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	02/22/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of five residents reviewed for pain management. 1. MA A failed to apply a pain patch on Resident #1 as ordered, which resulted in the resident having pain at a level 8 out of 10. 2. MA A failed to report Resident #1's request for a PRN muscle relaxant to the nurse, which resulted in the resident having pain at a level 8 out of 10. These failures resulted in the resident experiencing preventable pain symptoms. Findings included: Review of Resident #1's EHR revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with emphysema, back pain, and difficulty swallowing. Resident #1 was hospitalized for her emphysema on 01/31/23 and incidental x-rays found fractures in her spine. The resident was diagnosed with compression fractures of the spine in her lower back. Review of Resident #1's admission MDS, dated [DATE], revealed her BIMS score had not been completed. Her Functional Status revealed she required limited assistance with most of her ADLs except her bed mobility and transfers for which she required extensive assistance. Review of Resident #1's care plan, dated 01/18/23, revealed she was at risk for self-care deficit related to back pain and for chronic pain related to back pain. Review of Resident #1's physician orders revealed the following orders written on 02/09/23: Cyclobenzaprine HCl Oral Tablet 5 MG (Cyclobenzaprine HCl) Give 1 tablet by mouth every 8 hours as needed for Muscle spasm. Lidoderm Patch 5 % (Lidocaine) Apply to per additional directions topically in the morning for Pain on right shoulder and remove per schedule. (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

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 02/22/2023
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Actual harm Residents Affected - Few	Interview and observation on 02/22/23 at 11:50 AM, Resident #1 stated she had back pain for quite some time. She did not recall having any falls that would have caused her to have fractures in her back. Resident #1 stated she suffered from back pain and muscle spasms in her back that made it hard for her to sit up, get out of bed, and participate in her therapy. Resident #1 stated she had pain medication prescribed routinely that helped with the pain, and her muscle relaxant was prescribed every eight hours as needed. Resident #1 stated she really needed her muscle relaxant first thing in the morning to make the rest of the day bearable. Resident #1 stated she woke around 6:30 AM and had asked her medication aide (MA A) for a muscle relaxant when she was given her pain pill around 9:00 AM today and was told by the medication aide that she could not have a pain pill and a muscle relaxant at the same time. Resident #1 stated the medication aide only gave her the pain pill and moved on. She also wanted her pain patch applied; it was scheduled, but the medication aide had not applied it. Resident #1 stated her pain was an 8 out of 10 before receiving hydrocodone. Resident #1 stated she had had her pain pill and muscle relaxant at the same time in the past, and those were good days for her. Resident #1 stated she was not able to go to therapy because she was not able to get out of bed. At the time of the interview, Resident #1 was lying on her side and complaining of back spasms and requested the surveyor to ask her nurse for a muscle relaxant. The surveyor notified RN B of the resident's request for a muscle relaxant. Interview and observation on 02/22/23 at 12:05 PM, RN B stated she had not been made aware Resident #1 wanted a muscle relaxant. RN B proceeded to Resident #1's room to ask if she wanted a muscle relaxant, Resident #1 stated she did. RN B assessed Resident #1 for the presence of her lidocaine patch, the lidocaine patch was not observed. Resident #1's pain was 8 out of 10. RN B stated she would ask the medication aide about the patch. Interview on 02/22/23 at 12:30 PM, MA A stated when Resident #1 had asked for a muscle relaxant she thought the resident could not have the muscle relaxant and a pain pill at the same time. MA A stated she had not informed RN B about the muscle relaxant request because of that. MA A stated she had documented the lidocaine patch as being given, but she had been called away before she could apply it and forgot to come back. MA A stated she had not followed up with Resident #1 about her pain level after the resident received hydrocodone. Review of Resident #1's February 2023 MAR revealed the Lidocaine patch had been documented as being given at 8:00 AM on 02/22/23. The last documented time the muscle relaxant was administered was on 02/20/23, although it was a PRN order and could be administered as needed for muscle spasms. Interview on 02/22/23 at 12:32 PM, RN B stated she had not rounded on Resident #1 that morning to see if she had received her medications and if she had any needs. RN B stated if she had made rounds she would have known Resident #1 had been having pain and needed additional medications. RN B would not state if she normally conducted rounds on her residents. RN B stated medications prescribed as needed were administered by the nursing staff, and medication aides only administered routine medications. RN B stated as needed medications required a nurse's assessment to determine if the medication requested was appropriate for the resident's complaint. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/22/23 at 12:55 PM, the DON stated all medications given were required to be documented in the resident's MAR at the time they were administered. The DON stated having an inaccurate MAR could lead to a resident being over medicated, missing a medication, and not receiving the therapeutic effects of a medication. The DON stated medication aides were expected to report a request for an as needed medication to the nurse so that the nurse could assess the resident for the appropriateness of the medication or find alternatives to medication. The DON stated MA A should have reported the request for a muscle relaxant by Resident #1 to RN B. She also stated MA A should not have documented she applied the lidocaine patch until she had actually placed it. Review of the facility's policy Administration of Medications, dated July 2017, reflected: .1. Only licensed medical and nursing personnel or any lawfully authorized staff member may prepare, administer, and record medication administration. 2. Medication must be administered in accordance with the resident's service plan. 3. Medications must be administered in accordance with the written orders of the attending physician. 8. The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the resident's next medication.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure that residents were free of any significant medication errors for one (Resident #1) of five residents reviewed for medications. 1. MA A failed to apply a pain patch on Resident #1 as ordered, which resulted in the resident having pain at a level 8 out of 10. 2. MA A failed to report Resident #1's request for a PRN muscle relaxant to the nurse, which resulted in the resident having pain at a level 8 out of 10. These failures resulted in the resident experiencing preventable pain symptoms. Findings included: Review of Resident #1's EHR revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with emphysema, back pain, and difficulty swallowing. Resident #1 was hospitalized for her emphysema on 01/31/23 and incidental x-rays found fractures in her spine. The resident was diagnosed with compression fractures of the spine in her lower back. Review of Resident #1's admission MDS, dated [DATE], revealed her BIMS score had not been completed. Her Functional Status revealed she required limited assistance with most of her ADLs except her bed mobility and transfers for which she required extensive assistance. Review of Resident #1's care plan, dated 01/18/23, revealed she was at risk for self-care deficit related to back pain and for chronic pain related to back pain. Review of Resident #1's physician orders revealed the following orders written on 02/09/23: Cyclobenzaprine HCl Oral Tablet 5 MG (Cyclobenzaprine HCl) Give 1 tablet by mouth every 8 hours as needed for Muscle spasm. Lidoderm Patch 5 % (Lidocaine) Apply to per additional directions topically in the morning for Pain on right shoulder and remove per schedule. (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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Interview and observation on 02/22/23 at 11:50 AM, Resident #1 stated she had back pain for quite some time. She did not recall having any falls that would have caused her to have fractures in her back. Resident #1 stated she suffered from back pain and muscle spasms in her back that made it hard for her to sit up, get out of bed, and participate in her therapy. Resident #1 stated she had pain medication prescribed routinely that helped with the pain, and her muscle relaxant was prescribed every eight hours as needed. Resident #1 stated she really needed her muscle relaxant first thing in the morning to make the rest of the day bearable. Resident #1 stated she woke around 6:30 AM and had asked her medication aide (MA A) for a muscle relaxant when she was given her pain pill around 9:00 AM today and was told by the medication aide that she could not have a pain pill and a muscle relaxant at the same time. Resident #1 stated the medication aide only gave her the pain pill and moved on. She also wanted her pain patch applied; it was scheduled, but the medication aide had not applied it. Resident #1 stated her pain was an 8 out of 10 before receiving hydrocodone. Resident #1 stated she had had her pain pill and muscle relaxant at the same time in the past, and those were good days for her. Resident #1 stated she was not able to go to therapy because she was not able to get out of bed. At the time of the interview, Resident #1 was lying on her side and complaining of back spasms and requested the surveyor to ask her nurse for a muscle relaxant. The surveyor notified RN B of the resident's request for a muscle relaxant. Interview and observation on 02/22/23 at 12:05 PM, RN B stated she had not been made aware Resident #1 wanted a muscle relaxant. RN B proceeded to Resident #1's room to ask if she wanted a muscle relaxant, Resident #1 stated she did. RN B assessed Resident #1 for the presence of her lidocaine patch, the lidocaine patch was not observed. Resident #1's pain was 8 out of 10. RN B stated she would ask the medication aide about the patch. Interview on 02/22/23 at 12:30 PM, MA A stated when Resident #1 had asked for a muscle relaxant she thought the resident could not have the muscle relaxant and a pain pill at the same time. MA A stated she had not informed RN B about the muscle relaxant request because of that. MA A stated she had documented the lidocaine patch as being given, but she had been called away before she could apply it and forgot to come back. MA A stated she had not followed up with Resident #1 about her pain level after the resident received hydrocodone. Review of Resident #1's February 2023 MAR revealed the Lidocaine patch had been documented as being given at 8:00 AM on 02/22/23. The last documented time the muscle relaxant was administered was on 02/20/23, although it was a PRN order and could be administered as needed for muscle spasms. Interview on 02/22/23 at 12:32 PM, RN B stated she had not rounded on Resident #1 that morning to see if she had received her medications and if she had any needs. RN B stated if she had made rounds she would have known Resident #1 had been having pain and needed additional medications. RN B would not state if she normally conducted rounds on her residents. RN B stated medications prescribed as needed were administered by the nursing staff, and medication aides only administered routine medications. RN B stated as needed medications required a nurse's assessment to determine if the medication requested was appropriate for the resident's complaint. (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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/22/23 at 12:55 PM, the DON stated all medications given were required to be documented in the resident's MAR at the time they were administered. The DON stated having an inaccurate MAR could lead to a resident being over medicated, missing a medication, and not receiving the therapeutic effects of a medication. The DON stated medication aides were expected to report a request for an as needed medication to the nurse so that the nurse could assess the resident for the appropriateness of the medication or find alternatives to medication. The DON stated MA A should have reported the request for a muscle relaxant by Resident #1 to RN B. She also stated MA A should not have documented she applied the lidocaine patch until she had actually placed it. Review of the facility's policy Administration of Medications, dated July 2017, reflected: .1. Only licensed medical and nursing personnel or any lawfully authorized staff member may prepare, administer, and record medication administration. 2. Medication must be administered in accordance with the resident's service plan. 3. Medications must be administered in accordance with the written orders of the attending physician. 8. The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the resident's next medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interviews and record reviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices on each resident that were complete and accurately documented for one (Resident #1) of five residents reviewed for medical records. The facility failed to maintain medication administration records that were complete and accurately documented for Resident #1. This failure placed residents at risk of not receiving therapeutic medications as needed. Findings included: Review of Resident #1's EHR revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with emphysema, back pain, and difficulty swallowing. Resident #1 was hospitalized for her emphysema on 01/31/23 and incidental x-rays found fractures in her spine. The resident was diagnosed with compression fractures of the spine in her lower back. Review of Resident #1's admission MDS, dated [DATE], revealed her BIMS score had not been completed. Her Functional Status revealed she required limited assistance with most of ADLs except her bed mobility and transfers where she required extensive assistance. Review of Resident #1's care plan, dated 01/18/23, revealed she was at risk for self-care deficit related to back pain, and for chronic pain related to back pain. Review of Resident #1's physician orders revealed the following orders written on 02/09/23: Cyclobenzaprine HCl Oral Tablet 5 MG (Cyclobenzaprine HCl) Give 1 tablet by mouth every 8 hours as needed for Muscle spasm. Lidoderm Patch 5 % (Lidocaine) Apply to per additional directions topically in the morning for Pain on right shoulder and remove per schedule Review of Resident #1's pill packs on 02/22/23 at 12:48 PM revealed Cyclobenzaprine HCl had been delivered by the pharmacy, and the pharmacy had dispensed 30 pills on 02/10/23 in a pill pack format. Seven pills had been removed from the pill pack to date. Review of Resident #1's MAR for February 2023 revealed the resident had only three Cyclobenzaprine HCl pills documented as given: one pill on 02/19/23 and two pills on 02/20/23. On 02/22/23, the MAR reflected Resident #1's lidocaine patch had been administered. Interview on 02/22/23 at 11:50 AM, Resident #1 stated she had back pain and had not received her lidocaine patch as prescribed. Resident #1 stated she usually requested it daily as it made it easier to participate in therapy and activities. (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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/22/23 at 12:30 PM, MA A stated she had signed off the lidocaine patch as administered for Resident #1, but she had been called away before she could apply the patch. She stated she had forgotten to go back and apply it. Interview on 02/22/23 at 12:55 PM, the DON stated she did not know why Resident #1's MAR did not reflect the total number of Cyclobenzaprine HCl pills removed from the pill pack. The DON stated it could be sloppy charting, or it could indicate medication diversion. The DON stated MA A should have placed the lidocaine patch on Resident #1 if she had documented it. She stated that was neglectful practice and allowed the resident to experience preventable pain. The DON stated it was imperative for the MAR to be accurate to prevent a resident from missing medications, being over medicated, and to ensure they received the therapeutic effects of the medications prescribed. Review of the facility's policy Administration of Medications, dated July 2017, reflected: .2. Medication must be administered in accordance with the resident's service plan. 3. Medications must be administered in accordance with the written orders of the attending physician. 8. The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the resident's next medication.