Printed: 01/09/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022	
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			agency.	
(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	support of resident choice.	e facility must promote and facilitate re		
Residents Affected - Some	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 the right to make choices related to	need assistance with activities of daily to their life in the facility.	living (ADLs), at risk of not having	
	Findings included:			
		dmission Record dated 10/29/22 indica on [DATE] with diagnoses which inclu		
	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 S	kin Assessment - Shower Sheets, indic	cated:	
	-09/20/22 - the resident received a	bed bath and had no documented skir	issues.	
	-09/22/22 - the resident received a	bed bath and had no documented skir	issues.	
	-09/27/22 - the resident received a	bed bath and had no documented skir	issues.	
	-09/29/22 - the resident received a	bed bath and had no documented skir	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

FORM CMS-2567 (02/99) Previous Versions Obsolete

Event ID:

Facility ID: 676029

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0561 Level of Harm - Minimal harm or	-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			
potential for actual harm Residents Affected - Some	and underarm. -10/11/22 - the resident received a underarm.	bed bath and redness was documente	d under the resident's right	
		ectronic medical record for bathing dod		
		eive a shower. She received a full-body		
		eive a shower. She received a full-body		
	-10/27/22 - the resident did not rec	eive 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 had 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		dmission Record dated 10/29/22 indicative on [DATE] with diagnoses which inc	,	
Residents Affected - Some		uarterly MDS dated [DATE] indicated the otally dependent on one staff for bathin		
		n-dated Care Plan indicated the resider to morbid obesity. She was to be provide		
	Record review of Resident #11's SI	kin Assessment - Shower Sheets, indic	eated:	
	-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 b	reasts, 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 we 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 th 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 Cou needed to make sure the residents	ncil Minutes dated 08/08/22 indicated twere getting their showers.	he residents reported the aides	
	Record review of the Resident Cou only getting showers once a week.	ncil Minutes dated 09/13/22 indicated t	the residents reported they were	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	EIENCIES full regulatory or LSC identifying informati	on)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was only getting bed baths; she saidid not know if that was case for Restaff was just wiping the residents of documented the residents were proshould have a shower. She said Refacility had a shower gurney, reclinity wished to have a shower were account the electronic medical record and nurses know if the resident had any documentation on both the electronic monitoring the showers and bed batto keep up because she did not have shower if they wanted one because In an interview on 10/28/22 at 12:4 equipment for residents with poor to reside and receive services in the except when the health or safety of	2 AM, the DON said she did not know it did if the resident had good trunk control esident #13. She said she would find on down and not giving them a proper bed ovided a bed bath. She said if residents esident #11 was safe to have a showering shower chair, or bariatric shower chair on paper shower sheets. She said the original records and the aldes had be in the said are accorded and the shower sheets and a point and a month ago. She said is we are an ADON, at this time. She said it was the residents' right to have a chair of the said it was the residents' right to have a chair of the said it was the residents of Needs policy in the facility with reasonable accommodation the individual or other residents would make reasonable accommodations to the said individual or other residents would make reasonable accommodations to the said individual or other residents.	I, she could be showered, but she ut. She said she was not aware bath because the aides were safe to have a shower, they. She said she was not sure if the nair, to ensure the residents who he said the aides were to document a paper shower sheets let the een inconsistent with the eets. She said the ADON who was the tried to monitor but it was hard as important to give the residents a noice. The analysis of the resident had the right on of needs and preferences, be endangered. The facility will

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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 0580	Immediately tell the resident, the re etc.) that affect the resident.	esident's doctor, and a family member o	of situations (injury/decline/room,	
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 26269	
Residents Affected - Few		ew, the facility failed to immediately no e resident's psychosocial status, for on condition.		
	The facility did not notify Resident room change.	#8's responsible party when she tested	positive for COVID-19 and had a	
	This failure could place all the residual aware of room changes and change	dents residing in the facility at risk of the es in the residents' conditions.	eir responsible parties not being	
	Findings included:			
		dmission Record dated 10/28/22 indicated no [DATE] with a diagnosis of stroke.		
	Record Review of Resident #8's ac assessed.	Imission MDS dated [DATE] indicated t	he resident's cognition was not	
	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 Ce	ensus Record indicated she changed re	ooms on 09/23/22.	
	Record Review of a Nursing Note of for COVID.	dated 9/28/2022 at 7:14 PM, indicated t	he resident continued on isolation	
	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 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 t resident's positive COVID status or room change. She said she arrived at the facility, she was not sure of t date, to find the resident had been moved and was in isolation.			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party of her COVID pos She said she did not believe the re- record, the resident did have room Admissions Coordinator, or the Soc said it was important to notify Resid responsible party and the responsible In an interview on 10/28/22 at 11:5' the resident was COVID positive, it responsible party of the room chan Record Review of the facility's un-d the resident, his/her responsible pa	O AM, the DON said an agency staff nusitive status, but the responsible party is sident had a room change but when look change on 09/23/22, when she tested cial Worker were usually responsible for the state of the	visited the next day and was aware. beked the in the electronic medical positive for COVID. She said the r room change notifications. She e resident was not her own anges. In Resident #8's case, because imediately notify the resident's ication for planned room changes. It is the policy of this facility to notify on and/or status. The nurse

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and neglect by anybody. **NOTE- TERMS IN BRACKETS IN Based on observation, interview are abuse for 4 (Resident #3, #12, #13). The facility failed to protect and assewas reported on 10/19/22 and 10/2 footage) and Residents #12, #13, at These failures placed residents, wherear. This failure resulted in an identificate removed on 10/29/22, the facility residentified as pattern due to the facility residentified as pattern due to the facilithe corrective actions. Findings included: In an interview, with the DON and A hidden in a Halloween decoration in 10/19/22 round 2:00 AM staff regard decoration and the camera in it. The un-approved extension cord. The Educate the resident's family disagreveal any abuse. The Administratic camera, and they had not reported Worker contact Resident #3's family he did not know if the Social Worker heard anything from the family regathem. On 10/20/22 at 10:43 AM, a video or recorded on 10/19/22 at 1:58 AM, in his wheelchair. She pulled him bactoom, she faced the resident and stop it, then she pulled her right had down on something that cannot be again saying, you stop it, the resident attempted to continue.	Administrator on 10/20/22 at 9:15 AM, in Resident #3's responside to Bon said she was not surprised to find the camera and was received the myet. The Administrator said they are not said Resident #3's family did not company concerns. The Administrator said yregarding the camera and no abuse or care was received from Resident #3's room. The DON said she was not surprised to find greed with an abuse investigation, condor said Resident #3's family did not company concerns. The Administrator said yregarding the camera and no abuse or care was received from Resident #3's responsite the camera and no abuse or care was received from Resident #3's responsite the camera and no abuse or care was received from Resident #3's responsite the camera and no abuse or care was received from Resident #3's responsite the first does not touch the resen in frame and a pop was heard, a cent told LVN C, fuck you, LVN C turned the altercation, but the images are obstingthing me?', then she said angrily, at	ovide a safe environment free from rabuse. 13, and #14 when verbal abuse by staff (recorded on video of by CNA E. e, and mental anguish caused by ation on 10/24/22. While the IJ was y level of actual harm, and a scope of and evaluate the effectiveness of the PON said staff found a camera the received the call from staff on the the received the call from staff on the her a picture of the Halloween accause it was plugged into an the hidden camera in the room, flucted on 09/15/22, that did not that the facility regarding the he was going to have the Social on Electronic Monitoring Form, but strator and DON said they had not be issues had been reported to the same time LVN C was heard towards the door and it appeared cured by the Halloween decoration.

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Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	bed. CNA D picked up the bed sheresident says, get off me, you moth the resident's bed and told he reside could not be understood on the vide. In a telephone interview on 10/20/2 complaint regarding staff treatment and found to be unsubstantiated or investigation and felt the facility was former employee, Housekeeper F, she should place a camera in his rout being acted on. She said House Resident #3 for not reporting the above a roommate and it was not vide recorded on the camera, she came hidden camera. She said the video 10/19/22 around 2:00 AM she could She said she could see several stafrom the facility just called her a few approved and that she would need they were concerned about what the	male staff person (CNA D) enter the reet but the resident tugs on the sheet, a ter fucker, and throws the sheet at CN/lent, I'm going to kick your ass. The resection of the resident, which she believed to a 109/15/22. She said she disagreed with section of the resident, which she believed to a covering up abuse and/or mistreatment informed her she believed Resident #3 to make the course reports to the Administration because reports to the Administration because reports to the Administration of the terminated for telling her buse allegations to the Administrator. So the actility to check on Resident #3 to the facility to check on Resident #3 showed Resident #3 was being abused see on the camera that staff discover fit members looking at the camera before with minutes ago, she did not know who, to sign a consent for its use. She said the camera revealed and the person did in in order for the camera to be approved.	and CNA D lets go of the sheet. The A D. CNA D walked to the foot of sident responds but his response ble party said she had a previous be abuse, that was investigated in the findings of the facility's ent of Resident #3. She said a swas being mistreated and told he ator and DON of mistreatment were about the mistreatment of the said based on her experience om. She said the resident did not e said when she saw the abuse but did not alert the facility to the led by the staff. She said on red the camera was in the room. One it was unplugged. She said, stated the teamer was not she asked the person that called it not answer the question, and just

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.

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

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.

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at the facility.

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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 Adm her hand to Resident #3. They said Record Review of Resident #3's Additional Record Review of Resident #3's Additional Record Review of Resident #3's quarternessive disorder. Record Review of Resident #3's quarternessive disorder. Record Review of Resident #3's uncombativeness, physical and verbal verbal cues to alleviate the resident reassure the resident, leave, and resident to answer any direct questions. In an interview on 10/20/22 at 2:44 raising her hand to the resident, but LVN C was reaching to roll the resident saked her if she was aware there here in the resident's responsible being abused by the staff. She said happen at the facility. She said LVN C	inistrator and DON said the third video I the other staff was CNA E. Idmission Record dated 10/20/22 indicative on [DATE] with diagnoses which incomplete the properties of t	was LVN C who appeared to raise atted the [AGE] year-old male cluded dementia and major are resident had short and long-term aviors. Inaviors which included, and included to provide physical and lifthe resident resists care, anself in his wheelchair. He was not said she did not think LVN C was ime. She said she thought maybe are any staff being abusive or the resident's responsible party aid she told her she was not aware. The room because the resident was rty she did not believe that would onsible party reported the resident t's responsible party and knew

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #3's hall and she felt staff staff were not assisting him with me Administrator and DON about her of to the resident's responsible party is resident's room because she believe she told the resident's responsible her if she knew who the Abuse Cor Administrator wanted to meet with for fear she would be terminated. So inaction regarding allegations made knew about things but don't report. She said there were employees, st abuser. In an observation on 10/24/22 at 9:43 investigation, verbal abuse, and inc LVN C and CNA D for abuse. They to the Administrator. The Administr neglect, or mistreatment of Residen provided orally and written for all st 09/15/22. On 10/24/22 at 12:43 PM the Administrator. On 10/25/22 at 3:58 PM Safe Survey received from the Administrator. On 10/25/22 at 4:18 PM the Immediate In an interview on 10/26/22 at 10:0 Surveys with residents on 10/20/22 Record Review of the Safe Surveys any completed by Medical Records. Record Review of the Resident Co customer service and respect from this was not identified. In an interview on 10/26/22 at 10:2	s, provided by the Administrator, on 10	priately. She said she believed the nim. She said she spoke with the ot addressed. She said she spoke e should put a camera in the she said when the facility found out salled her on 09/10/22, to question he Administrator. She said the ce, but she did not meet with him as 09/11/22. She said the facility's g. She said other facility employees he names of the other employees. esidents. She named CNA E, as an enself in his wheelchair. He was uestions appropriately. The videos showed, based on their videos showed,

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NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI	P CODE
		Euless, TX 76040	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She said during the surveys on 10/at her so close to her she thought to roommate, Resident #14 said she pyelled at them again and stated, which said Resident #14 was the Re E after that. She said Resident #14 Residents #13 and #14 told her the 9:00 AM -11:00 AM on Thursday, 10/20/22. She said the residents to 10:00 PM shift. She said, after she interviewed Resident #12 on 10/20 verbally abused her too by yelling a and DON of the verbal abuse alleg. On 10/26/22 at 12:10 PM the invessurveys and if the facility had any resident was admitted to the facility disease and bipolar disorder (a me. Record Review of Resident #13's A resident was admitted to the facility disease and bipolar disorder (a me. Record Review of Resident #13's owith a BIMS score of 15 (a score of ln an observation and interview on She said on 10/17/22, her roomman screaming, upset, that the call light was screaming and pointing her fin CNA E was mad that her roommate threatened and scared by CNA E's question, she put the call light on, a again after she had just been in the person she told, about the abuse, we resident was admitted to the facility disabilities, depression and, the ne.	tigator sent the Administrator an email new allegations of abuse. Admission Record dated 10/29/22 indic on [DATE] with diagnoses which inclu	at ther and was pointing her finger d not. She said Resident 13's son, to ask a question, and CNA E our problem? I was just in here!. hat they just tried not to bother CNA ak up to get it to stop. She said a said the interviews were between strator and DON immediately on onday, 10/17/22 on the 2:00 PM - Administrator and DON, she the resident told her CNA E had iately informed the Administrator requesting any additional safe ated the [AGE] year-old female ded, chronic obstructive pulmonary the resident was cognitively intact ent). Is in her room in her wheelchair. CNA E came in the room and was a her while she was in her bed and a was going to hit her. She said she was shocked, she felt evening, wanted to just ask a sked why they were on the light er on 10/17/22. She said the only /20/22. Ated the [AGE] year-old female nitive impairment, mild intellectual

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NAME OF PROVIDER OR SUPPLIE	+	STREET ADDRESS, CITY, STATE, Z	P CODE
Westpark Rehabilitation and Living		900 Westpark Way Euless, TX 76040	PCODE
For information on the nursing home's	plan to correct this deficiency, please con		agency.
(X4) ID PREFIX TAG	D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on two or three weeks ago, CNA E car said CNA E started yelling at her, s unable to physically help more, and a little scared of her. She said it wa know the lady's name, and the DOI said the DON told her they would d the silent treatment from CNA E aft to the Medical Records person. At 10/26/22 at 2:41 PM, there was In an interview on 10/26/22 at 2:58 Surveys on 10/20/22. He said she of #12, #13, and #14. He said staff co of abuse and/or mistreatment to hir Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 CNA E. She said she was not contact CNA E. She said she would immed CNA E was terminated on Monday, abuse to the Administrator. Record Review of Resident #14's A resident was readmitted to the facil and anxiety. Record Review of Resident #14's A resident Review of Resident Record	10/26/22 at 1:46 PM, Resident #12 wame in her room and was going to assis aying the resident could help more with a she started crying. She said she was son a weekend, and she told a lady well was called. She said she told the DC o some additional training with staff. She reshe reported her. She said she reported her. She said she reported her she reported her said Medical Redid not notify him of the verbal abuse and ucting the Safe Surveys were told to mimmediately. He said he would look acted on a weekend regarding an incidiately tell the Administrator of any allegation of the properties of the pr	as in her wheelchair. She said about the with her incontinent care. She had the care. She said she was verbally abused by CNA E and was verbally abused by CNA E and was verbally abused by CNA E. She had the said she felt like she received orted the incident again on 10/20/22 agarding the email sent at 12:10 PM. Records conducted some Safe allegations reported by Residents of immediately report any allegations for the Safe Surveys conducted by the said of the new allegations regarding abuse. She said of the said of th

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NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	had been the Resident Council Pre October 2022 it was discussed how perceived some of the staff to be s the staff acted like they were doing residents. She said this was discus getting worse not better. She said I treatment in the facility. She said si requested to be transferred from he her go to room and get in position. the call light on. She said CNA E caput the call light on and that she hagoing to report her, and CNA E told said CNA E was screaming over her (Resident #13) side of the bed, the yelling, and pointing her finger but She said Resident #13 became afr she told Resident #13 not to cry be room, and Resident #13 just wanted room screaming again. She said CShe said Resident #13 apologized been a resident at the facility for 5 attitude like she was invincible bec fired. She said CNA E had always not tell anyone about the incident usaid she was verbally abused and In an interview on 10/26/22 at 4:47 the Safe Surveys dated 10/20/22, Records reported them verbally to the Administrator and Medical Record Review of Safe Surveys dated -Record Review of Safe Surveys dated -Resident #12 - verbal abuse	PM, the DON and the Clinical Resource on her person, for Residents #12, #13, the Administrator on 10/20/22 but did rords were suspended pending the outcome at the 10/20/22, not timed, indicated the nomember?	Resident Council Meeting in ats, at times. She said the residents when a resident needed something that the staff worked for the ides towards the residents were er, last week on 10/20/22 about her ay 10/17/22 around 5:00 PM, she intinent care. She said CNA E told waited over an hour and then put ing that the resident should not have the said she told CNA E she was have to answer to the resident. She in A E then went to her roommate's inding over Resident #13, still in not the roommate (Resident #13). In the roommate (Resident #13). In the roommate (Resident #13). In the roommate (Resident #14). She said CNA E left the out an hour later, the same gight on, and CNA E came in the mwhy is the call light on again? In something. She said she had might have said conditions and the said conditions on 10/20/22. She can be call with the said she did her about abuse on 10/20/22. She can be call the said Medical room of the investigation. In the resident were said she did her about abuse on 10/20/22. She can be said Medical Records had and #14. She said Medical room of the investigation. In the resident were said she did her about abuse on 10/20/22. She can be said Medical room of the investigation. In the resident were said she did her about abuse on 10/20/22. She can be said she did her about abuse on 10/20/22. She can be said Medical room of the investigation.

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
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For information on the nursing home's p	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	timed, and all three residents' answ member? were changed to, No. In an interview on 10/27/22 at 10:02 in-services with all staff on the type Coordinator. The facility began interview on 10/20/22 with Reside CNA E worked on 10/21/22, after the 10/20/22. She said CNA E did not were porting the allegation of abuse may of verbal abuse. Record Review of CNA E's time she PM, 7.4 hours. Attempts were made to interview C was no answer to the phone call an interview, no return call was received. In a telephone interview on 10/27/2 immediately about each of the allegallegation was made. She said the said the administrator told her to she She said the daministrator told her to she said the administrator asked about the 412, #13, and #14 out of the shred 10/20/22 Residents #12, #13, and #14 abuse, as stated above, on 10/20/2 residents (Residents #12, #13, and In a telephone interview on 10/27/2 Medical Records discussed the verification.	2 at 5:45 PM, the Administrator said D bal abuse allegations. He said Medical tions. He said with everything going or	ON said the facility began on was made the Abuse Prevention gations had been reported to the halysis. She said the Safe Surveys abuse by CNA E. The DON said ported to the Administrator on as terminated on 10/24/22 for not r, but not related to the allegations and 10/21/22 from 2:24 PM - 9:48 M, and 10/29/22 at 12:19 PM, there 0/29/22 at 12:20 PM requesting an PM. The told the Administrator has aid she told him after each cussion with the Administrator. She weys that revealed verbal abuse. Initially injured. She said the nots again. She said on 10/26/22, ginal Safe Surveys for Resident aid the Administrator understood on used by CNA E. The control of the three on the three on the said on the three on the verbal abuse allegations did

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NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	verbal abuse from CNA E and just anti-anxiety medication. Record Review of the facility's Abuverbal abuse included the use of orderogatory terms to residents or the [NAME], ability to comprehend, or encouraged to report incidents and correct any inappropriate or unprofivation abuse is more likely to occur Administrator immediately. After rewill ensure that all residents are profit included and all allegations abuse will be reported to the approapplicable regulations. The Administrator and DON were reflected on 10/25/22 at 4:18 PM. Review of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of the Plan of Removal included and the Information of	ysician notified of IJ (Immediate Jeopar on 10-24-22 for employees, educated to service to be completed by all staff by end and quizzed prior to starting their shift or ordinator and Grievance Coordinator, ee icy, which are:	inst dated October 2022 indicated willfully includes disparaging and g distance, regardless of their is, residents and visitors are on. Supervising staff to identify and ing, and intervening in situations in events are reported to the the investigation, the Administrator I harm. Protection included - in allegation of abuse is reported. It of the Administrator. Allegations of meframes, as per the policy and included. The Plan of Removal was included in the floor. The in-service will included in the floor. The in-service will included in the floor. The in-service will included in the floor.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency please con	tact the nursing home or the state survey	agency
			адепсу.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informat	ion)
F 0600	iv. Identification - identifying differe	nt types of abuse	
Level of Harm - Immediate jeopardy to resident health or safety	v. Investigation - complete and thro	ough investigative process and docume	entation of [TRUNCATED]
Residents Affected - Some			

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	676029	A. Building B. Wing	11/14/2022	
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P CODE	
Westpark Rehabilitation and Living		900 Westpark Way Euless, TX 76040		
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(X4) ID PREFIX TAG	(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIE (Each deficiency must be preceded by full		on)	
F 0607	Develop and implement policies an	d procedures to prevent abuse, neglec	et, and theft.	
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 26269	
safety Residents Affected - Some		nd record review, the facility failed to in nt abuse of residents for 4 (Resident #3		
	The facility failed to implement a po and reporting allegations of abuse	olicy and process for immediately inveswhen:	tigating, protecting the residents,	
	1. Resident #3's responsible party made allegations of abuse to CNA E on 10/19/22 and she did not report 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.			
	removed on 10/29/22, the facility re	tion of an Immediate Jeopardy (IJ) situ emained out of compliance at a severity lity's need to complete in-service training	level of actual harm, and a scope	
	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 an 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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NAME OF PROMPTS OF SUPPLIES		STREET ADDRESS CITY STATE 7	ID CODE
NAME OF PROVIDER OR SUPPLIF Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way	PCODE
Woodpant Nonabilitation and Eiving		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)		ion)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	hidden in a Halloween decoration in 10/19/22 round 2:00 AM staff regardecoration and the camera in it. The un-approved extension cord. The Edecause the resident's family disagreveal any abuse. The Administrate camera, and they had not reported Worker contact Resident #3's family he did not know if the Social Worker heard anything from the family regard them. On 10/20/22 at 10:43 AM, a video or recorded on 10/19/22 at 1:58 AM, in his wheelchair. She pulled him bac room, she faced the resident and so stop it, then she pulled her right had down on something that cannot be again saying, you stop it, the resident attempted to continue LVN C asked the resident, are you shuts the door. On 10/20/22 at 11:08 AM, a video of 10/16/22 at 12:09 AM, it showed a bed. CNA D picked up the bed she resident says, get off me, you mother the stage of the stage of the stage of the policy of the provided the resident says, get off me, you mother the stage of the stage of the provided th	Administrator on 10/20/22 at 9:15 AM, in Resident #3's room. The DON said is rading the camera. She said the staff text is a DON had staff unplug the camera be DON said she was not surprised to find greed with an abuse investigation, concorriging the camera to get to sign a ser had contacted them yet. The Administrator said y regarding the camera and no abuse or care was received from Resident #3's responsite to the second of the se	the received the call from staff on sted her a picture of the Halloween ecause it was plugged into an the hidden camera in the room, ducted on 09/15/22, that did not attact the facility regarding the he was going to have the Social an Electronic Monitoring Form, but strator and DON said they had not re issues had been reported to ansible party. The video was consible party the resident and said, you resident, but her left hand came to the same time LVN C was heard at the same time LVN C was heard at the same time LVN C was heard at cured by the Halloween decoration. The door, you stay there and then consible party, it was recorded on esident's room the resident was in and CNA D lets go of the sheet. The A D. CNA D walked to the foot of

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	complaint regarding staff treatment and found to be unsubstantiated or investigation and felt the facility wa former employee, Housekeeper F, she should place a camera in his rouse to being acted on. She said House Resident #3 for not reporting the atwith the facility; she decided to place have a roommate and it was not view recorded on the camera, she came hidden camera. She said the video 10/19/22 around 2:00 AM she could She said she could see several stafrom the facility just called her a few approved and that she would need they were concerned about what the told her she needed to sign the form she had already removed the camera about the camera prior to the phon one additional video that she had not resident to another facility but had accept him. She said she feels studied at the facility. On 10/20/22 at 12:04 PM, the Adm purposes. They said both videos she video and CNA D in the second video and the facility. On 10/20/22 at 12:38 PM, the third recorded on 10/13/22 at 7:36 PM, in while he was in bed. LVN C was at saying don't do that, CNA E was of The resident could be heard saying open, while she leaned forward and to be a gesture like she was going On 10/20/22 at 12:45 PM, the Adm her hand to Resident #3. They said	and final video was received from Res t showed two staff (LVN C and CNA E) the head of the resident's bed encourabserved getting some wipes, she joined, God dammit, at that point, LVN C's led told the resident to stop it, she does reto slap the resident.	be abuse, that was investigated in the findings of the facility's ent of Resident #3. She said a was being mistreated and told her ator and DON of mistreatment were enabout the mistreatment of the said based on her experience om. She said the resident did not estaid when she saw the abuse but did not alert the facility to the ed by the staff. She said on red the camera was in the room. The it was unplugged. She said, staff to tell her the camera was not she asked the person that called if not answer the question, and just ed. She said she informed the staff the said no one reached out to her red the facility. She said there was said she wanted to move the before her facility of choice would annot trust that he won't be harmed to ve videos for staff identification intified LVN C as the staff in the first reports or concerns regarding the would be notified and suspended wident #3's responsible party, it was a providing care to the resident aging him to allow care but he was a LVN C at the resident's bedside. The staff in the first reports or the resident was a LVN C at the resident's bedside. The first was a providing care to the resident was a LVN C at the resident, but it appeared was LVN C who appeared to raise the ted the [AGE] year-old male

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	memory problems. He was severel Record Review of Resident #3's ur combativeness, physical and verbat verbal cues to alleviate the resident reassure the resident, leave, and reference and the resident on 10/20/22 at 1: able to answer any direct questions. In an interview on 10/20/22 at 2:44 raising her hand to the resident, but LVN C was reaching to roll the resimistreating the resident. She said asked her if she was aware there here in She said the resident's responsible being abused by the staff. She said happen at the facility. She said she had been abused. She said LVN C about the allegation. She said LVN C about the allegation. She said she however, she did not report it. In an interview on 10/20/22 at 4:21 awake around 2:00 AM and staff ground to the said she wideo she said she wideo she said she wideo she said she was speaking loudly the resident to stay in his room and could get a CNA to assist her to pure resident. She said staff discovered CNA E speaking to Resident #3's resaid that maybe CNA E told her so busy at the time. She said she was leaving She said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she was leaving the said she never raised her hand she said she never raised her hand she said she never raised her hand she said she ne	parterly MDS dated [DATE] indicated the y cognitively impaired. He had no behall aggression with staff. The intervention it's anxiety and give positive feedback. Seturn 5-10 minutes later and try again. 34 PM, Resident #3 was propelling hims. PM, CNA E watched third video. She is it she was not paying attention, at the tid dent over. She said she had never see around 10:00 PM yesterday, 10/19/22, and been a camera in the room. She said party told her she put the camera in the dishe told the resident's responsible party told her she put the camera in the did not tell anyone the resident's responsible party overheard her talking with the resident was supposed to inform the Administrative PM, with the DON present, LVN C said to thim up in his wheelchair and assisted the came combative, threw things off the howed her pulling him in his room back all was in a fist and pulled back because ake physical contact with the resident. It was because the resident was had closed the door, but it was only for aput the resident back to bed. She denied the camera after 2:00 AM and let the Eesponsible party but she did not hear the mething about the allegation, but she did report abuse to the DON, she was not do return to the facility until find the resident. The DON informed at was not to return to the facility until find was not to return to the facility until find was not to return to the facility until find was not to return to the facility until find was not to return to the facility until find the party was also and the camera after 2:00 and and the party until find was not to return to the facility until find the party was not to return to the facility until find the party was not to return to the facility until find the party was not to return to the facility until find the party was not to return to the facility until find the party was not to return to the facility until find the party was not to return to the facility until find the party was not to return to the facility until find the party was not to return to the	aviors. naviors which included, ns included to provide physical and If the resident resists care, nself in his wheelchair. He was not said she did not think LVN C was me. She said she thought maybe n any staff being abusive or the resident's responsible party id she told her she was not aware. He room because the resident was rty she did not believe that would consible party reported the resident t's responsible party and knew tor of any abuse allegations; If on 10/19/22 Resident #3 was d him to the nurses' station for nurses' station, and tried to hit, kick twards because he was being she thought he was going to grab She said the slap sound on the ras being abusive to the resident. rd of hearing. She said she did tell proximately 5 minutes until she ever threatening or hitting the 200N know. She said she did hear the allegation of abuse. She later id not remember, and she was ot aware the Administrator was the resident. She said Resident #3 I him if he was trying to fight her. If her she was suspended pending

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLI Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Westpark Way Euless, TX 76040	
For information on the hursing nomes	plan to correct this deliciency, please con	tact the hursing home of the state survey	ауепсу.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	combative, he was supposed to ge that aggressive on 10/16/22. He saknow, at the time, the camera was because he was under pressure, b heart to do so. He said what he sai mean. He said he had not seen or apologized dearly for his actions a report to work and was under investigation of the said had not seen or apologized dearly for his actions a report to work and was under investigation.	PM, the Administrator said staff knew ced and it was posted in the facility. He of any allegations of abuse or mistreatr	not feel the resident was being d he let go, he said he did not ident he was going to kick his ass e resident because it was not in his d and tired of the resident being so essive with the resident. He said he DON informed him he could not he was the Abuse Coordinator said it was his expectation that
	In a telephone interview on 10/20/2	22 at 5:42 PM, Resident #3's responsib	, ,

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)

CTATEMENT OF STREET	()(1) PROVIDED (2007)	(/0) / / / / / / / / / / / / / / / / / /	()/7) DATE CONT.
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		P CODE
Westpark Rehabilitation and Living 900 Westpark Way Euless, TX 76040			
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying informati	on)
F 0607	On 10/24/22 at 12:43 PM the Admi	nistrator and DON were informed of an	Immediate Jeopardy.
Level of Harm - Immediate jeopardy to resident health or safety	On 10/25/22 at 3:58 PM Safe Surveys (interviews with residents regarding abuse and/or mistreatment) were received from the Administrator.		
Residents Affected - Some	On 10/25/22 at 4:18 PM the Immed	liate Jeopardy Plan of Removal was ac	ccepted.
	In an interview on 10/26/22 at 10:0 Surveys with residents on 10/20/22	4 AM, the Social Worker said Medical I 2.	Records had completed Safe
	Record Review of the Safe Surveys any completed by Medical Records	s, provided by the Administrator, on 10, s.	/25/22 at 3:58 PM, did not include
	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.		
		7 AM, the AD said the Resident Counc to be more respectful, but no abuse wa	
	She said during the surveys on 10/ at her so close to her she thought t roommate, Resident #14 said she yelled at them again and stated, wh She said Resident #14 was the Re E after that. She said Resident #14 Residents #13 and #14 told her the 9:00 AM -11:00 AM on Thursday, 1 10/20/22. She said the residents to 10:00 PM shift. She said, after she interviewed Resident #12 on 10/20	5 AM, Medical Records said she condu- 20/22, Resident #13 said CNA E yelled the aide was going to hit her, but she di- put on the light again for a different rea- ny are you on the light again? What's y- sident Council President and told her the told Resident #13 they needed to spe- ey were verbally abused by CNA E. She 10/20/22. She said she told the Adminis old her the verbal abuse occurred on Mo- reported the allegation of abuse to the 1/22 between 11:00 AM -12:00 PM and at her. She said once again she immed attion on 10/20/22.	d at her and was pointing her finger id not. She said Resident 13's son, to ask a question, and CNA E our problem? I was just in here!. nat they just tried not to bother CNA ak up to get it to stop. She said a said the interviews were between strator and DON immediately on onday, 10/17/22 on the 2:00 PM - Administrator and DON, she the resident told her CNA E had
	On 10/26/22 at 12:10 PM the inves surveys and if the facility had any r	tigator sent the Administrator an email new allegations of abuse.	requesting any additional safe
		Admission Record dated 10/29/22 indic on [DATE] with diagnoses which incluntal illness).	
		quarterly MDS dated [DATE] indicated t f 13-15 indicated no cognitive impairme	
	(continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She said on 10/17/22, her roomma screaming, upset, that the call light was screaming and pointing her fin CNA E was mad that her roommate threatened and scared by CNA E's question, she put the call light on, a again after she had just been in the person she told, about the abuse, we resident was admitted to the facility disabilities, depression and, the ne Record Review of Resident #12's A resident was admitted to the facility disabilities, depression and, the ne Record Review of Resident #12's of cognitively impaired with a BIMS so In an observation and interview on two or three weeks ago, CNA E can said CNA E started yelling at her, so unable to physically help more, and a little scared of her. She said it was know the lady's name, and the DOI said the DON told her they would do the silent treatment from CNA E afto to the Medical Records person. At 10/26/22 at 2:41 PM, there was In an interview on 10/26/22 at 2:58 Surveys on 10/20/22. He said she was 112, #13, and #14. He said staff co of abuse and/or mistreatment to him Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 CNA E. She said she was not conto CNA E. She said she was not conto CNA E. She said she would immedical Record Review of Resident #14's A Record Review of Res	10/26/22 at 1:22 PM, Resident #13 was te, Resident #14, had the call light and was on. She said CNA E came over to ger so close to her; she was afraid she had turned on the call light. She said outburst. She said she later, the same and CNA E came in yelling again and a gre. She said CNA E verbally abused howas the Medical Records person on 10 admission Record dated 10/29/22 indicated from 10 (DATE) with diagnoses of mild cog ed for assistance with personal care. Quarterly MDS dated [DATE] indicated from 10/26/22 at 1:46 PM, Resident #12 was me in her room and was going to assistance in her room and was going to assistance of 10 (a score of 8-12 indicated me in her room and was going to assistance of the started crying. She said she was so on a weekend, and she told a lady who was called. She said she told the DC to some additional training with staff. Ster she reported her. She said she reported her. She said she reported her she she she she sample of the world look from the DON said she was not aware acted on a weekend regarding an inciditately tell the Administrator of any allegon, 10/24/22 for not reporting Resident #3. Admission Record dated 10/29/22 indicately on [DATE] with diagnoses which income in the property of the	CNA E came in the room and was a her while she was in her bed and a was going to hit her. She said she was shocked, she felt a evening, wanted to just ask a laked why they were on the light er on 10/17/22. She said the only //20/22. atted the [AGE] year-old female initive impairment, mild intellectual the resident was moderately oderate cognitive impairment). It is in her wheelchair. She said about the with her incontinent care. She in the care. She said she was verbally abused by CNA E and was working the 500 Hall, she did not be with the said she felt like she received orted the incident again on 10/20/22 agarding the email sent at 12:10 PM. Decords conducted some Safe allegations reported by Residents of immediately report any allegations for the Safe Surveys conducted by of the new allegations regarding lent between Resident #12 and gations regarding abuse. She said 3's responsible party's allegation of lated the [AGE] year-old female

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Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #14's of with a BIMS score of 15 (a scor	quarterly MDS dated [DATE] indicated of 13-15 indicated no cognitive impairment of 10/26/22 at 4:04 PM, Resident #14 was esident about a month. She said, in the vothe staff were speaking to the resider notty and argumentative, at times, like the resident a favor instead of the fact issed in the council because staffs' attitudedical Records came in and asked he he told her about an incident on Mondater wheelchair to bed and provided income into the room yelling and screaming that to just wait her turn for assistance. So the room go ahead because she did not the rand pointing her finger. She said CN roommate was in bed, CNA E was stawas directed at her (Resident #14) and aid CNA E was going to hit her and Resides not cuss, said Holy Shit!. She said ab to ask a question, so she put the call linnades and continued to ask the AE and always had a term and said she just wanted to ask the AE ause nothing ever happened to her, and had a bad temper, but it had never bee intil the Medical Records person asked intimidated by CNA E on 10/17/22. PM, the DON and the Clinical Resource on her person, for Residents #12, #13, the Administrator on 10/20/22 but did nords were suspended pending the outcome of the process of the person of the person, for Residents #12, #13, the Administrator on 10/20/22 but did nords were suspended pending the outcome of the person of the p	the resident was cognitively intact ent). It is in bed in her room. She said she Resident Council Meeting in this, at times. She said the residents when a resident needed something that the staff worked for the ides towards the residents were er, last week on 10/20/22 about her ay 10/17/22 around 5:00 PM, she intinent care. She said CNA E told it waited over an hour and then put not that the resident should not have the said she told CNA E she was have to answer to the resident. She in A E then went to her roommate's inding over Resident #13, still in not the roommate (Resident #13). It is ident #13 started crying. She said int #14). She said CNA E left the out an hour later, the same gift on, and CNA E came in the mown why is the call light on again? On something. She said she had mad she felt like she would not get en like this before. She said she did ther about abuse on 10/20/22. She one RN said Medical Records had and #14. She said Medical not give him the forms. They said some of the investigation.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	timed, and all three residents' answ member? were changed to, No. In an interview on 10/27/22 at 10:0 in-services with all staff on the type Coordinator. The facility began inte Administrator that were not acted u conducted on 10/20/22 with Reside CNA E worked on 10/21/22, after the 10/20/22. She said CNA E did not be reporting the allegation of abuse more of verbal abuse. Record Review of CNA E's time she PM, 7.4 hours. Attempts were made to interview C was no answer to the phone call are interview, no return call was received. In a telephone interview on 10/27/2 immediately about each of the allegaliegation was made. She said the said the administrator told her to she She said he told her State was not Administrator, then gave her new from the investigator asked about the #12, #13, and #14 out of the shred 10/20/22 Residents #12, #13, and In an interview on 10/27/22 at 5:41 abuse, as stated above, on 10/20/2 residents (Residents #12, #13, and In a telephone interview on 10/27/2 Medical Records discussed the vertous his mind again. He said y shred bin, but he did not tell her to her to conduct new Safe Surveys of was applicable to the question, Do	Records completed the three above Safe vers to Do you feel you have been interest of Do you feel you have been interest of Do you feel you have been interest version of abuse, with a written quiz. The DO serview with staff to see if any abuse allest pon. The facility began a root cause arents #12, #13, and #14 revealed verbal ne allegations of verbal abuse were reported work after 10/21/22. She said CNA E wade by Resident #3's responsible party eet dated 10/27/22 indicated she worked that it is not not seen that the party of the existence of the existence of the party of the existence of the party of the existence of the existe	ON said the facility began ON was made the Abuse Prevention egations had been reported to the nalysis. She said the Safe Surveys abuse by CNA E. The DON said orted to the Administrator on vas terminated on 10/24/22 for not v, but not related to the allegations ed on 10/21/22 from 2:24 PM - 9:48 M, and 10/29/22 at 12:19 PM, there 10/29/22 at 12:20 PM requesting an PM. The told the Administrator the said she told him after each cussion with the Administrator. She reveys that revealed verbal abuse. Itionally injured. She said the ants again. She said on 10/26/22, ginal Safe Surveys for Resident aid the Administrator understood on used by CNA E. The conversation regarding the se being reported on the three ON was not in the room when I Records did notify him on the verbal abuse allegations did did get the Safe Surveys out of the ide in his office. He said he did ask whe did not believe verbal abuse Illy injured by a team member? He

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	verbal abuse from CNA E and just anti-anxiety medication. The Interim Administrator, Clinical 10/27/22 at 4:01 PM, a Plan of Rer The Plan of Removal was accepted Review of the Plan of Removal incl Immediate Action: 1. Administrator suspended on 10/22. Medical Director / Resident's phy 3. In-service regarding Abuse: Prev scheduled facility staff, educated by scheduled facility staff, by 4:30PM be in-serviced on this policy upon states.	uded: 26/22 pending the outcome of the inverse visician notified of IJ by Director of Nurse vention of and Prohibition Against was by Clinical Resource/designee. Inservice on 10-28-22. Remaining facility staff are start of their shift by the Director of Nurse ct education on the facility ANE policy of the control of th	of the Immediate Jeopardy on the Jeopardy template was provided. Stigation. Stigation at 5:25 PM via phone. Started on 10-27-22 for routinely to be completed with routinely and agency staff will be required to sing/designee.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Each deficiency must be preceded by full regulatory or LSC identifying information) 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.		
	hidden in a Halloween decoration i 10/19/22 round 2:00 AM staff regar decoration and the camera in it. Th un-approved extension cord. The D because the resident's family disag- reveal any abuse. The Administrate camera, and they had not reported Worker contact Resident #3's famil he did not know if the Social Worker	Administrator on 10/20/22 at 9:15 AM, in Resident #3's room. The DON said is rding the camera. She said the staff texter DON had staff unplug the camera be DON said she was not surprised to find greed with an abuse investigation, conduct said Resident #3's family did not contany concerns. The Administrator said by regarding the camera to get to sign a ser had contacted them yet. The Administrating the camera and no abuse or care	the received the call from staff on staff on staff her a picture of the Halloween scause it was plugged into an the hidden camera in the room, lucted on 09/15/22, that did not stact the facility regarding the he was going to have the Social in Electronic Monitoring Form, but strator and DON said they had not

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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 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 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 her again saying, you stop it, the resident told LVN C, fuck you, LVN C turned towards the door and it appears the resident attempted to continue the altercation, but the images are obscured by the Halloween decorate. LVN C asked the resident, are you fighting me?', then she said angrily, at the door, you stay there and the shuts the door. On 10/20/22 at 11:08 AM, a video was received from Resident #3's responsible party, it was recorded or 10/16/22 at 12:09 AM, it showed a male staff person (CNA D) enter the resident's room the resident was bed. CNA D picked up the bed sheet but the resident tugs on the sheet, and CNA D lets go of the sheet, 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		
	complaint regarding staff treatment and found to be unsubstantiated or investigation and felt the facility wa former employee, Housekeeper F, she should place a camera in his rout being acted on. She said House Resident #3 for not reporting the all with the facility; she decided to place have a roommate and it was not virecorded on the camera, she came hidden camera. She said the video 10/19/22 around 2:00 AM she could She said she could see several stafform the facility just called her a few approved and that she would need they were concerned about what the told her she needed to sign the form she had already removed the camera about the camera prior to the phon one additional video that she had resident to another facility but had resident to another facility but had	22 at 11:25 AM, Resident #3's responsition of the resident, which she believed to an 09/15/22. She said she disagreed with secovering up abuse and/or mistreatmer informed her she believed Resident #3 com, because reports to the Administration, because reports to the Administration. She are hidden camera in the resident's proposition of the facility to check on Resident #3 is showed Resident #3 was being abused see on the camera that staff discover of the facility to check on Resident #3 is showed Resident #3 was being abused see on the camera that staff discover ff members looking at the camera before minutes ago, she did not know who, to sign a consent for its use. She said the camera revealed and the person did min order for the camera to be approved the camera that staff the investigator enter the content of the camera that the camera that staff discover from the room and took it home. She call today, after the investigator enter to seen yet, but she would send it. She to wait for his Medicaid to be approved the camera that staff discover the camera that staff discover from the camera that	be abuse, that was investigated he the findings of the facility's ent of Resident #3. She said a was being mistreated and told her ator and DON of mistreatment were en about the mistreatment of the said based on her experience om. She said the resident did not esaid when she saw the abuse but did not alert the facility to the ed by the staff. She said on red the camera was in the room. The it was unplugged. She said, staff to tell her the camera was not she asked the person that called if not answer the question, and just ed. She said she informed the staff the said no one reached out to her red the facility. She said there was said she wanted to move the before her facility of choice would

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety	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.			
Residents Affected - Some	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 Adm her hand to Resident #3. They said	ninistrator and DON said the third video If the other staff was CNA E.	was LVN C who appeared to raise	
	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: able to answer any direct questions	34 PM, Resident #3 was propelling hins.	nself in his wheelchair. He was not	
	In an interview on 10/20/22 at 2:44 PM, CNA E watched third video. She said she did not think LVN raising her hand to the resident, but she was not paying attention, at the time. She said she thought LVN C was reaching to roll the resident over. She said she had never seen any staff being abusive comistreating the resident. She said around 10:00 PM yesterday, 10/19/22, the resident's responsible pasked her if she was aware there had been a camera in the room. She said she told her she was nown She said the resident's responsible party told her she put the camera in the room because the resident being abused by the staff. She said she told the resident's responsible party she did not believe that happen at the facility. She said she did not tell anyone the resident's responsible party reported the resident been abused. She said LVN C overheard her talking with the resident's responsible party and known abuse allegation. She said she was supposed to inform the Administrator of any abuse allegation however, she did not report it.			
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	P CODE
Westpark Rehabilitation and Living		900 Westpark Way Euless, TX 76040	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	awake around 2:00 AM and staff gormonitoring. She said the resident be and bite staff. She said the video she combative. She said her right hand or bite her. She said she did not may video was when she slapped her or She said she was speaking loudly the resident to stay in his room and could get a CNA to assist her to puresident. She said staff discovered CNA E speaking to Resident #3's resaid that maybe CNA E told her soo busy at the time. She said she wou Abuse Coordinator. She said she stried to kick her as she was leaving She said she never raised her hand the outcome of the investigation and In a telephone interview on 10/20/2 combative, he was supposed to ge that aggressive on 10/16/22. He sak know, at the time, the camera was because he was under pressure, be heart to do so. He said what he said mean. He said he had not seen or apologized dearly for his actions ar report to work and was under investigater, and notify him immediately of investigate, and notify the police are In a telephone interview on 10/20/2 spoke to CNA E regarding her abus could show CNA E the videos. She to the videos. She	PM, the Administrator said staff knew ced and it was posted in the facility. He of any allegations of abuse or mistreatr	d him to the nurses' station for nurses' station, and tried to hit, kick wards because he was being she thought he was going to grab She said the slap sound on the was being abusive to the resident. It of hearing. She said she did tell proximately 5 minutes until she ever threatening or hitting the DON know. She said she did hear he allegation of abuse. She later lid not remember, and she was to aware the Administrator was the resident. She said Resident #3 I him if he was trying to fight her. If her she was suspended pending urther notice. ENA D said if the resident was too not feel the resident was being die he let go, he said he did not dent he was going to kick his asser eresident because it was not in his die and tired of the resident. He said he DON informed him he could not he was the Abuse Coordinator said it was his expectation that ment. He said the facility would let party said on 10/19/22 she camera. She said she asked if she sight was not good and she did not not see the videos because she

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #3's hall and she felt staff staff were not assisting him with me Administrator and DON about her of to the resident's responsible party is resident's room because she believe she told the resident's responsible her if she knew who the Abuse Cor Administrator wanted to meet with for fear she would be terminated. So inaction regarding allegations made knew about things but don't report. She said there were employees, st abuser. In an observation on 10/24/22 at 9:43 investigation, verbal abuse, and inc LVN C and CNA D for abuse. They to the Administrator. The Administr neglect, or mistreatment of Residen provided orally and written for all st 09/15/22. On 10/24/22 at 12:43 PM the Administrator. On 10/25/22 at 3:58 PM Safe Survey received from the Administrator. On 10/25/22 at 4:18 PM the Immediate In an interview on 10/26/22 at 10:0 Surveys with residents on 10/20/22 Record Review of the Safe Surveys any completed by Medical Records. Record Review of the Resident Co customer service and respect from this was not identified. In an interview on 10/26/22 at 10:2	s, provided by the Administrator, on 10	priately. She said she believed the nim. She said she spoke with the ot addressed. She said she spoke e should put a camera in the she said when the facility found out alled her on 09/10/22, to question ne Administrator. She said the ce, but she did not meet with him as 09/11/22. She said the facility's g. She said other facility employees he names of the other employees. Seidents. She named CNA E, as an anself in his wheelchair. He was uestions appropriately. The videos showed, based on their said they were going to terminate of reporting the allegation of abuse er F never reported any abuse, ON said in-service training was allegation regarding Resident #3 on a lamediate Jeopardy. In a lamediate Jeopardy. In a days a side of the property of the said they were going to terminate of reporting the allegation of abuse er F never reported any abuse, on said in-service training was allegation regarding Resident #3 on the lamediate Jeopardy. In a lamediate Jeopardy. In a side of the said they needed more number of residents who voiced all did bring up, in the meeting on

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She said during the surveys on 10/at her so close to her she thought to roommate, Resident #14 said she pyelled at them again and stated, where She said Resident #14 was the Resident #14. She said Resident #14 Residents #13 and #14 told her the 9:00 AM -11:00 AM on Thursday, 10/20/22. She said the residents to 10:00 PM shift. She said, after she interviewed Resident #12 on 10/20 verbally abused her too by yelling a and DON of the verbal abuse alleg. On 10/26/22 at 12:10 PM the invest surveys and if the facility had any resident was admitted to the facility disease and bipolar disorder (a me). Record Review of Resident #13's A resident was admitted to the facility disease and bipolar disorder (a me). Record Review of Resident #13's of with a BIMS score of 15 (a score of ln an observation and interview on She said on 10/17/22, her roomman screaming, upset, that the call light was screaming and pointing her find CNA E was mad that her roommate threatened and scared by CNA E's question, she put the call light on, a again after she had just been in the person she told, about the abuse, we resident was admitted to the facility disabilities, depression and, the ne Record Review of Resident #12's A resident was admitted to the facility disabilities, depression and, the ne	tigator sent the Administrator an email new allegations of abuse. Admission Record dated 10/29/22 indic or on [DATE] with diagnoses which inclu	d at her and was pointing her finger id not. She said Resident 13's son, to ask a question, and CNA E our problem? I was just in here! hat they just tried not to bother CNA ak up to get it to stop. She said a said the interviews were between strator and DON immediately on onday, 10/17/22 on the 2:00 PM - Administrator and DON, she the resident told her CNA E had iately informed the Administrator requesting any additional safe ated the [AGE] year-old female ded, chronic obstructive pulmonary the resident was cognitively intact ent). It is in her room in her wheelchair. CNA E came in the room and was on her while she was in her bed and a was going to hit her. She said she was shocked, she felt evening, wanted to just ask a tasked why they were on the light er on 10/17/22. She said the only //20/22. It is resident was moderately

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	two or three weeks ago, CNA E cal said CNA E started yelling at her, sunable to physically help more, and a little scared of her. She said it waknow the lady's name, and the DOI said the DON told her they would dethe silent treatment from CNA E aft to the Medical Records person. At 10/26/22 at 2:41 PM, there was In an interview on 10/26/22 at 2:58 Surveys on 10/20/22. He said she #12, #13, and #14. He said staff co of abuse and/or mistreatment to him Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 CNA E. She said she was not contic CNA E. She said she would immedicated to the Administrator. Record Review of Resident #14's A resident was readmitted to the faciliand anxiety.	10/26/22 at 1:46 PM, Resident #12 warme in her room and was going to assis aying the resident could help more with the started crying. She said she was son a weekend, and she told a lady which was called. She said she told the DC o some additional training with staff. She she reported her. She said she reported her. She said she reported her. She said she reported her said Medical Redid not notify him of the verbal abuse a sunducting the Safe Surveys were told to mimmediately. He said he would look in the DON said she was not aware acted on a weekend regarding an inciditately tell the Administrator of any alleg, 10/24/22 for not reporting Resident #3 admission Record dated 10/29/22 indicated in the properties of the proper	th with her incontinent care. She had the care. She said she was verbally abused by CNA E and was verbilly abused by CNA E and was verking the 500 Hall, she did not 50N what happened with CNA E. She he said she felt like she received orted the incident again on 10/20/22 garding the email sent at 12:10 PM. Becords conducted some Safe allegations reported by Residents of immediately report any allegations for the Safe Surveys conducted by the new allegations regarding lent between Resident #12 and gations regarding abuse. She said 3's responsible party's allegation of sated the [AGE] year-old female cluded mild cognitive impairment

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	had been the Resident Council Pre October 2022 it was discussed how perceived some of the staff to be so the staff acted like they were doing residents. She said this was discus getting worse not better. She said I treatment in the facility. She said I requested to be transferred from he her go to room and get in position. the call light on. She said CNA E caput the call light on and that she ha going to report her, and CNA E told said CNA E was screaming over he (Resident #13) side of the bed, the yelling, and pointing her finger but She said Resident #13 became afr she told Resident #13 not to cry be room, and Resident #13, who does evening, Resident #13 just wanted room screaming again. She said C She said Resident #13 apologized been a resident at the facility for 5 thattitude like she was invincible becifired. She said CNA E had always not tell anyone about the incident usaid she was verbally abused and in an interview on 10/26/22 at 4:47 the Safe Surveys dated 10/20/22, Records reported them verbally to the Administrator and Medical Record Review of Safe Surveys dateen intentionally injured by a team -Resident #12 - verbal abuse	PM, the DON and the Clinical Resource on her person, for Residents #12, #13, the Administrator on 10/20/22 but did rords were suspended pending the outcome of the design of the content of the	Resident Council Meeting in hits, at times. She said the residents when a resident needed something that the staff worked for the ides towards the residents were er, last week on 10/20/22 about her ay 10/17/22 around 5:00 PM, she ntinent care. She said CNA E told waited over an hour and then put ing that the resident should not have the said she told CNA E she was have to answer to the resident. She in A E then went to her roommate's inding over Resident #13, still in not the roommate (Resident #13). In the roommate (Resident #13). In the roommate (Resident #13). In the roommate (Resident #14). She said CNA E left the out an hour later, the same gight on, and CNA E came in the my is the call light on again? In something. She said she had might have said con the said con the said she had and she felt like she would not get an like this before. She said she did her about abuse on 10/20/22. She can be call the said Medical into give him the forms. They said some of the investigation. In the resident were resident and the said Medical into give him the forms. They said some of the investigation.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	timed, and all three residents' answ member? were changed to, No. In an interview on 10/27/22 at 10:0 in-services with all staff on the type Coordinator. The facility began inte Administrator that were not acted u conducted on 10/20/22 with Reside CNA E worked on 10/21/22, after the 10/20/22. She said CNA E did not be reporting the allegation of abuse more of verbal abuse. Record Review of CNA E's time she PM, 7.4 hours. Attempts were made to interview C was no answer to the phone call are interview, no return call was received. In a telephone interview on 10/27/2 immediately about each of the allegation was made. She said the said the administrator told her to she She said he told her State was not Administrator, then gave her new from the investigator asked about the #12, #13, and #14 out of the shred 10/20/22 Residents #12, #13, and In an interview on 10/27/22 at 5:41 abuse, as stated above, on 10/20/27 residents (Residents #12, #13, and In a telephone interview on 10/27/24 Medical Records discussed the vertous the first part of the verbal abuse allegation to cross his mind again. He said y shred bin, but he did not tell her to her to conduct new Safe Surveys of was applicable to the question, Do	Records completed the three above Safe vers to Do you feel you have been interested to Do you feel you have been interested verse to Do you feel you have been interested verse to Do you feel you have been interested verse to Do you feel you have been interested verse to grain the allegations of verbal abuse were reported after 10/21/22. She said CNA E was also yet and the party of the party o	ON said the facility began ON was made the Abuse Prevention gations had been reported to the nalysis. She said the Safe Surveys abuse by CNA E. The DON said orted to the Administrator on vas terminated on 10/24/22 for not v, but not related to the allegations ed on 10/21/22 from 2:24 PM - 9:48 M, and 10/29/22 at 12:19 PM, there 10/29/22 at 12:20 PM requesting an PM. The told the Administrator the said she told him after each cussion with the Administrator. She reveys that revealed verbal abuse. Itionally injured. She said the ants again. She said on 10/26/22, ginal Safe Surveys for Resident aid the Administrator understood on used by CNA E. The conversation regarding the se being reported on the three ON was not in the room when a Records did notify him on the verbal abuse allegations did did get the Safe Surveys out of the ide in his office. He said he did ask whe did not believe verbal abuse ally injured by a team member? He	

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	verbal abuse from CNA E and just anti-anxiety medication. Record Review of the facility's Abuverbal abuse included the use of orderogatory terms to residents or the [NAME], ability to comprehend, or encouraged to report incidents and correct any inappropriate or unprof which abuse is more likely to occur Administrator immediately. After rewill ensure that all residents are profimmediately removing the employe Reporting included - all allegations abuse will be reported to the approapplicable regulations. The Interim Administrator was notif Removal was requested and the Inaccepted on 11/14/22 at 12:56 PM. Review of the Plan of Removal included Administrator suspended on 10/22. Medical Director/Resident's physical subsection of the physical subsection of the physical subsection of the physical		inst dated October 2022 indicated villfully includes disparaging and g distance, regardless of their increase in supervising staff to identify and ing, and intervening in situations in events are reported to the the investigation, the Administrator I harm. Protection included - in allegation of abuse is reported. To the Administrator. Allegations of meframes, as per the policy and 4/22 at 10:55 AM, a Plan of ded. The Plan of Removal was stigation. In g at 5:25 PM via phone. Started on 10-27-22 for routinely et to be completed with routinely

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F 0610	Respond appropriately to all allege	d violations.			
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 26269		
safety Residents Affected - Some	Based on observations, interview and record reviews the facility failed to ensure allegations of abuse wer 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 n be taken for 4 (Residents #3, #12, #13, and #14) of 14 residents reviewed for abuse.				
	The facility failed to immediately in	vestigate, protect the residents, and rep	port 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
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		
	complaint regarding staff treatment and found to be unsubstantiated or investigation and felt the facility wa former employee, Housekeeper F, she should place a camera in his ront being acted on. She said House Resident #3 for not reporting the all with the facility; she decided to place have a roommate and it was not virecorded on the camera, she came hidden camera. She said the video 10/19/22 around 2:00 AM she could She said she could see several stafform the facility just called her a few approved and that she would need they were concerned about what the told her she needed to sign the form she had already removed the camera about the camera prior to the phon one additional video that she had resident to another facility but had resident to another facility but had	22 at 11:25 AM, Resident #3's responsition to the resident, which she believed to an 09/15/22. She said she disagreed with so covering up abuse and/or mistreatme informed her she believed Resident #3 com, because reports to the Administration between F was terminated for telling her between F was terminated for the resident's roolating any other resident's privacy. She to the facility to check on Resident #3 was being abused see on the camera that staff discover ff members looking at the camera before with minutes ago, she did not know who, to sign a consent for its use. She said the camera revealed and the person did me in order for the camera to be approved that the person did me in order for the camera to be approved to sent yet, but she would send it. She to wait for his Medicaid to be approved the because she cannot move him but to	be abuse, that was investigated h the findings of the facility's ent of Resident #3. She said a 8 was being mistreated and told her ator and DON of mistreatment were are about the mistreatment of the said based on her experience om. She said the resident did not e said when she saw the abuse but did not alert the facility to the ed by the staff. She said on red the camera was in the room. The it was unplugged. She said, staff to tell her the camera was not she asked the person that called if not answer the question, and just ed. She said she informed the staff the said no one reached out to her red the facility. She said there was said she wanted to move the before her facility of choice would

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIE Westpark Rehabilitation and Living	R	STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's p	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety	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.		
Residents Affected - Some	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 Adm her hand to Resident #3. They said	inistrator and DON said the third video I the other staff was CNA E.	was LVN C who appeared to raise
		dmission Record dated 10/20/22 indicatity on [DATE] with diagnoses which inc	
	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: able to answer any direct questions	34 PM, Resident #3 was propelling hin	nself in his wheelchair. He was not
	raising her hand to the resident, bu LVN C was reaching to roll the resimistreating the resident. She said a asked her if she was aware there he said the resident's responsible being abused by the staff. She said happen at the facility. She said LVN C had been abused. She said LVN C	PM, CNA E watched third video. She stands and paying attention, at the tident over. She said she had never see around 10:00 PM yesterday, 10/19/22, ad been a camera in the room. She sa party told her she put the camera in the she told the resident's responsible party told the resident was supposed to inform the Administration.	me. She said she thought maybe n any staff being abusive or the resident's responsible party id she told her she was not aware. The room because the resident was rety she did not believe that would possible party reported the resident t's responsible party and knew
	(continued on next page)		

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			NO. 0930-039 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIE Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
		,	
For information on the nursing home's p	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	awake around 2:00 AM and staff go monitoring. She said the resident be and bite staff. She said the video she combative. She said her right hand or bite her. She said she did not may video was when she slapped her on She said she was speaking loudly be the resident to stay in his room and could get a CNA to assist her to pure sident. She said staff discovered CNA E speaking to Resident #3's resaid that maybe CNA E told her soon busy at the time. She said she wou Abuse Coordinator. She said she stried to kick her as she was leaving She said she never raised her hand the outcome of the investigation and In a telephone interview on 10/20/2 combative, he was supposed to get that aggressive on 10/16/22. He saknow, at the time, the camera was because he was under pressure, be heart to do so. He said what he said mean. He said he had not seen or lapologized dearly for his actions ar report to work and was under investigating would notify him immediately controlled in the police and In a telephone interview on 10/20/22 spoke to CNA E regarding her abus could show CNA E the videos. She the videos. She	PM, the Administrator said staff knew ted and it was posted in the facility. He of any allegations of abuse or mistreatr	d him to the nurses' station for nurses' station, and tried to hit, kick wards because he was being she thought he was going to grab She said the slap sound on the ras being abusive to the resident. It of hearing. She said she did tell proximately 5 minutes until she ever threatening or hitting the DON know. She said she did hear the allegation of abuse. She later id not remember, and she was not aware the Administrator was the resident. She said Resident #3 him if he was trying to fight her. If her she was suspended pending urther notice. ENA D said if the resident was too not feel the resident was being did he let go, he said he did not dent he was going to kick his asseresident because it was not in his did and tired of the resident. He said he DON informed him he could not the was the Abuse Coordinator said it was his expectation that the nent. He said the facility would the party said on 10/19/22 she camera. She said she asked if she sight was not good and she did not to see the videos because she

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIF Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #3's hall and she felt staff staff were not assisting him with me Administrator and DON about her of to the resident's responsible party resident's room because she believe she told the resident's responsible her if she knew who the Abuse Coo Administrator wanted to meet with for fear she would be terminated. So inaction regarding allegations made knew about things but don't report. She said there were employees, st abuser. In an observation on 10/24/22 at 9:43 investigation, verbal abuse, and inc LVN C and CNA D for abuse. They to the Administrator. The Administrator heglect, or mistreatment of Resided provided orally and written for all st 09/15/22. On 10/24/22 at 12:43 PM the Administrator. On 10/25/22 at 3:58 PM Safe Survey received from the Administrator. On 10/25/22 at 4:18 PM the Immedian interview on 10/26/22 at 10:0 Surveys with residents on 10/20/22. Record Review of the Safe Survey any completed by Medical Records. Record Review of the Resident Cocustomer service and respect from this was not identified. In an interview on 10/26/22 at 10:2	s, provided by the Administrator, on 10	priately. She said she believed the nim. She said she spoke with the ot addressed. She said she spoke e should put a camera in the she said when the facility found out alled her on 09/10/22, to question ne Administrator. She said the ce, but she did not meet with him as 09/11/22. She said the facility's g. She said other facility employees he names of the other employees. Seidents. She named CNA E, as an anself in his wheelchair. He was uestions appropriately. The videos showed, based on their said they were going to terminate of reporting the allegation of abuse er F never reported any abuse, ON said in-service training was allegation regarding Resident #3 on a lamediate Jeopardy. In a lamediate Jeopardy. In a days a side of the property of the said they were going to terminate of reporting the allegation of abuse er F never reported any abuse, on said in-service training was allegation regarding Resident #3 on the lamediate Jeopardy. In a lamediate Jeopardy. In a side of the said they needed more number of residents who voiced all did bring up, in the meeting on

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIF Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She said during the surveys on 10/at her so close to her she thought to roommate, Resident #14 said she yelled at them again and stated, where said Resident #14 was the Resident #14. She said Resident #14 Residents #13 and #14 told her the 9:00 AM -11:00 AM on Thursday, 10/20/22. She said the residents to 10:00 PM shift. She said, after she interviewed Resident #12 on 10/20 verbally abused her too by yelling and DON of the verbal abuse alleg. On 10/26/22 at 12:10 PM the invest surveys and if the facility had any resident was admitted to the facility disease and bipolar disorder (a medicate with a BIMS score of 15 (a score of 15	stigator sent the Administrator an email new allegations of abuse. Admission Record dated 10/29/22 indic y on [DATE] with diagnoses which inclu	d at her and was pointing her finger id not. She said Resident 13's son, to ask a question, and CNA E our problem? I was just in here! hat they just tried not to bother CNA ak up to get it to stop. She said e said the interviews were between strator and DON immediately on onday, 10/17/22 on the 2:00 PM - Administrator and DON, she the resident told her CNA E had liately informed the Administrator requesting any additional safe ated the [AGE] year-old female aded, chronic obstructive pulmonary the resident was cognitively intact ent). It is in her room in her wheelchair. CNA E came in the room and was a her while she was in her bed and a was going to hit her. She said she was shocked, she felt evening, wanted to just ask a tasked why they were on the light er on 10/17/22. She said the only //20/22. It is resident was moderately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLII	ED.	STREET ADDRESS, CITY, STATE, Z	ID CODE
Westpark Rehabilitation and Living		900 Westpark Way Euless, TX 76040	FCODE
For information on the nursing home's	plan to correct this deficiency, please con-	Lact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on two or three weeks ago, CNA E car said CNA E started yelling at her, s unable to physically help more, and a little scared of her. She said it wa know the lady's name, and the DOI said the DON told her they would d the silent treatment from CNA E aft to the Medical Records person. At 10/26/22 at 2:41 PM, there was In an interview on 10/26/22 at 2:58 Surveys on 10/20/22. He said she of #12, #13, and #14. He said staff co of abuse and/or mistreatment to hir Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 CNA E. She said she was not contact CNA E. She said she would immed CNA E was terminated on Monday, abuse to the Administrator. Record Review of Resident #14's A resident was readmitted to the facil and anxiety. Record Review of Resident #14's A resident Review of Resident Record	10/26/22 at 1:46 PM, Resident #12 ware in her room and was going to assistation as the process of the process o	as in her wheelchair. She said about at with her incontinent care. She he the care. She said she was verbally abused by CNA E and was verbally abused by CNA E and was verbally abused by CNA E. She he said she felt like she received orted the incident again on 10/20/22 agarding the email sent at 12:10 PM. ecords conducted some Safe allegations reported by Residents of immediately report any allegations for the Safe Surveys conducted by agations regarding abuse. She said 3's responsible party's allegation of the IAGE year-old female cluded mild cognitive impairment the resident was cognitively intact.

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIF		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	had been the Resident Council Pre October 2022 it was discussed how perceived some of the staff to be si the staff acted like they were doing residents. She said this was discus getting worse not better. She said I treatment in the facility. She said si requested to be transferred from he her go to room and get in position. the call light on. She said CNA E caput the call light on and that she ha going to report her, and CNA E tolk said CNA E was screaming over her (Resident #13) side of the bed, the yelling, and pointing her finger but y She said Resident #13 hoctocry be room, and Resident #13 pust wanted room screaming again. She said C She said Resident #13 apologized been a resident at the facility for 5 the said Resident #13 apologized been a resident at the facility for 5 the said CNA E had always not tell anyone about the incident us said she was verbally abused and in an interview on 10/26/22 at 4:47 the Safe Surveys dated 10/20/22, C Records reported them verbally to the Administrator and Medical Record Review of Safe Surveys dated not intentionally injured by a team -Resident #12 - verbal abuse	PM, the DON and the Clinical Resource on her person, for Residents #12, #13, the Administrator on 10/20/22 but did rords were suspended pending the outcome of the design of the content of the	Resident Council Meeting in ats, at times. She said the residents when a resident needed something that the staff worked for the ades towards the residents were er, last week on 10/20/22 about her by 10/17/22 around 5:00 PM, she antinent care. She said CNA E told waited over an hour and then put ag that the resident should not have he said she told CNA E she was have to answer to the resident. She A E then went to her roommate's nding over Resident #13, still anot the roommate (Resident #13). sident #13 started crying. She said ant #14). She said CNA E left the out an hour later, the same ght on, and CNA E came in the n why is the call light on again?. O something. She said she had mper. She said CNA E had and d she felt like she would not get an like this before. She said she did her about abuse on 10/20/22. She can be RN said Medical Records had and #14. She said Medical and #14. She sai

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIE Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZII 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please conf	l tact the nursing home or the state survey a	agency.
X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying information	on)
Level of Harm - Immediate leopardy to resident health or safety Residents Affected - Some	timed, and all three residents' answ member? were changed to, No. In an interview on 10/27/22 at 10:02 in-services with all staff on the type Coordinator. The facility began inte Administrator that were not acted u conducted on 10/20/22 with Reside CNA E worked on 10/21/22, after the 10/20/22. She said CNA E did not were porting the allegation of abuse may of verbal abuse. Record Review of CNA E's time she PM, 7.4 hours. Attempts were made to interview C was no answer to the phone call an interview, no return call was received. In a telephone interview on 10/27/2 immediately about each of the allegallegation was made. She said the said the administrator told her to she said the administrator told her to she said the investigator asked about the said the investigator asked about the 10/20/22 Residents #12, #13, and #14 out of the shred 10/20/22 Residents #12, #13, and In an interview on 10/27/22 at 5:41 abuse, as stated above, on 10/20/2 residents (Residents #12, #13, and In a telephone interview on 10/27/2 Medical Records discussed the ver 10/20/22 of the verbal abuse allegant rocoss his mind again. He said y shred bin, but he did not tell her to should be said to tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said y shred bin, but he did not tell her to should be said to the said the said y shred bin, but he did not tell her to should be said to the said the said t	2 at 5:45 PM, the Administrator said Dobal abuse allegations. He said Medical tions. He said with everything going on esterday (10/26/22) Medical Records deshred them. He told her to set them asi	DN said the facility began N was made the Abuse Prevention gations had been reported to the alysis. She said the Safe Surveys abuse by CNA E. The DON said orted to the Administrator on as terminated on 10/24/22 for not but not related to the allegations and on 10/21/22 from 2:24 PM - 9:48 If, and 10/29/22 at 12:19 PM, there 10/29/22 at 12:20 PM requesting an 10/29/24 at 12:20 PM requesting an 10/29/25 at 12:20 PM requesting an 10/29/26 at 12:20 PM requesting an 10/29/26 at 12:20 PM requesting an 10/29/27 at 12:20 PM requesting an 10/29/26 at 12:20 PM requesting an 10/29/27 at 12:20 PM requesting an 10/29/29 at 12:19 PM, there 10/29/29 at 12:19 PM, ther

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 676029 STREET ADDRESS, CITY, STATE, ZIP CODE 30 Westpark Way Euless, TX 78040 STREET ADDRESS, CITY, STATE, ZIP CODE 30 Westpark Way Euless, TX 78040 SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency, please contact the nursing home or the state survey agency. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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-anti-anti-anti-anti-anti-anti-anti-	And PLAN OF CORRECTION IDENTIFICATION NUMBER: 676029 RABUIding B. Wing COMPLETED 11/14/2022 NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living STREET ADDRESS, CITY, STATE, ZIP CODE 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. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety relat verbal abuse from CNA E and just a combination of things. She said she might need an increase i anti-anxiety medication. Record Review of the facility's Abuse: Prevention of and Prohibition Against dated October 2022 is verbal abuse included the use of oral, written, or gestured language that willfully includes disparage derogatory terms to residents or their representative, or within their dear of retribution. Supervising staff to correct any inappropriate or unprofessional behaviors. Identifying, correcting, and intervening in si which abuse is more likely to occur. Investigation, during and after the investigation, the Administrator immediately. After receiving the allegation, during and after the investigation, intervening in si which abuse will be reported from physical and psychosocial harm. Protection included will be reported to the appropriate State Agency in the applicable timeframes, as per the po applicable regulations. The Interim Administrator, Clinical Resource RN, and DON were notified of the Immediate Jeopard 10/27/22 at 4:01 PM, a Plan of Removal was requested and the Immediate Jeopard 10/27/22 at 4:01 PM, a Plan of Removal was requested and the Immediate Jeopardy template was 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 10/28/22 pending the outcome of the investigation. 2. Medical Director/Residen				
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. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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 INAME], ability to comprehend, or disability. Prevention included - 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 indentified 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 template was provided. The Plan of Removal was requ	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. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety relat verbal abuse from CNA E and just a combination of things. She said she might need an increase is anti-anxiety medication. Record Review of the facility's Abuse: Prevention of and Prohibition Against dated October 2022 is verbal abuse included the use of oral, written, or gestured language that willfully included silparary derivatives and prevances without the feat willfully included silparary in the properties of retribution. Supervising staff to its correct any inappropriate or unprofessional behaviors. Identifying, correcting, and intervening in significant will ensure that all residents are protected from physical and psychosocial harm. Protection include immediately are receiving the allegation, during and after the investigation, the Administrator immediately. After receiving the allegation, during and after the investigation, the Administrator immediately are received in the applicable timeframes, as per the posphicable regulations. The Interim Administrator, Clinical Resource RN, and DON were notified of the Immediate Jeopard 10/27/22 at 4:01 PM, a 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 recording the control of		IDENTIFICATION NUMBER:	A. Building	COMPLETED
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F 0610	[Each deficiency must be preceded by full regulatory or LSC identifying information) In an interview on 10/27/22 at 6:35 PM, Resident #14 said she was having increased anxiety relat verbal abuse from CNA E and just a combination of things. She said she might need an increase is anti-anxiety medication. Residents Affected - Some Residents Af	For information on the nursing home's p	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
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		Level of Harm - Immediate jeopardy to resident health or safety	In an interview on 10/27/22 at 6:35 verbal abuse from CNA E and just anti-anxiety medication. Record Review of the facility's Abuserbal abuse included the use of or derogatory terms to residents or the [NAME], ability to comprehend, or encouraged to report incidents and correct any inappropriate or unprofewhich abuse is more likely to occur Administrator immediately. After rewill ensure that all residents are professionally removing the employe Reporting included - all allegations abuse will be reported to the approapplicable regulations. The Interim Administrator, Clinical I 10/27/22 at 4:01 PM, a Plan of Ren The Plan of Removal was accepted Review of the Plan of Removal incl Immediate Action: 1. Administrator suspended on 10/2 2. Medical Director/Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident's phys 3. In-service regarding Abuse: Preview of the Plan of Resident physical ph	PM, Resident #14 said she was havina combination of things. She said she se: Prevention of and Prohibition Agairal, written, or gestured language that weir representative, or within their hearindisability. Prevention included - all staff grievances without the fear of retributivessional behaviors. Identifying, correct. Investigation included - all identified eceiving the allegation, during and after offected from physical and psychosocial er from the care of any resident when a of abuse she be reported immediately priate State Agency in the applicable to Resource RN, and DON were notified and on 10/28/22 at 2:50 PM. But the said she was having a said she was having as having a said she was havi	g increased anxiety related to the might need an increase in her and the state of the might need an increase in her and the state of th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIE Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate act **NOTE- TERMS IN BRACKETS H Based on observation, interview ar were followed for 1 (Resident #6) of The facility failed to ensure LVNs H dressing was changed, according to This failure could place, residents whealth status. Findings included: Record review of Resident #6's Add resident was admitted to the facility infection. Record review of Resident #6's phy plastic caps on the end of each line needed. Record review of Resident #6's add which indicated moderately cognitive transfers, personal hygiene, and be Record review of Resident #6's Ca Record review of Resident #6's Ca Record review of Resident #6's Och however, the IV had two lines with each dressing change every 7 days was provided every 7 days on Sund In an interview on 10/24/22 at 12:4 responsible party regarding his nur weekend nurses, who are all agence of care. In an observation on 10/28/22 at 2:	dministration of IV fluids for a resident variable. ANVE BEEN EDITED TO PROTECT Conductor of the review the facility failed to ensure of 1 resident reviewed for quality of care of 1. J and K followed the physician's order to the physician's order on 10/22. Who required IV dressing changes, at right of the physician's order on IDATE] with diagnoses which inclusively included the physician's order dated 09/10/22 indicated the physician's order d	when needed. ONFIDENTIALITY** 26269 sure the physician order for IV care e. or to ensure Resident #6's IV sk for infection and decline in ed the [AGE] year-old male ded, sepsis (an infection), and skin december of the IV had two lines with two dessing change every 7 days and as the resident had a BIMS score of 12 with activities of daily living, are plan for the IV. Ident did not receive an IV antibiotic; the that were to be changed with andicated the physician ordered care and 10/23/22. Tople concerns from Resident #6's the resident daily and she gave the stand condition to ensure continuity whis wheelchair. An IV site dressing

			No. 0936-0391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented, the DON contacted the The physician said he would not be the DON to change the dressing are changed the dressing. The resident drainage, or pain. The physician's learn the physician's learn the physician's learn the resident's physician was notified she was not aware the physician's she looked at the IV site today (10). She said the resident did not report In a telephone interview on 10/29/2 on Sunday, 10/09/22 and it was not shift. He said he did not know when agency about the working condition to do even basic nursing care, like specifics regarding his IV care, drewing a computer to access the clir the residents. She said she did not In a telephone interview on 10/29/2 dressing on Sunday, 10/16/22. He his documentation on 10/16/22 was IV care.	rsing Progress Note dated 10/28/22 at the resident's physician regarding the late able to come to the facility and assess and assess the site. The Clinical Resourt did not have any signs or symptoms of Nurse Practitioner would be by this event the PM, LVN M said the dressing to Resident and PM, the Clinical Resource RN and DC and 09/30/22. The DON said all the age go was changed as ordered every 7 day, and he did not want to discontinue to orders for the IV were not being follow 28/22), and there was no redness or dot any pain. Part at 11:49 AM, Agency LVN H said he to a good experience. He said he was note the facility kept the wound care supplies and would not work for the facility against dressing changes. He said he did not assing change or what he documented. The said he did not receive reposited records. She said it was very diffication remember anything about Resident #6. The said he just looked to see if the dressing signs of the provious provided the did not all dressing Clinical IV - Solutions Polipplied, and all dressing should be labe	ck of IV site care since 09/30/22. Is the site, at this time. He instructed ce RN and the Charge Nurse of redness, warmth, swelling, ening to assess the site. Ident #6's IV site was dated hift. IN said Resident #6's dressing to oncy nurses that documented, on oncy nurses that documented, on oncy nurses that documented, on oncy at this time. The DON said one IV, at this time. The DON said one IV, at this time. The DON said one IV, at the clinical Resource RN said rainage. She changed the dressing. In only worked at the facility one day of given report when he started his olies. He said he complained to the opain because he felt he was unable remember Resident #6 or any It worked at the facility one time on, on the residents and was not call for her to get anything done for S's dressing or IV care. In did not change Resident #6's no was clean and intake. He said one of the said

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AND PEAN OF CORRECTION	676029	A. Building	11/14/2022		
	070020	B. Wing			
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE		
Westpark Rehabilitation and Living	I	900 Westpark Way			
	Euless, TX 76040				
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)		
F 0835	Administer the facility in a manner	that enables it to use its resources effe	ctively and efficiently.		
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	AVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 26269		
safety		ew, the facility failed to ensure the facil			
Residents Affected - Some		effectively and efficiently to attain or m well-being of each resident for 4 (Resi			
	1) CNA E failed to report Resident 10/19/22.	#3's responsible party's allegation of al	buse to the Administrator on		
	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 re	esidents, 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 ca hidden in a Halloween decoration in Resident #3's room. The DON said she received the call from staff 10/19/22 round 2:00 AM staff regarding the camera. She said the staff texted her a picture of the Hallow 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 roo because the resident's family disagreed with an abuse investigation, conducted on 09/15/22, that did no 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 Soc Worker contact Resident #3's family regarding the camera to get to sign an Electronic Monitoring Form he did not know if the Social Worker had contacted them yet. The Administrator and DON said they had 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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NAME OF PROVIDER OR SUPPLIE	-p	STREET ADDRESS, CITY, STATE, ZI	P CODE
Westpark Rehabilitation and Living		900 Westpark Way Euless, TX 76040	. 3352
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 at 10:43 AM, a videous recorded on 10/19/22 at 1:58 AM, it his wheelchair. She pulled him back room, she faced the resident and stop it, then she pulled her right had down on something that cannot be again saying, you stop it, the reside the resident attempted to continue LVN C asked the resident, are you shuts the door. On 10/20/22 at 11:08 AM, a videous 10/16/22 at 12:09 AM, it showed a bed. CNA D picked up the bed she resident says, get off me, you moth the resident's bed and told he reside could not be understood on the vidual in a telephone interview on 10/20/2 complaint regarding staff treatment and found to be unsubstantiated or investigation and felt the facility was former employee, Housekeeper F, she should place a camera in his root being acted on. She said House Resident #3 for not reporting the all with the facility; she decided to place have a roommate and it was not virecorded on the camera, she came hidden camera. She said the videous 10/19/22 around 2:00 AM she could she said she could see several stafform the facility just called her a few approved and that she would need they were concerned about what the told her she needed to sign the form she had already removed the camera about the camera prior to the phon one additional video that she had resident to another facility but had resident t	was received from Resident #3's respont showed a female staff person (LVN Colorwards into the room in his wheelchair, aid, there you go, she pointed her right and in a fist, the fist does not touch the reseen in frame and a pop was heard, at ent told LVN C, fuck you, LVN C turned the altercation, but the images are obstighting me?', then she said angrily, at was received from Resident #3's respontant staff person (CNA D) enter the reset but the resident tugs on the sheet, and throws the sheet at CNA dent, I'm going to kick your ass. The reset at the resident tugs on the sheet at CNA dent, I'm going to kick your ass.	nsible party. The video was by taking Resident #3 to his room in LVN C, once in the resident's finger at the resident and said, you resident, but her left hand came to the same time LVN C was heard towards the door and it appeared cured by the Halloween decoration. The door, you stay there and then nsible party, it was recorded on resident's room the resident was in nd CNA D lets go of the sheet. The A.D. CNA D walked to the foot of sident responds but his response ble party said she had a previous be abuse, that was investigated the findings of the facility's ent of Resident #3. She said a twas being mistreated and told her atter and DON of mistreatment were the said based on her experience om. She said the resident did not the said when she saw the abuse but did not alert the facility to the ed by the staff. She said on re it was unplugged. She said, staff to tell her the camera was not she asked the person that called if not answer the question, and just the said she wanted to move the before her facility. She said there was said she wanted to move the

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NAME OF PROVIDER OR SUPPLIE	-D	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Westpark Rehabilitation and Living		900 Westpark Way Euless, TX 76040	PCODE	
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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 0835 Level of Harm - Immediate jeopardy to resident health or safety	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.			
Residents Affected - Some	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 Adm her hand to Resident #3. They said	inistrator and DON said the third video I the other staff was CNA E.	was LVN C who appeared to raise	
	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: able to answer any direct questions	34 PM, Resident #3 was propelling hims.	nself in his wheelchair. He was not	
	In an interview on 10/20/22 at 2:44 PM, CNA E watched third video. She said she did not think LVN C w raising her hand to the resident, but she was not paying attention, at the time. She said she thought may 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 aw She said the resident's responsible party told her she put the camera in the room because the resident v being abused by the staff. She said she told the resident's responsible party she did not believe that wo happen at the facility. She said she did not tell anyone the resident's responsible party reported the residend 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)			

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Westpark Rehabilitation and Living		900 Westpark Way Euless, TX 76040	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	awake around 2:00 AM and staff green monitoring. She said the resident be and bite staff. She said the video stombative. She said she did not may video was when she slapped her of She said she was speaking loudly the resident to stay in his room and could get a CNA to assist her to pure resident. She said staff discovered CNA E speaking to Resident #3's resident. She said staff discovered CNA E speaking to Resident #3's resident that maybe CNA E told her so busy at the time. She said she wou Abuse Coordinator. She said she stried to kick her as she was leaving She said she never raised her hand the outcome of the investigation and In a telephone interview on 10/20/2 combative, he was supposed to ge that aggressive on 10/16/22. He saknow, at the time, the camera was because he was under pressure, bheart to do so. He said what he said mean. He said he had not seen or apologized dearly for his actions ar report to work and was under investigating would notify him immediately of investigate, and notify the police are In a telephone interview on 10/20/22 spoke to CNA E regarding her abus could show CNA E the videos. She think she could see the videos. She	PM, the Administrator said staff knew ced and it was posted in the facility. He of any allegations of abuse or mistreatr	d him to the nurses' station for nurses' station, and tried to hit, kick twards because he was being she thought he was going to grab She said the slap sound on the was being abusive to the resident. In of hearing. She said she did tell proximately 5 minutes until she ever threatening or hitting the DON know. She said she did hear the allegation of abuse. She later did not remember, and she was not aware the Administrator was the resident. She said Resident #3 I him if he was trying to fight her. If her she was suspended pending urther notice. CNA D said if the resident was too I not feel the resident was being do he let go, he said he did not dident he was going to kick his assident he was going to kick his assident eresident because it was not in his do and tired of the resident being so resident because it was not in his down the was the Abuse Coordinator as aid it was his expectation that the was the Abuse Coordinator as aid it was his expectation that ment. He said on 10/19/22 she camera. She said she asked if she sight was not good and she did not not see the videos because she

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #3's hall and she felt staff staff were not assisting him with me Administrator and DON about her of to the resident's responsible party resident's room because she believe she told the resident's responsible her if she knew who the Abuse Coo Administrator wanted to meet with for fear she would be terminated. So inaction regarding allegations made knew about things but don't report. She said there were employees, st abuser. In an observation on 10/24/22 at 9:43 investigation, verbal abuse, and inc LVN C and CNA D for abuse. They to the Administrator. The Administrator heglect, or mistreatment of Resided provided orally and written for all st 09/15/22. On 10/24/22 at 12:43 PM the Administrator. On 10/25/22 at 3:58 PM Safe Survey received from the Administrator. On 10/25/22 at 4:18 PM the Immedian interview on 10/26/22 at 10:0 Surveys with residents on 10/20/22. Record Review of the Safe Survey any completed by Medical Records. Record Review of the Resident Cocustomer service and respect from this was not identified. In an interview on 10/26/22 at 10:2	s, provided by the Administrator, on 10	priately. She said she believed the nim. She said she spoke with the ot addressed. She said she spoke e should put a camera in the she said when the facility found out alled her on 09/10/22, to question ne Administrator. She said the ce, but she did not meet with him as 09/11/22. She said the facility's g. She said other facility employees he names of the other employees. Seidents. She named CNA E, as an anself in his wheelchair. He was uestions appropriately. The videos showed, based on their said they were going to terminate of reporting the allegation of abuse er F never reported any abuse, ON said in-service training was allegation regarding Resident #3 on a lamediate Jeopardy. In a lamediate Jeopardy. In a days a side of the property of the said they were going to terminate of reporting the allegation of abuse er F never reported any abuse, on said in-service training was allegation regarding Resident #3 on the lamediate Jeopardy. In a lamediate Jeopardy. In a side of the said they needed more number of residents who voiced all did bring up, in the meeting on

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She said during the surveys on 10/at her so close to her she thought to roommate, Resident #14 said she yelled at them again and stated, where said Resident #14 was the Resident #14. She said Resident #14 Residents #13 and #14 told her the 9:00 AM -11:00 AM on Thursday, 10/20/22. She said the residents to 10:00 PM shift. She said, after she interviewed Resident #12 on 10/20 verbally abused her too by yelling and DON of the verbal abuse alleg. On 10/26/22 at 12:10 PM the invest surveys and if the facility had any resident was admitted to the facility disease and bipolar disorder (a medicate with a BIMS score of 15 (a score of 15	stigator sent the Administrator an email new allegations of abuse. Admission Record dated 10/29/22 indic on [DATE] with diagnoses which inclu	d at her and was pointing her finger id not. She said Resident 13's son, to ask a question, and CNA E our problem? I was just in here! hat they just tried not to bother CNA ak up to get it to stop. She said a said the interviews were between strator and DON immediately on onday, 10/17/22 on the 2:00 PM - Administrator and DON, she the resident told her CNA E had iately informed the Administrator requesting any additional safe ated the [AGE] year-old female ded, chronic obstructive pulmonary the resident was cognitively intact ent). It is in her room in her wheelchair. CNA E came in the room and was on her while she was in her bed and a was going to hit her. She said she was shocked, she felt evening, wanted to just ask a tasked why they were on the light er on 10/17/22. She said the only //20/22. It is resident was moderately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS CITY STATE 71	D CODE
Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	PCODE
For information on the nursing home's	plan to correct this deficiency, please con		agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	ion)
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on two or three weeks ago, CNA E cal said CNA E started yelling at her, s unable to physically help more, and a little scared of her. She said it wa know the lady's name, and the DOI said the DON told her they would dithe silent treatment from CNA E aft to the Medical Records person. At 10/26/22 at 2:41 PM, there was In an interview on 10/26/22 at 2:58 Surveys on 10/20/22. He said she will staff coof abuse and/or mistreatment to him Medical Records on 10/20/22. In an interview on 10/26/22 at 3:12 CNA E. She said she was not contact CNA E. She said she would immed CNA E was terminated on Monday abuse to the Administrator. Record Review of Resident #14's A resident was readmitted to the faciliand anxiety. Record Review of Resident #14's A resident Review of Resident Recodent Review of Resident #14's A resident Recodent Review of Resident Recodent Recodent Review of Resident Recodent	10/26/22 at 1:46 PM, Resident #12 wame in her room and was going to assis aying the resident could help more with the started crying. She said she was son a weekend, and she told a lady who was called. She said she told the DC o some additional training with staff. She reshe reported her. She said she reported her. She said she reported her said Medical Redid not notify him of the verbal abuse and ucting the Safe Surveys were told to mimmediately. He said he would look to mimmediately. He said he would look to the power of any allegated on a weekend regarding an incidental state of the Administrator of any allegated on a weekend reporting Resident #3 admission Record dated 10/29/22 indicated to IDATE] with diagnoses which incompared the power of the	as in her wheelchair. She said about the with her incontinent care. She had the care. She said she was verbally abused by CNA E and was verbally abused by CNA E and was verbally abused by CNA E and was verbally abused by CNA E. She had said she felt like she received orted the incident again on 10/20/22 agarding the email sent at 12:10 PM. Records conducted some Safe allegations reported by Residents of immediately report any allegations for the Safe Surveys conducted by the of the new allegations regarding alent between Resident #12 and gations regarding abuse. She said 3's responsible party's allegation of the IAGE year-old female cluded mild cognitive impairment the resident was cognitively intact.

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NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	had been the Resident Council Pre October 2022 it was discussed how perceived some of the staff to be so the staff acted like they were doing residents. She said this was discuss getting worse not better. She said I treatment in the facility. She said so requested to be transferred from he her go to room and get in position. The call light on. She said CNA E caput the call light on and that she has going to report her, and CNA E tolesaid CNA E was screaming over her (Resident #13) side of the bed, the yelling, and pointing her finger but she said Resident #13 hoctocry be room, and Resident #13 pust wanted room screaming again. She said C She said Resident #13 apologized been a resident at the facility for 5 attitude like she was invincible bec fired. She said CNA E had always not tell anyone about the incident usaid she was verbally abused and In an interview on 10/26/22 at 4:47 the Safe Surveys dated 10/20/22, Records reported them verbally to the Administrator and Medical Record Review of Safe Surveys dated intentionally injured by a team -Resident #12 - verbal abuse	PM, the DON and the Clinical Resource on her person, for Residents #12, #13, the Administrator on 10/20/22 but did rords were suspended pending the outcome of the design of the content of the	Resident Council Meeting in ats, at times. She said the residents when a resident needed something that the staff worked for the ades towards the residents were er, last week on 10/20/22 about her by 10/17/22 around 5:00 PM, she antinent care. She said CNA E told waited over an hour and then put ag that the resident should not have he said she told CNA E she was have to answer to the resident. She A E then went to her roommate's nding over Resident #13, still anot the roommate (Resident #13). sident #13 started crying. She said ant #14). She said CNA E left the out an hour later, the same ght on, and CNA E came in the n why is the call light on again?. O something. She said she had mper. She said CNA E had and d she felt like she would not get an like this before. She said she did her about abuse on 10/20/22. She can be RN said Medical Records had and #14. She said Medical and #14. She sai

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	timed, and all three residents' answ member? were changed to, No. In an interview on 10/27/22 at 10:00 in-services with all staff on the type Coordinator. The facility began interview on 10/20/22 with Reside CNA E worked on 10/21/22, after the 10/20/22. She said CNA E did not be reporting the allegation of abuse mof verbal abuse. Record Review of CNA E's time she PM, 7.4 hours. Attempts were made to interview C was no answer to the phone call arbiterview, no return call was received. In a telephone interview on 10/27/2 immediately about each of the allegation was made. She said the said the administrator told her to she said the administrator told her to she said the investigator asked about the sheat of the investigator asked about the sheat of	Records completed the three above Safers to Do you feel you have been interested to Do you with staff to see if any abuse alles and the allegations of verbal abuse were reported after 10/21/22. She said CNA E was also yet and by Resident #3's responsible party feet dated 10/27/22 indicated she worked the dated 10/27/22 indicated she worked the dated 10/27/22 indicated she worked the dated 10/27/22 at 5:23 PM, 7:24 PM and messages, a text was also sent on 10/20/22 at 1:00 feet prior to the exit on 10/29/22 at 1:00 feet prior to the exit on 10/29/22 at 1:00 feet prior to the exit on 10/29/22 at 1:00 feet prior to the exit on 10/29/22 at 1:00 feet prior to the exit on 10/29/22 at 1:00 feet prior to the exit on 10/29/22 at 1:00 feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 at 1:00 feet feet prior to the exit on 10/29/22 feet feet prior to 10/29/29 feet feet	ON said the facility began ON was made the Abuse Prevention gations had been reported to the nalysis. She said the Safe Surveys abuse by CNA E. The DON said orted to the Administrator on vas terminated on 10/24/22 for not v, but not related to the allegations ed on 10/21/22 from 2:24 PM - 9:48 M, and 10/29/22 at 12:19 PM, there 10/29/22 at 12:20 PM requesting an PM. The told the Administrator the said she told him after each sussion with the Administrator. She reveys that revealed verbal abuse. Itionally injured. She said the ants again. She said on 10/26/22, ginal Safe Surveys for Resident aid the Administrator understood on used by CNA E. The conversation regarding the se being reported on the three ON was not in the room when I Records did notify him on the verbal abuse allegations did did get the Safe Surveys out of the ide in his office. He said he did ask whe did not believe verbal abuse ally injured by a team member? He	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZI 900 Westpark Way Euless, TX 76040	P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	verbal abuse from CNA E and just anti-anxiety medication. Record Review of the facility's Abuverbal abuse included the use of orderogatory terms to residents or the [NAME], ability to comprehend, or encouraged to report incidents and correct any inappropriate or unprofivation of which abuse is more likely to occur Administrator immediately. After rewill ensure that all residents are profimmediately removing the employed Reporting included - all allegations abuse will be reported to the approapplicable regulations. The Interim Administrator was notificated on 11/14/22 at 12:56 PM Review of the Plan of Removal incidence and the Information of the Plan of Removal incidence and the Information of the Plan of Removal incidence and the Information of the Plan of Removal incidence and the Information of the Plan of Removal incidence and the Information of the Plan of Removal incidence and Information of the Informat		inst dated October 2022 indicated villfully includes disparaging and g distance, regardless of their , residents and visitors are on. Supervising staff to identify and ing, and intervening in situations in events are reported to the the investigation, the Administrator I harm. Protection included - in allegation of abuse is reported. To the Administrator. Allegations of meframes, as per the policy and 4/22 at 10:55 AM, a Plan of ded. The Plan of Removal was stigation. Ing at 5:25 PM via phone. Started on 10-27-22 for routinely et to be completed with routinely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER OB SUPPLIER Westpark Rehabilitation and Living STREET ADDRESS, CITY, STATE, ZIP CODE 300 Westpark Way Euless, TX 76040 STREET ADDRESS, CITY, STATE, ZIP CODE 300 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. (X4) ID PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accopted profressional 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 accordance with accopted 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 ski infection. Record review of Resident #6's admission redord dated 09/10/22 indicated the resident was moderately cognitively impaired with a BIMS score of 12 (a score of 6+12 indicated the resident was moderately cognitively impaired with a BIMS score of 12 (a score of 6+12 indicated the resident was moderately cognitively impaired with a BIMS score of 12 (a score of 6+12 indicated the resident was moderately cognitively impaired with a BIMS score of 12 (a score of 6+12 indicated the resident date of the resident 46 scor		.a.a 50.7.655		No. 0938-0391
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. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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 were 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 ski infection. 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 5-12 indicated moderate cognitive impairment). He required assistance with activities of daily living, transfers, personal hygiene, and bathing. Record review of Resident #6's October 2022 IV MAR, indicated the resident daily and however, the IV had two lines with two plastic caps on the end of each line that were to be changed with nowwer, the IV had two lines with two plastic caps on the end of each line that were to be changed with nowwer, the IV had two lines with two plastic caps on the end of each line that were to be changed with n		IDENTIFICATION NUMBER:	A. Building	COMPLETED
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0842 Level of Hamr - Minimal harm or potential for actual harm Residents Affected - Few Based on interview and record review, the facility failed to 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 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 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 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 October 2022 IV MAR, indicated the re			900 Westpark Way	P CODE
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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 #8) 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 ski infection. Record review of Resident #6's Admission MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS soore of 12 (a score of 8-12 indicated the resident was moderately cognitively impaired with a BIMS soore of 12 (a score of 8-12 indicated the resident was moderately cognitively impaired with a BIMS soore of 12 (a score of 8-12 indicated the resident did not receive an IV antibioti 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. Record review of Resident #6's October 2022 IV MAR, indicated the resident did not receive an IV antibioti 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 the documentation indicated the physician ordered complete the sev	For information on the nursing home's	plan to correct this deficiency, please con		agency.
Level of Harm - Minimal harm or potential for actual harm or potential harm or potential for actual harm or potential harm or potentia	(X4) ID PREFIX TAG			on)
	Level of Harm - Minimal harm or potential for actual harm	Safeguard resident-identifiable info accordance with accepted profession **NOTE- TERMS IN BRACKETS Here Based on interview and record revisaccordance with accepted profession documented for 1 (Resident #6) of the staff failed to accurately documented for 1 (Resident #6) of the staff failed to accurately documented medical records. Findings included: Record review of Resident #6's Addresident was admitted to the facility infection. Record review of Resident #6's phy plastic caps on the end of each line needed. Record review of Resident #6's addresident was admitted with a BIMS so required assistance with activities of Record review of Resident #6's Call Record review of Resident #6's Oct however, the IV had two lines with each dressing change every 7 days was provided every 7 days on Sund In an interview on 10/24/22 at 12:40 responsible party regarding his number weekend nurses, who are all agency of care. In an observation on 10/28/22 at 2: to his right arm was dated 09/30/22	rmation and/or maintain medical record conal standards. IAVE BEEN EDITED TO PROTECT Consumption of the property of the proper	ds on each resident that are in ONFIDENTIALITY** 26269 al records on each resident, in example the and accurately received for accuracy. October 2022 TAR. of incomplete and inaccurately ed the [AGE] year-old male ded, sepsis (an infection) and skin d the IV had two lines with two essing change every 7 days and as the resident was moderately oderate cognitive impairment). He had, and bathing. The plan for the IV. Lent did not receive an IV antibiotic; that were to be changed with indicated the physician ordered care and 10/23/22. The concerns from Resident #6's the resident daily and she gave the sand condition to ensure continuity This wheelchair. An IV site dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2022
NAME OF PROVIDER OR SURPLIER		STREET ADDRESS CITY STATE ZID CODE	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Westpark Way	
Westpark Rehabilitation and Living		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.			
(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	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.		
	Sunday 10/23/22, she said it was regiven a computer to access the clir	1/22 at 11:56 AM, Agency LVN J said she worked at the facility one time on, or rough because she did not receive report on the residents and was not elinical records. She said it was very difficult for her to get anything done for ot 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.		
		ated Clinical Documentation policy indi- e resident's clinical record. The policy of	