safe Surveys again on 10/20/22, not timed, and all three residents' answers to Do you feel you have been intentionally injured by a team member? were changed to, No. In an interview on 10/27/22 at 10:02 AM, the Clinical Resource RN and DON said the facility began in-services with all staff on the types of abuse, with a written quiz. The DON was made the Abuse Prevention Coordinator. The facility began interview with staff to see if any abuse allegations had been reported to the Administrator that were not acted upon. The facility began a root cause analysis. She said the Safe Surveys conducted on 10/20/22 with Residents #12, #13, and #14 revealed verbal abuse by CNA E. The DON said CNA E worked on 10/21/22, after the allegations of verbal abuse were reported to the Administrator on 10/20/22. She said CNA E did not work after 10/21/22. She said CNA E was terminated on 10/24/22 for not reporting the allegation of abuse made by Resident #3's responsible party, but not related to the allegations of verbal abuse. Record Review of CNA E's time sheet dated 10/27/22 indicated she worked on 10/21/22 from 2:24 PM - 9:48 PM, 7.4 hours. Attempts were made to interview CNA E on 10/28/22 at 5:23 PM, 7:24 PM, and 10/29/22 at 12:19 PM, there was no answer to the phone call and messages, a text was also sent on 10/29/22 at 12:20 PM requesting an interview, no return call was received prior to the exit on 10/29/22 at 1:00 PM. In a telephone interview on 10/27/22 at 5:26 PM, Medical Records said she told the Administrator immediately about each of the allegations of verbal abuse on 10/20/22. She said she told him after each allegation was made. She said the DON was also present, during the discussion with the Administrator. She said the administrator told her to shred Resident #12, #13, #14's Safe Surveys that revealed verbal abuse. She said he told her State was not looking at verbal abuse as being intentionally injured. She said the Administrator, then gave her new forms to complete with the same residents again. She said on 10/26/22, after the investigator asked about the Safe Surveys, she got the three original Safe Surveys for Resident #12, #13, and #14 out of the shred bin to give to the Administrator. She said the Administrator understood on 10/20/22 Residents #12, #13, and #14 had alleged they were verbally abused by CNA E. In an interview on 10/27/22 at 5:41 PM, the DON said she was not involved in the conversation regarding the abuse, as stated above, on 10/20/22. She said she was not aware of abuse being reported on the three residents (Residents #12, #13, and #14) in question. In a telephone interview on 10/27/22 at 5:45 PM, the Administrator said DON was not in the room when Medical Records discussed the verbal abuse allegations. He said Medical Records did notify him on 10/20/22 of the verbal abuse allegations. He said with everything going on the verbal abuse allegations did not cross his mind again. He said yesterday (10/26/22) Medical Records did get the Safe Surveys out of the shred bin, but he did not tell her to shred them. He told her to set them aside in his office. He said he did ask her to conduct new Safe Surveys on Resident #12, #13, and #14 because he did not believe verbal abuse was applicable to the question, Do you feel that you have been intentionally injured by a team member?. He said he was aware of the facility abuse policy and reporting requirements. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety related to the verbal abuse from CNA E and just a combination of things. She said she might need an increase in her anti-anxiety medication. Record Review of the facility's Abuse: Prevention of and Prohibition Against dated October 2022 indicated verbal abuse included the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representative, or within their hearing distance, regardless of their [NAME], ability to comprehend, or disability. Prevention included - all staff, residents and visitors are encouraged to report incidents and grievances without the fear of retribution. Supervising staff to identify and correct any inappropriate or unprofessional behaviors. Identifying, correcting, and intervening in situations in which abuse is more likely to occur. Investigation included - all identified events are reported to the Administrator immediately. After receiving the allegation, during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. Protection included - immediately removing the employee from the care of any resident when an allegation of abuse is reported. Reporting included - all allegations of abuse she be reported immediately to the Administrator. Allegations of abuse will be reported to the appropriate State Agency in the applicable timeframes, as per the policy and applicable regulations. The Interim Administrator, Clinical Resource RN, and DON were notified of the Immediate Jeopardy on 10/27/22 at 4:01 PM, a Plan of Removal was requested and the Immediate Jeopardy template was provided. The Plan of Removal was accepted on 10/28/22 at 2:50 PM. Review of the Plan of Removal included: Immediate Action: 1. Administrator suspended on 10/26/22 pending the outcome of the investigation. 2. Medical Director/Resident's physician notified of IJ by Director of Nursing at 5:25 PM via phone. 3. In-service regarding Abuse: Prevention of and Prohibition Against was started on 10-27-22 for routinely scheduled facility staff,

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on observation, interview and record review the facility failed to ensure the physician order for IV care were followed for 1 (Resident #6) of 1 resident reviewed for quality of care. The facility failed to ensure LVNs H, J and K followed the physician's order to ensure Resident #6's IV dressing was changed, according to the physician's order on 10/22. This failure could place, residents who required IV dressing changes, at risk for infection and decline in health status. Findings included: Record review of Resident #6's Admission Record dated 10/29/22 indicated the [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses which included, sepsis (an infection), and skin infection. Record review of Resident #6's physician's order dated 09/10/22 indicated the IV had two lines with two plastic caps on the end of each line that were to be changed with each dressing change every 7 days and as needed. Record review of Resident #6's admission MDS dated [DATE] indicated the resident had a BIMS score of 12 which indicated moderately cognitively impaired. He required assistance with activities of daily living, transfers, personal hygiene, and bathing. Record review of Resident #6's Care Plan dated 09/29/22 indicated no care plan for the IV. Record review of Resident #6's October 2022 IV MAR, indicated the resident did not receive an IV antibiotic; however, the IV had two lines with two plastic caps on the end of each line that were to be changed with each dressing change every 7 days and as needed. The documentation indicated the physician ordered care was provided every 7 days on Sundays for 10/02/22, 10/09/22, 10/16/22, and 10/23/22. In an interview on 10/24/22 at 12:46 PM, the DON said she received multiple concerns from Resident #6's responsible party regarding his nursing care. She said she checked on the resident daily and she gave the weekend nurses, who are all agency staff, a report on the resident's needs and condition to ensure continuity of care. In an observation on 10/28/22 at 2:20 PM, Resident #6 was in his room in his wheelchair. An IV site dressing to his right arm and was dated 09/30/22. He was not receiving any IV medication. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's Nursing Progress Note dated 10/28/22 at 4:07 PM, the Clinical Resource RN documented, the DON contacted the resident's physician regarding the lack of IV site care since 09/30/22. The physician said he would not be able to come to the facility and assess the site, at this time. He instructed the DON to change the dressing and assess the site. The Clinical Resource RN and the Charge Nurse changed the dressing. The resident did not have any signs or symptoms of redness, warmth, swelling, drainage, or pain. The physician's Nurse Practitioner would be by this evening to assess the site. In an interview on 10/28/22 at 2:30 PM, LVN M said the dressing to Resident #6's IV site was dated 09/30/22, but it should have been changed every 7 days but not on her shift. In an interview on 10/28/22 at 3:50 PM, the Clinical Resource RN and DON said Resident #6's dressing to the IV site on his right arm was dated 09/30/22. The DON said all the agency nurses that documented, on the October 2022 TAR, the dressing was changed as ordered every 7 days. The Clinical Resource RN said the resident's physician was notified, and he did not want to discontinue the IV, at this time. The DON said she was not aware the physician's orders for the IV were not being followed. The Clinical Resource RN said she looked at the IV site today (10/28/22), and there was no redness or drainage. She changed the dressing. She said the resident did not report any pain. In a telephone interview on 10/29/22 at 11:49 AM, Agency LVN H said he only worked at the facility one day on Sunday, 10/09/22 and it was not a good experience. He said he was not given report when he started his shift. He said he did not know where the facility kept the wound care supplies. He said he complained to the agency about the working conditions and would not work for the facility again because he felt he was unable to do even basic nursing care, like dressing changes. He said he did not remember Resident #6 or any specifics regarding his IV care, dressing change or what he documented. In a telephone interview on 10/29/22 at 11:56 AM, Agency LVN J said she worked at the facility one time on, Sunday 10/23/22, she said it was rough because she did not receive report on the residents and was not given a computer to access the clinical records. She said it was very difficult for her to get anything done for the residents. She said she did not remember anything about Resident #6's dressing or IV care. In a telephone interview on 10/29/22 at 12:02 PM, Agency LVN R said he did not change Resident #6's dressing on Sunday, 10/16/22. He said he just looked to see if the dressing was clean and intake. He said his documentation on 10/16/22 was just to verify he observed the dressing; however, he did not provide any IV care. Record review of the facility's un-dated Nursing Clinical IV - Solutions Policy indicated all central lines will be capped or have an extension set applied, and all dressing should be labeled with the date, time, and nurses' initials.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on interview and record review, the facility failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 4 (Residents #3, #12, #13, and #14) of 14 residents reviewed for abuse. 1) CNA E failed to report Resident #3's responsible party's allegation of abuse to the Administrator on 10/19/22. 2) The Administrator (the Abuse Coordinator) failed the residents by not implementing the Abuse Policy when he was informed, on 10/20/22, of Resident #12, #13, and #14's allegations that CNA E verbally abused them. CNA E continued to work after the Administrator was notified of the abuse. Safe Surveys conducted on 10/20/22, identified abuse and indicated additional residents were being abused. The Safe Surveys were not provided to the investigator until repeated inquiry and were found in the shred bin. These failures could place all the residents, who resided in the facility, at risk for abuse and mental anguish. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 11/14/22. While the IJ was removed on 11/14/22, the facility remained out of compliance at a severity level of actual harm, and a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective actions. Findings included: In an interview, with the DON and Administrator on 10/20/22 at 9:15 AM, the DON said staff found a camera hidden in a Halloween decoration in Resident #3's room. The DON said she received the call from staff on 10/19/22 round 2:00 AM staff regarding the camera. She said the staff texted her a picture of the Halloween decoration and the camera in it. The DON had staff unplug the camera because it was plugged into an un-approved extension cord. The DON said she was not surprised to find the hidden camera in the room, because the resident's family disagreed with an abuse investigation, conducted on 09/15/22, that did not reveal any abuse. The Administrator said Resident #3's family did not contact the facility regarding the camera, and they had not reported any concerns. The Administrator said he was going to have the Social Worker contact Resident #3's family regarding the camera to get to sign an Electronic Monitoring Form, but he did not know if the Social Worker had contacted them yet. The Administrator and DON said they had not heard anything from the family regarding the camera and no abuse or care issues had been reported to them. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 10:43 AM, a video was received from Resident #3's responsible party. The video was recorded on 10/19/22 at 1:58 AM, it showed a female staff person (LVN C) taking Resident #3 to his room in his wheelchair. She pulled him backwards into the room in his wheelchair. LVN C, once in the resident's room, she faced the resident and said, there you go, she pointed her right finger at the resident and said, you stop it, then she pulled her right hand in a fist, the fist does not touch the resident, but her left hand came down on something that cannot be seen in frame and a pop was heard, at the same time LVN C was heard again saying, you stop it, the resident told LVN C, fuck you, LVN C turned towards the door and it appeared the resident attempted to continue the altercation, but the images are obscured by the Halloween decoration. LVN C asked the resident, are you fighting me?', then she said angrily, at the door, you stay there and then shuts the door. On 10/20/22 at 11:08 AM, a video was received from Resident #3's responsible party, it was recorded on 10/16/22 at 12:09 AM, it showed a male staff person (CNA D) enter the resident's room the resident was in bed. CNA D picked up the bed sheet but the resident tugs on the sheet, and CNA D lets go of the sheet. The resident says, get off me, you mother fucker, and throws the sheet at CNA D. CNA D walked to the foot of the resident's bed and told he resident, I'm going to kick your ass. The resident responds but his response could not be understood on the video. In a telephone interview on 10/20/22 at 11:25 AM, Resident #3's responsible party said she had a previous complaint regarding staff treatment of the resident, which she believed to be abuse, that was investigated and found to be unsubstantiated on 09/15/22. She said she disagreed with the findings of the facility's investigation and felt the facility was covering up abuse and/or mistreatment of Resident #3. She said a former employee, Housekeeper F, informed her she believed Resident #3 was being mistreated and told her she should place a camera in his room, because reports to the Administrator and DON of mistreatment were not being acted on. She said Housekeeper F was terminated for telling her about the mistreatment of Resident #3 for not reporting the abuse allegations to the Administrator. She said based on her experience with the facility; she decided to place a hidden camera in the resident's room. She said the resident did not have a roommate and it was not violating any other resident's privacy. She said when she saw the abuse recorded on the camera, she came to the facility to check on Resident #3 but did not alert the facility to the hidden camera. She said the videos showed Resident #3 was being abused by the staff. She said on 10/19/22 around 2:00 AM she could see on the camera that staff discovered the camera was in the room. She said she could see several staff members looking at the camera before it was unplugged. She said, staff from the facility just called her a few minutes ago, she did not know who, to tell her the camera was not approved and that she would need to sign a consent for its use. She said she asked the person that called if they were concerned about what the camera revealed and the person did not answer the question, and just told her she needed to sign the form in order for the camera to be approved. She said she informed the staff she had already removed the camera from the room and took it home. She said no one reached out to her about the camera prior to the phone call today, after the investigator entered the facility. She said there was one additional video that she had not sent yet, but she would send it. She said she wanted to move the resident to another facility but had to wait for his Medicaid to be approved before her facility of choice would accept him. She said she feels stuck because she cannot move him but cannot trust that he won't be harmed at the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 12:04 PM, the Administrator and DON were shown the above videos for staff identification purposes. They said both videos showed abuse of Resident #3. They identified LVN C as the staff in the first video and CNA D in the second video. The DON said there had been no reports or concerns regarding the employees' care and treatment of the residents. She said the employees would be notified and suspended pending the outcome of the investigation. On 10/20/22 at 12:38 PM, the third and final video was received from Resident #3's responsible party, it was recorded on 10/13/22 at 7:36 PM, it showed two staff (LVN C and CNA E) providing care to the resident while he was in bed. LVN C was at the head of the resident's bed encouraging him to allow care but he was saying don't do that, CNA E was observed getting some wipes, she joined LVN C at the resident's bedside. The resident could be heard saying, God dammit, at that point, LVN C's left hand went up with her hand open, while she leaned forward and told the resident to stop it, she does not hit the resident, but it appeared to be a gesture like she was going to slap the resident. On 10/20/22 at 12:45 PM, the Administrator and DON said the third video was LVN C who appeared to raise her hand to Resident #3. They said the other staff was CNA E. Record Review of Resident #3's Admission Record dated 10/20/22 indicated the [AGE] year-old male resident was readmitted to the facility on [DATE] with diagnoses which included dementia and major depressive disorder. Record Review of Resident #3's quarterly MDS dated [DATE] indicated the resident had short and long-term memory problems. He was severely cognitively impaired. He had no behaviors. Record Review of Resident #3's un-dated Care Plan indicated he had behaviors which included, combativeness, physical and verbal aggression with staff. The interventions included to provide physical and verbal cues to alleviate the resident's anxiety and give positive feedback. If the resident resists care, reassure the resident, leave, and return 5-10 minutes later and try again. In an observation on 10/20/22 at 1:34 PM, Resident #3 was propelling himself in his wheelchair. He was not able to answer any direct questions. In an interview on 10/20/22 at 2:44 PM, CNA E watched third video. She said she did not think LVN C was raising her hand to the resident, but she was not paying attention, at the time. She said she thought maybe LVN C was reaching to roll the resident over. She said she had never seen any staff being abusive or mistreating the resident. She said around 10:00 PM yesterday, 10/19/22, the resident's responsible party asked her if she was aware there had been a camera in the room. She said she told her she was not aware. She said the resident's responsible party told her she put the camera in the room because the resident was being abused by the staff. She said she told the resident's responsible party she did not believe that would happen at the facility. She said she did not tell anyone the resident's responsible party reported the resident had been abused. She said LVN C overheard her talking with the resident's responsible party and knew about the allegation. She said she was supposed to inform the Administrator of any abuse allegations; however, she did not report it. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/20/22 at 4:21 PM, with the DON present, LVN C said on 10/19/22 Resident #3 was awake around 2:00 AM and staff got him up in his wheelchair and assisted him to the nurses' station for monitoring. She said the resident became combative, threw things off the nurses' station, and tried to hit, kick and bite staff. She said the video showed her pulling him in his room backwards because he was being combative. She said her right hand was in a fist and pulled back because she thought he was going to grab or bite her. She said she did not make physical contact with the resident. She said the slap sound on the video was when she slapped her own leg. She said she did not feel she was being abusive to the resident. She said she was speaking loudly but it was because the resident was hard of hearing. She said she did tell the resident to stay in his room and closed the door, but it was only for approximately 5 minutes until she could get a CNA to assist her to put the resident back to bed. She denied ever threatening or hitting the resident. She said staff discovered the camera after 2:00 AM and let the DON know. She said she did hear CNA E speaking to Resident #3's responsible party but she did not hear the allegation of abuse. She later said that maybe CNA E told her something about the allegation, but she did not remember, and she was busy at the time. She said she would report abuse to the DON, she was not aware the Administrator was the Abuse Coordinator. She said she should not have raised her voice to the resident. She said Resident #3 tried to kick her as she was leaving the room and that was why she asked him if he was trying to fight her. She said she never raised her hand to hit the resident. The DON informed her she was suspended pending the outcome of the investigation and was not to return to the facility until further notice. In a telephone interview on 10/20/22 at 3:35 PM, with the DON present, CNA D said if the resident was too combative, he was supposed to get another CNA to assist him, but he did not feel the resident was being that aggressive on 10/16/22. He said the resident tugged on the sheet and he let go, he said he did not know, at the time, the camera was in the room. He said he did tell the resident he was going to kick his ass because he was under pressure, but he would not have physically hurt the resident because it was not in his heart to do so. He said what he said was abuse. He said he was frustrated and tired of the resident being so mean. He said he had not seen or heard any other staff be mean or aggressive with the resident. He said he apologized dearly for his actions and would never hurt the residents. The DON informed him he could not report to work and was under investigation. In an interview on 10/20/22 at 5:00 PM, the Administrator said staff knew he was the Abuse Coordinator because they had all been in-serviced and it was posted in the facility. He said it was his expectation that staff would notify him immediately of any allegations of abuse or mistreatment. He said the facility would investigate, and notify the police and State Agency. In a telephone interview on 10/20/22 at 5:42 PM, Resident #3's responsible party said on 10/19/22 she spoke to CNA E regarding her abuse concerns and why she installed the camera. She said she asked if she could show CNA E the videos of the abuse, but the CNA told her her eyesight was not good and she did not think she could see the videos. She said she believed CNA E did not wish to see the videos because she would have to report the abuse to the Administrator. She said it further showed how staff wanted to turn a blind eye to reports of abuse. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 10/20/22 at 6:07 PM, Former Housekeeper F said she was the housekeeper on Resident #3's hall and she felt staff were not caring for the resident appropriately. She said she believed the staff were not assisting him with meals, were abrupt and discourteous to him. She said she spoke with the Administrator and DON about her concerns, but she believed they were not addressed. She said she spoke to the resident's responsible party regarding her concerns and told her she should put a camera in the resident's room because she believed he was being mistreated by staff. She said when the facility found out she told the resident's responsible party she suspected abuse, the DON called her on 09/10/22, to question her if she knew who the Abuse Coordinator was, and she told her it was the Administrator. She said the Administrator wanted to meet with her in the next day 09/11/22, in his office, but she did not meet with him for fear she would be terminated. She said her last day of employment was 09/11/22. She said the facility's inaction regarding allegations made employees not want to report anything. She said other facility employees knew about things but don't report it. She would not give the investigator the names of the other employees. She said there were employees, still working at the facility, who abused residents. She named CNA E, as an abuser. In an observation on 10/24/22 at 9:30 AM, Resident #3 was propelling himself in his wheelchair. He was smiling and appeared to be in a good mood. He was not able to answer questions appropriately. In an interview on 10/24/22 at 9:43 AM, the Administrator and DON said the videos showed, based on their investigation, verbal abuse, and included intimidation and seclusion. They said they were going to terminate LVN C and CNA D for abuse. They said CNA E would be terminated for not reporting the allegation of abuse to the Administrator. The Administrator and DON said Former Housekeeper F never reported any abuse, neglect, or mistreatment of Resident #3 to them. The Administrator and DON said in-service training was provided orally and written for all staff on all three shifts, after the abuse allegation regarding Resident #3 on 09/15/22. On 10/24/22 at 12:43 PM the Administrator and DON were informed of an Immediate Jeopardy. On 10/25/22 at 3:58 PM Safe Surveys (interviews with residents regarding abuse and/or mistreatment) were received from the Administrator. On 10/25/22 at 4:18 PM the Immediate Jeopardy Plan of Removal was accepted. In an interview on 10/26/22 at 10:04 AM, the Social Worker said Medical Records had completed Safe Surveys with residents on 10/20/22. Record Review of the Safe Surveys, provided by the Administrator, on 10/25/22 at 3:58 PM, did not include any completed by Medical Records. Record Review of the Resident Council Minutes dated 10/17/22 indicated resident said they needed more customer service and respect from the staff. No staff was named and the number of residents who voiced this was not identified. In an interview on 10/26/22 at 10:27 AM, the AD said the Resident Council did bring up, in the meeting on 10/17/22, that they would like staff to be more respectful, but no abuse was alleged. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 1:46 PM, Resident #12 was in her wheelchair. She said about two or three weeks ago, CNA E came in her room and was going to assist with her incontinent care. She said CNA E started yelling at her, saying the resident could help more with the care. She said she was unable to physically help more, and she started crying. She said she was verbally abused by CNA E and was a little scared of her. She said it was on a weekend, and she told a lady working the 500 Hall, she did not know the lady's name, and the DON was called. She said she told the DON what happened with CNA E. She said the DON told her they would do some additional training with staff. She said she felt like she received the silent treatment from CNA E after she reported her. She said she reported the incident again on 10/20/22 to the Medical Records person. At 10/26/22 at 2:41 PM, there was no response from the Administrator regarding the email sent at 12:10 PM. In an interview on 10/26/22 at 2:58 PM, the Administrator said Medical Records conducted some Safe Surveys on 10/20/22. He said she did not notify him of the verbal abuse allegations reported by Residents #12, #13, and #14. He said staff conducting the Safe Surveys were told to immediately report any allegations of abuse and/or mistreatment to him immediately. He said he would look for the Safe Surveys conducted by Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 PM, the DON said she was not aware of the new allegations regarding CNA E. She said she was not contacted on a weekend regarding an incident between Resident #12 and CNA E. She said she would immediately tell the Administrator of any allegations regarding abuse. She said CNA E was terminated on Monday, 10/24/22 for not reporting Resident #3's responsible party's allegation of abuse to the Administrator. Record Review of Resident #14's Admission Record dated 10/29/22 indicated the [AGE] year-old female resident was readmitted to the facility on [DATE] with diagnoses which included mild cognitive impairment and anxiety. Record Review of Resident #14's quarterly MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated no cognitive impairment). (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 10/26/22 at 4:04 PM, Resident #14 was in bed in her room. She said she had been the Resident Council President about a month. She said, in the Resident Council Meeting in October 2022 it was discussed how the staff were speaking to the residents, at times. She said the residents perceived some of the staff to be snotty and argumentative, at times, like when a resident needed something the staff acted like they were doing the resident a favor instead of the fact that the staff worked for the residents. She said this was discussed in the council because staffs' attitudes towards the residents were getting worse not better. She said Medical Records came in and asked her, last week on 10/20/22 about her treatment in the facility. She said she told her about an incident on Monday 10/17/22 around 5:00 PM, she requested to be transferred from her wheelchair to bed and provided incontinent care. She said CNA E told her go to room and get in position. She said she followed instructions and waited over an hour and then put the call light on. She said CNA E came into the room yelling and screaming that the resident should not have put the call light on and that she had to just wait her turn for assistance. She said she told CNA E she was going to report her, and CNA E told her to go ahead because she did not have to answer to the resident. She said CNA E was screaming over her and pointing her finger. She said CNA E then went to her roommate's (Resident #13) side of the bed, the roommate was in bed, CNA E was standing over Resident #13, still yelling, and pointing her finger but was directed at her (Resident #14) and not the roommate (Resident #13). She said Resident #13 became afraid CNA E was going to hit her and Resident #13 started crying. She said she told Resident #13 not to cry because CNA E was mad at her (Resident #14). She said CNA E left the room, and Resident #13, who does not cuss, said Holy Shit!. She said about an hour later, the same evening, Resident #13 just wanted to ask a question, so she put the call light on, and CNA E came in the room screaming again. She said CNA E asked them What is your problem why is the call light on again?. She said Resident #13 apologized and said she just wanted to ask the AD something. She said she had been a resident at the facility for 5 years and CNA E had always had a temper. She said CNA E had an attitude like she was invincible because nothing ever happened to her, and she felt like she would not get fired. She said CNA E had always had a bad temper, but it had never been like this before. She said she did not tell anyone about the incident until the Medical Records person asked her about abuse on 10/20/22. She said she was verbally abused and intimidated by CNA E on 10/17/22. In an interview on 10/26/22 at 4:47 PM, the DON and the Clinical Resource RN said Medical Records had the Safe Surveys dated 10/20/22, on her person, for Residents #12, #13, and #14. She said Medical Records reported them verbally to the Administrator on 10/20/22 but did not give him the forms. They said the Administrator and Medical Records were suspended pending the outcome of the investigation. Record Review of Safe Surveys dated 10/20/22, not timed, indicated the question, Do you feel that you have been intentionally injured by a team member? -Resident #12 - verbal abuse -Resident #13 - verbal abuse with violently yelling and afraid CNA E would hit her on Monday (10/17/22) -Resident #14 - verbally abused with attitude - CNA E (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review revealed Medical Records completed the three above Safe Surveys again on 10/20/22, not timed, and all three residents' answers to Do you feel you have been intentionally injured by a team member? were changed to, No. In an interview on 10/27/22 at 10:02 AM, the Clinical Resource RN and DON said the facility began in-services with all staff on the types of abuse, with a written quiz. The DON was made the Abuse Prevention Coordinator. The facility began interview with staff to see if any abuse allegations had been reported to the Administrator that were not acted upon. The facility began a root cause analysis. She said the Safe Surveys conducted on 10/20/22 with Residents #12, #13, and #14 revealed verbal abuse by CNA E. The DON said CNA E worked on 10/21/22, after the allegations of verbal abuse were reported to the Administrator on 10/20/22. She said CNA E did not work after 10/21/22. She said CNA E was terminated on 10/24/22 for not reporting the allegation of abuse made by Resident #3's responsible party, but not related to the allegations of verbal abuse. Record Review of CNA E's time sheet dated 10/27/22 indicated she worked on 10/21/22 from 2:24 PM - 9:48 PM, 7.4 hours. Attempts were made to interview CNA E on 10/28/22 at 5:23 PM, 7:24 PM, and 10/29/22 at 12:19 PM, there was no answer to the phone call and messages, a text was also sent on 10/29/22 at 12:20 PM requesting an interview, no return call was received prior to the exit on 10/29/22 at 1:00 PM. In a telephone interview on 10/27/22 at 5:26 PM, Medical Records said she told the Administrator immediately about each of the allegations of verbal abuse on 10/20/22. She said she told him after each allegation was made. She said the DON was also present, during the discussion with the Administrator. She said the administrator told her to shred Resident #12, #13, #14's Safe Surveys that revealed verbal abuse. She said he told her State was not looking at verbal abuse as being intentionally injured. She said the Administrator, then gave her new forms to complete with the same residents again. She said on 10/26/22, after the investigator asked about the Safe Surveys, she got the three original Safe Surveys for Resident #12, #13, and #14 out of the shred bin to give to the Administrator. She said the Administrator understood on 10/20/22 Residents #12, #13, and #14 had alleged they were verbally abused by CNA E. In an interview on 10/27/22 at 5:41 PM, the DON said she was not involved in the conversation regarding the abuse, as stated above, on 10/20/22. She said she was not aware of abuse being reported on the three residents (Residents #12, #13, and #14) in question. In a telephone interview on 10/27/22 at 5:45 PM, the Administrator said DON was not in the room when Medical Records discussed the verbal abuse allegations. He said Medical Records did notify him on 10/20/22 of the verbal abuse allegations. He said with everything going on the verbal abuse allegations did not cross his mind again. He said yesterday (10/26/22) Medical Records did get the Safe Surveys out of the shred bin, but he did not tell her to shred them. He told her to set them aside in his office. He said he did ask her to conduct new Safe Surveys on Resident #12, #13, and #14 because he did not believe verbal abuse was applicable to the question, Do you feel that you have been intentionally injured by a team member?. He said he was aware of the facility abuse policy and reporting requirements. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety related to the verbal abuse from CNA E and just a combination of things. She said she might need an increase in her anti-anxiety medication. Record Review of the facility's Abuse: Prevention of and Prohibition Against dated October 2022 indicated verbal abuse included the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representative, or within their hearing distance, regardless of their [NAME], ability to comprehend, or disability. Prevention included - all staff, residents and visitors are encouraged to report incidents and grievances without the fear of retribution. Supervising staff to identify and correct any inappropriate or unprofessional behaviors. Identifying, correcting, and intervening in situations in which abuse is more likely to occur. Investigation included - all identified events are reported to the Administrator immediately. After receiving the allegation, during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. Protection included - immediately removing the employee from the care of any resident when an allegation of abuse is reported. Reporting included - all allegations of abuse she be reported immediately to the Administrator. Allegations of abuse will be reported to the appropriate State Agency in the applicable timeframes, as per the policy and applicable regulations. The Interim Administrator was notified of the Immediate Jeopardy on 11/14/22 at 10:55 AM, a Plan of Removal was requested and the Immediate Jeopardy template was provided. The Plan of Removal was accepted on 11/14/22 at 12:56 PM. Review of the Plan of Removal included: Immediate Action 1. Administrator suspended on 10/26/22 pending the outcome of the investigation. 2. Medical Director/Resident's physician notified of IJ by Director of Nursing at 5:25 PM via phone. 3. In-service regarding Abuse: Prevention of and Prohibition Against was started on 10-27-22 for routinely scheduled facility staff, educated by Clinical Resource/designee. Inservice to be completed with routinely scheduled facility staff, by 4:30PM on 10-28-22. Remaining facility staff and agency staff will be required to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676029	A. Building B. Wing	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on interview and record review, the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurately documented for 1 (Resident #6) of 14 residents whose clinical records were reviewed for accuracy. The staff failed to accurately document Resident #6's IV site care on his October 2022 TAR. This failure could place, all the residents who resided in the facility, at risk of incomplete and inaccurately documented medical records. Findings included: Record review of Resident #6's Admission Record dated 10/29/22 indicated the [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses which included, sepsis (an infection) and skin infection. Record review of Resident #6's physician's order dated 09/10/22 indicated the IV had two lines with two plastic caps on the end of each line that were to be changed with each dressing change every 7 days and as needed. Record review of Resident #6's admission MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS score of 12 (a score of 8-12 indicated moderate cognitive impairment). He required assistance with activities of daily living, transfers, personal hygiene, and bathing. Record review of Resident #6's Care Plan dated 09/29/22 indicated no care plan for the IV. Record review of Resident #6's October 2022 IV MAR, indicated the resident did not receive an IV antibiotic; however, the IV had two lines with two plastic caps on the end of each line that were to be changed with each dressing change every 7 days and as needed. The documentation indicated the physician ordered care was provided every 7 days on Sundays for 10/02/22, 10/09/22, 10/16/22, and 10/23/22. In an interview on 10/24/22 at 12:46 PM, the DON said she received multiple concerns from Resident #6's responsible party regarding his nursing care. She said she checked on the resident daily and she gave the weekend nurses, who are all agency staff, a report on the resident's needs and condition to ensure continuity of care. In an observation on 10/28/22 at 2:20 PM, Resident #6 was in his room in his wheelchair. An IV site dressing to his right arm was dated 09/30/22. He was not receiving any IV medication. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's Nursing Progress Note dated 10/28/22 at 4:07 PM, the Clinical Resource RN documented, the DON contacted the resident's physician regarding the lack of IV site care since 09/30/22. The physician said he would not be able to come to the facility and assess the site, at this time. He instructed the DON to change the dressing and assess the site. The Clinical Resource RN and the Charge Nurse changed the dressing. The resident did not have any signs or symptoms of redness, warmth, swelling, drainage, or pain. The physician's Nurse Practitioner would be by this evening to assess the site. In an interview on 10/28/22 at 2:30 PM, LVN M said the dressing to Resident #6's IV site was dated 09/30/22, but it should have been changed every 7 days but not on her shift. In an interview on 10/28/22 at 3:50 PM, the Clinical Resource RN and DON said Resident #6's dressing to the IV site on his right arm was dated 09/30/22. The DON said all the agency nurses that documented, on the October 2022 TAR , the dressing was changed as ordered every 7 days. The Clinical Resource RN said resident's physician was notified, and he did not want to discontinue the IV, at this time. The DON said she was not aware the physician's orders for the IV were not being followed. The Clinical Resource RN said she looked at the IV site today (10/28/22), and there was no redness or drainage. She changed the dressing. She said the resident did not report any pain. In a telephone interview on 10/29/22 at 11:49 AM, Agency LVN H said he only worked at the facility one day on Sunday, 10/09/22 and it was not a good experience. He said he was not given report when he started his shift. He said he did not know where the facility kept the wound care supplies. He said he complained to the agency about the working conditions and would not work for the facility again because he felt he was unable to do even basic nursing care, like dressing changes. He said he did not remember Resident #6 or any specifics regarding his IV care, dressing change or what he documented. In a telephone interview on 10/29/22 at 11:56 AM, Agency LVN J said she worked at the facility one time on, Sunday 10/23/22, she said it was rough because she did not receive report on the residents and was not given a computer to access the clinical records. She said it was very difficult for her to get anything done for the residents. She said she did not remember anything about Resident #6's dressing or IV care. In a telephone interview on 10/29/22 at 12:02 PM, Agency LVN R he said he did not change Resident #6's dressing on Sunday, 10/16/22. He said he just looked to see if the dressing was clean and intact. He said his documentation on 10/16/22 was just to verify he observed the dressing; however, he did not provide any IV care. Record review of the facility's un-dated Clinical Documentation policy indicated services provided to the resident shall be documented in the resident's clinical record. The policy did not address the accuracy of the clinical record documentation.