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	01/05/2023

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observation, interview and record review the facility failed to ensure residents had the right to be from abuse, neglect, misappropriation of resident property, and exploitation for six of 16 residents (Residents #2, #3, #4, #5, #6 and #7) reviewed for abuse. The facility failed to protect Residents #2, #3, #4, #5, #6 and #7 from Resident #1, who had a known history of physical and verbal aggression towards residents. An Immediate Jeopardy (IJ) situation was identified on 01/05/23. The IJ began on 11/04/22 and removed on 12/22/22. While the IJ was removed on 12/22/22, the facility remained out of compliance at a scope of potential for more than minimal harm that is not Immediate Jeopardy and a severity level of pattern, due to the facility's need to implement corrective systems. This failure placed residents at risk of subsequent abuse, mental anguish, and emotional distress. Findings included: Record review of Resident #1's face sheet, dated 12/22/22, revealed the resident was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included alcohol dependence with alcohol induced persisting dementia (brain disorder that causes memory loss), alcoholic polyneuropathy (alcohol induced nerve disorder), aphasia (speech disorder), schizoaffective disorder (psychotic/mood disorder), major depressive disorder (mood disorder), and cognitive communication deficit. Record review of Resident #1's Quarterly MDS assessment, dated 11/28/22, reflected Resident #1 had a diagnosis which included non-Alzheimer's dementia. The resident had a BIMS score of 0, due to the BIMs not being completed due to cognitive deficits. The MDS reflected Resident #1 rarely had the ability to make himself clear and understand others. Resident #1 was severely impaired when it came to making decisions regarding tasks of daily life. The MDS reflected Resident #1 was short-tempered and easily annoyed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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	Record review of Resident #1's care plan, revised 11/07/22, revealed: Resident #1 was at risk for impaired cognitive function or impaired thought processes r/t dementia. Resident #1 had poor attention span, fidgety, unable to sit for a very long time and was constantly on the move. Goal: resident will maintain current level of cognitive function through review date. Interventions: administer Memantine as ordered, administer Thiamine as ordered, identify self at each interaction, and give step-by-step instructions one at a time as needed to support cognitive function. Resident #1 had the potential for psychosocial well-being problem r/t resident wandering into other residents' spaces, grabs their wrists, their items, food on trays in dining room, then other residents retaliate against him. Goals: resident will have no indications of psychosocial well-being problems through review date. Interventions: 1:1 supervision, monitor for injuries every shift for 3 days, monitor/document resident's feelings relative to the other residents. Resident #1 had the potential to demonstrate physical behaviors r/t Dementia, hitting, kicking at staff, unable to redirect behavior. Resident combative, verbally aggressive, going in and out of resident rooms, upset with redirection, cursing staff, and refusing care. Goals: resident will not harm self or other residents. Interventions: 1:1 supervision, administer Benadryl as ordered, provide physical and verbal cues to alleviate anxiety, document observed behaviors and attempted interventions, and give as many choices as possible regarding care and activities. Record review of Resident #2's face sheet, dated 12/22/22, revealed the resident was a [AGE] year-old female, who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included age-related osteoporosis (weak bones), unspecified dementia without behavioral disturbances (brain disorder that causes memory loss), speech language deficits, and profound intellectual disabilities. Record review of Resident #2's Quarterly MDS assessment, dated 10/21/22, reflected a BIMS score of 06, which indicated severe impairment. Record review of Resident #2's care plan, dated 06/21/22, revealed the resident was to be monitored for re-traumatization r/t assault in 2013. The family complained of poor care at prior living situation. Resident noted to cry a lot, but not abnormal per guardian. Goals: resident will have no evidence of emotional, physical, and psychological problems by review date. Interventions: anticipate and meet needs, document behaviors and resident's response to interventions. Record review of Resident #3's face sheet, dated 12/22/22, revealed the resident was a [AGE] year-old female, who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease), unspecified dementia and essential hypertension (high blood pressure). Record review of Resident #3's Quarterly MDS assessment, dated 12/21/22, reflected a BIMS score of 0, due to the BIMs not being completed, due to cognitive deficits. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's care plan, dated 11/04/22, revealed the resident had potential for injury related to another resident hitting her in the chest, monitoring needed for injury. Interventions: Monitor res for pain, bruising chest area q shift. Resident #3 also had potential for pain and inability to communicate. Goal: If or when res shows signs of pain, pain med will be effective. Interventions: Anticipate need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Record review of Resident #4's face sheet, dated 12/22/22, revealed the resident was an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease), respiratory failure, anxiety disorder. Record review of Resident 4's Quarterly MDS assessment, dated 10/02/22, reflected the resident had a BIMS of 08, which indicated moderately impaired cognition. Record review of Resident #4's care plan, dated 01/22/20, revealed: Resident #4 had a terminal prognosis related to chronic obstructive pulmonary disease. Goal: to be free of depression and anxiety. Interventions: assess resident coping strategies and respect resident wishes, monitor significant changes in patients physical, mental, social, or emotional status and/or concerns including pain and uncomfortable situations. Record review of Resident #5's face sheet, dated 12/22/22, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease), asthma, abnormalities of gait and mobility and major depressive disorder. Record review of Resident #5's Quarterly MDS assessment, dated 11/15/22, reflected the resident had a BIMS of 12, which indicated moderately impaired cognition. Record review of Resident #5's care plan, dated 04/01/22, revealed: Resident #5 was at risk for Re-traumatization related to history of alleged verbal abuse and history of alleged physical abuse. Goal: have no evidence of emotional, physical, and psychological problems. Interventions: monitoring behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Anticipate and meet needs. Record review of Resident #6's electronic face sheet, dated 12/22/22, revealed Resident #6 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included moderate intellectual disabilities, manic episode without psychotic symptoms and cognitive communication deficit. Record review of Resident #6's Quarterly MDS assessment, dated 07/13/22, revealed Resident #6's BIMS score was 0, due to the BIMs not being completed due to cognitive deficits. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's care plan, dated 08/04/22, revealed Resident #6 had Anti-anxiety medication use related to anxiety disorder. Goal revealed resident will be free from discomfort or adverse reactions related to anti-anxiety therapy. Interventions included Lorazepam as ordered by physician. 8/3/2022 Increased Dosage. Record review of Resident #7's face sheet, dated 12/22/22, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease), type II diabetes, aphasia (speech disorder), hemiplegia (severe or complete paralysis), hemiparesis (mild or partial weakness), osteoporosis (weak bones) and dementia (brain disorder that causes memory loss). Record review of Resident #7's Quarterly MDS assessment, dated 12/15/22, reflected the resident had a BIMS of 13, which indicated her cognition was intact. Record review of Resident #7's care plan, dated 06/08/22, revealed: Resident #7 had potential for aggressive behaviors and psychosocial well-being problem related to a resident-to-resident incident. Goal: resident will have no indications of psychosocial well-being problems and will identify coping mechanisms. Interventions: skin assessments, monitor for mood change, separate from other resident in incident, when conflict arises, remove Resident #7 to a calm safe environment and allow to vent/share feelings. Record review of Progress Notes, dated 12/11/2022, regarding Resident #1 revealed Resident was found in another resident's room scooting around. He took her picture frame and threw it and broke it. The other resident was pushing the seat of the wheelchair into his back over and over to scoot him out of her room. Resident removed from her room and avoiding glass on the floor, assisted back into wheelchair. Head to toe assessment shows no apparent injuries. Record review of Progress Notes, dated 12/12/2022, regarding Resident #1 revealed Resident remains on follow up related to resident-to-resident altercation with no other incidents observed or reported . Record review of Progress Notes, dated 12/13/2022, regarding Resident #1 revealed Resident wandering aimless into resident room with re-direction given . Record review of Progress Notes, dated 12/14/2022, regarding Resident #1 revealed Resident wandering aimless into resident room with re-direction given . Record review of Progress Notes, dated 12/21/2022, regarding Resident #1 revealed Resident agitated, moving from room to room waking up residents, resisting care Lorazepam Tablet 0.5 MG . Record review of Incident Report, dated 10/9/2022, regarding Resident #1 revealed Resident wheeled himself into room [ROOM NUMBER] and was found crawling around the floor there. Wheelchair was also knocked over. Left forearm skin tear noted. Range of motion per baseline. No signs of pain. Record review of Incident Report, dated 12/11/2022, regarding Resident #1 revealed Resident was in another residents' room and was bothering her things. He got out of his wheelchair and got onto the floor, found and broke a picture frame. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An attempted interview and observation on 12/22/22 at 11:51 AM with Resident #1 revealed he was unable to participate in an interview due to cognitive deficits. When asked a question, the resident did not respond and was not aware of what was being said. Resident #1 was observed self-propelling around the facility in a wheelchair. He was seen entering a resident's room without any intervention. An interview and observation on 12/22/22 at 11:53 AM with RN C revealed she saw Resident #1 enter room [ROOM NUMBER]. RN C stated Resident #1 was always going into other rooms, and it was hard for staff to stop him because he would become angry. RN C stated she did not intervene because there were no residents in room [ROOM NUMBER], although Resident #1 was not supposed to be in that room. RN C proceeded to go into room [ROOM NUMBER] and redirected Resident #1 out. RN C stated Resident #1 went all over the facility and usually did not disturb anyone until he was redirected and unable to do what he wanted. RN C stated staff had been trained to do frequent checks on Resident #1 to prevent him from going into other resident rooms. An interview on 12/22/22 at 11:30 AM with Resident #2 revealed she was sitting in a wheelchair on the 200 Hall near her room. Resident #2 denied being abused or neglected by staff. When asked about other residents, Resident #2 stated she was afraid of Resident #1 and immediately became teary-eyed and hysterical. Resident #2 was so upset she could barely speak, but she was able to state Resident #1 was always coming into her room to take things and curse at her and her roommate. Resident #2 stated she was afraid Resident #1 was going to hurt her and her roommate. Resident #2 continued to cry and stated she had to protect her roommate from Resident #1. An attempted interview on 12/22/22 at 11:15 AM with Resident #3 revealed she was unable to participate in an interview due to cognitive deficits. Resident #3 was dressed and well-groomed with no visible marks or bruises. An interview on 12/22/22 at 11:55 AM with Resident #4 revealed she had recently relocated to another room because of having issues with another resident who she described as Resident #1. Resident #4 stated Resident #1 had just been in her room the previous night going through her personal items. Resident #4 stated Resident #1 liked to get close to her, in her personal space and this made her feel uncomfortable. Resident #4 stated Resident #1 needed to be in a different facility because staff were not able properly care for him because he liked to roam the facility, curse at residents, and cause problems with other residents. Resident #4 stated she always alerted staff to remove him from her room, but it sometimes took a long time to remove him. She stated she would use the saltshaker, telling him it was evil, to get Resident #1 away from her. Resident #4 denied ever being physically harmed by Resident #1 but stated she was afraid of him. An interview on 12/22/22 at 12:33 PM with Resident #5 revealed she had an encounter with Resident #1 while sitting in the dining room. She stated Resident #1 jumped on her. Resident #5 stated she was physically attacked but did not indicate having any pain or injuries from the incident. She stated she was nervous around Resident #1 since then. She stated Resident #1 would always come in her personal space as if he did not understand boundaries. Resident #5 stated when she saw Resident #1 getting too close, she would have to stop him to keep him from grabbing her. She stated he could have become very aggressive. Resident #5 stated Resident #1 needed to be at a different facility, because of the way he treated people and he could harm someone. Resident #5 stated she was scared he would cause harm to her again. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on 12/22/22 at 12:42 PM with Resident #6 revealed she was hit in the stomach by Resident #1 in the dining hall during lunch. Resident #6 stated she reported the altercation to the Speech Therapist. Resident #6 did not recall any pain or injuries after the altercation. Resident #6 stated she did not like Resident #1 and he was mean and made her feel uncomfortable. An interview on 12/22/22 at 2:45 PM with the Speech Therapist revealed on 11/07/22, he was walking in the dining area and Resident #6 reported to him she was hit in the stomach. When asked to identify the person who hit her, she pointed out Resident #1. The Speech Therapist stated he saw Resident #1 having aggressive behaviors towards staff and other residents on many occasions. The Speech Therapist stated he was told by several residents they were fearful of Resident #1. Residents stated they have woken to him being in their rooms throughout the night. The Speech Therapist stated he alerted the Administrator about all concerns that were brought to him by residents, and he would try to assist with redirecting Resident #1 as much as possible. An interview on 12/22/22 at 11:41 AM with Resident #7, revealed the only person she was afraid of at the facility was Resident #1. She stated, He's a pain in the butt! Resident #7 stated Resident #1 would always come in her room and take her personal belongings. She stated he was caught in her room about a week ago and when she broke a special picture frame of hers. Resident #7 stated staff would try to keep him out of her room, but he would find a way to get in. She stated she was recently moved to a different room to get away from Resident #1 and now felt safer. She denied ever being physically abused by Resident #1. An interview on 12/22/22 at 1:05 PM with CNA A, revealed she had worked at the facility since 2019. CNA A stated she worked on the 200 Hall with Resident #1. She stated Resident #1 would beat on the staff and other residents periodically since being admitted . CNA A stated he would sneak into other resident rooms and if staff were unable to catch him in a timely manner, he would grab or hit the residents. She stated if Resident #1 was seen going into another resident's room, staff would redirect and guide him out immediately. CNA A stated she last witnessed Resident #1 hit another resident about a month ago; however, he was constantly cursing and yelling at everyone. She stated Resident #1 was placed on 1:1 supervision after this incident, but she believed it was discontinued because he would attack the staff who were supervising him, and staff started refusing to work with him. This incident was reported and investigated on this date. CNA A stated Resident #1 was able to be redirected sometimes but most times he could not be due to his cognition. CNA A stated staff could not reason with Resident #1 or help him understand why he was unable to wander in other rooms or intrude on the space of other residents. She stated staff were told to check on Resident #1 more frequently, but it was hard to do so and care for all other residents. She stated most residents on the 200 Hall were afraid of Resident #1, and some had even been moved to different halls to get away from him. CNA A stated staff were trained on abuse, neglect and handling aggressive behaviors with the last training being about a month ago. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on 12/22/22 at 1:25 PM with RN B, revealed she had worked at the facility since 2017. RN B stated she worked on the 200 Hall with Resident #1. She stated Resident #1 was a difficult resident with aggressive behaviors. RN B stated most of the residents were afraid of him. She stated there were interventions in place to check on him every 15 mins and sometimes he was placed on 1:1 supervision. RN B stated she tried to keep Resident #1 close to her station, but it was hard because he liked to wander and go into other resident rooms. RN B stated Resident #1 had been on psychotropic medications to help control his behaviors; however, the family would have them adjusted or discontinued. RN B stated the medications Resident #1 was currently on, was not helping him. She stated the other residents were not safe with Resident #1 in the facility and she felt he belonged in a psychiatric hospital. An interview on 12/22/22 at 2:14 PM with the COTA revealed she worked at the facility for 5 months. She stated she witnessed a physical altercation between Resident #1 and Resident #3 on 11/4/22. The COTA stated she was standing in the dining room when she heard groans coming from the table where Resident #3 was sitting. The COTA stated she turned and saw Resident #1 trying to take food from one of the trays and when staff intervened, he became angry. The COTA stated Resident #1 was able to ball up his fist and reach across to punch Resident #3 in the chest twice before staff were able to pull him away. The COTA stated Resident #3 was assessed by the nurse and did not sustain any injuries to her knowledge. The COTA stated she saw Resident #1 become verbally aggressive and knock over things, but she denied ever seeing him physically harm any residents prior to that incident. The COTA stated the Administrator was immediately notified about the incident. An interview on 12/22/22 at 5:45 PM with the DON revealed she had been employed at the facility for about 5 months. The DON stated shortly after starting at the facility, she recommended Resident #1 be transferred to a memory care facility. However, he was Medicaid pending and the family would not provide the necessary documents for the application to be approved. The DON stated Resident #1 was not receiving proper care at their facility because he needed a more structured environment with staff who were trained to better handle his behaviors. The DON stated Resident #1 was in an advanced stage of dementia and his cognitive deficits was beyond what the facility was capable of managing. The DON stated Resident #1 would wander around the entire facility, going in other residents' rooms causing them to become upset. She stated there were incidents where Resident #1 would become physically aggressive towards other residents, break their personal items, and use profanity. She stated the physical aggression had not happened in about a month; however, the wandering and verbal aggression was continuous. The DON stated she was concerned with the safety of all residents but more so for Resident #1 because of his unawareness and the conflict he would cause. The DON stated she was concerned he would wander into another confused or aggressive resident's room. The DON stated Resident #1 was also physically and verbally aggressive towards staff, especially when care was being provided. The DON stated the MD placed Resident #1 on 1:1 supervision for about 2 weeks then discontinued after there were no new incidents. The DON stated he was then placed on 15-minute checks. The DON stated she could not say the interventions were effective, because Resident #1 was not suitable for the facility. She stated Resident #1 was previously on psychotropic medications that seemed to be working. However, the family decided to take him off and refused any other psychiatric services. The DON stated she was able to convince them to consent to low dose PRN psychotropic medications that were not as effective. The DON stated Resident #1's family would threaten to sue the facility if they transferred him or sent him out to be evaluated at a psychiatric hospital. The DON stated she was not sure what other options they had to protect everyone's safety and rights. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 12/22/22 at 6:05 PM with the Administrator, revealed she had been employed at the facility since 12/01/22. The Administrator stated she was not yet familiar with all of Resident #1's history. However, he had presented many challenges since the start of her employment. She described Resident #1 as having extreme mood swings, presenting very friendly and happy at times and then frustrated and aggressive at other times. The Administrator stated Resident #1 was not easily redirected, and staff would have a hard time keeping him content. The Administrator stated Resident #1 required a higher level of care the facility could not provide due to not having a secured unit and because Resident #1's family would not consent to any psychiatric services, which included psychotropic medications and/or evaluations at a psychiatric hospital. The Administrator stated Resident #1's family also would not cooperate in providing documents to get him Medicare so he could be transferred to a more appropriate facility. She also stated Resident #1 had a balance of $60,000 owed to their facility, which made it even more difficult to find appropriate placement. The Administrator stated it was her responsibility to ensure the proper care and safety of all residents in the facility. However, she felt like there was not a simple solution and either way she would face a dilemma. The Administrator stated she knew it was best for Resident #1 to be discharged from the facility, but with his family not giving consent for him to be transferred or sent out to a psychiatric hospital, she would be at risk for an inappropriate discharge tag. The Administrator stated her hands were tied. She stated the facility had interventions in place for Resident #1's behaviors such as frequent redirection, checks every 15 minutes, and allowing him to self-redirect and have self-determination as much as possible; however, these interventions were not always effective. The Administrator stated the facility had decided to discharge Resident #1 to a psychiatric hospital and was in the process of doing so on this date. The Administrator stated keeping Resident #1 at the facility where he was not receiving the proper treatment was a risk to his safety as well as others; however, she did not know what else to do. Interview on 01/05/23 at 11:43 AM with CNA D revealed she had worked at the facility for 8 years and worked with Resident #1 until he was discharged on [DATE]. CNA D stated Resident #1 was a wanderer and was verbally and physically aggressive towards staff and other residents. CNA D stated she had not witnessed any incidents where Resident #1 was physically aggressive towards other residents; however, she witnessed him go throughout the halls yelling and cursing. CNA D stated residents were annoyed by Resident #1 and did not like for him to be in their space. CNA D stated she witnessed Resident #2 become visibly shaken and tearful in the presence of Resident #1. CNA D stated Resident #2's family informed staff Resident #1 resembled Resident #2's father, who abused her as a child, and Resident #1 triggered her post traumatic stress disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 01/05/23 at 12:10 PM with the Administrator and the DON revealed there were currently no other residents in the facility who exhibited similar aggressive behaviors as Resident #1. The DON stated Resident #1 was discharged from the facility on 12/22/22 and the facility put measures in place to prevent further abuse from occurring. The Administrator stated the facility already had interventions in place that would have been effective for Resident #1 had the family been cooperative and would still be effective for other residents who might exhibit similar aggressive behaviors. The DON further stated they hit many brick walls with the family by not allowing Resident #1 to get the assistance he required. The DON stated the family had requested Resident #1 be taken off all psychotropic medications 09/12/22 because they thought the resident appeared to be more confused. Two other nursing facilities had agreed to accept Resident #1, but only if they had the Medicaid application pending, but the POA was not assisting with the Medicaid application process by failing to produce the required documentation. They had also contacted the local ombudsman for assistance and the family kept making promises they would get the necessary paperwork for the Medicaid application, but they never received them. The Administrator stated that management had been in-serviced on the processes of discharges and transfers. The DON stated clinicals for potential residents would be screened closer for keywords such as agitation, aggression, and confusion to prevent the facility from admitting residents who may not receive appropriate services. The DON stated for current residents, the facility would continue to monitor for changes in conditions and a new onset of aggressive behaviors so appropriate interventions could be put in place immediately. The Administrator stated if interventions proved to be ineffective, the facility would meet with the resident and family to begin the process of discharge. Review of Resident #1's IDT meeting notes dated 12/23/22 reflected the following: Note Text: Discussed initial patient behaviors upon admission compared to most recent behaviors. The patient's behaviors have progressed to an increasingly difficult to manage level. POA previously requested termination of all pharmacological psychotropic interventions, which were initially prescribed to address diagnosis of dementia with agitation, schizoaffective disorder, alcohol induced persisting amnestic disorder, Wernicke's Korsakoff's syndrome, and major depression disorder. Team discussed how termination of psych meds has contributed to progressively increased behaviors and a higher risk of harm to self or others. Prior discussions have been had with POA regarding cooperative efforts needed to find alternative placement considering increased behaviors. POA and family continue to appear to be in denial regarding resident's disease process, resulting in unproductive discussions. Current non-pharmacological interventions currently in place: - Distract resident from wandering of offering pleasant diversions, structured activities, food, conversation, television, book. - Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. - Monitor resident and redirect from entering other resident rooms. - Intervene as necessary to protect the rights and safety of others. - Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. (continued on next page)

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	01/05/2023

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Give as many choices as possible about care and activities. - Q15 minute checks - D/t the increase progression of negative behaviors and barriers related to current POA allowed interventions becoming increasingly ineffective resident was transferred to an acute care hospital for higher level of care and assessment. Acute care hospital case manager advised that hospital has identified two facilities with memory care units that can provide increased level of care not available at this facility. Interview on 01/05/23 at 1:23 PM with the Physician revealed Resident #1 was under her care while he was at the facility. She stated when the resident was taken off of his psych medications, per family request, and it had a big impact on Resident #1's increased behaviors. The Physician said the facility kept in communication with her regarding his behaviors and the family later agreed for the resident to begin taking Zoloft and lorazepam because he was hitting staff and throwing things. She further stated she had given an order for Resident #1 to begin psych services but upon reading the psych notes, the resident remained agitated and combative. The Physician said there was nothing else the facility could do other than discharge him from the facility. Record review of the facility's policy titled Abuse: Prevention of and Prohibition Against, revised 10/2022, revealed the following: Policy: It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation . Definitions: Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances on abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish . Prevention: .2. The Facility will act to protect and prevent abuse and neglect from occurring within the Facility by: -Identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: -Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating; -Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; -Wandering into other's rooms/space . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protection: 1. If an allegation of abuse, neglect, misappropriat [TRUNCATED]