

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 01/11/2024
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #1) of three residents reviewed for care plans.</p> <p>The facility failed to ensure two staff performed incontinence care per the care plan for Resident #1.</p> <p>This failure could place residents at risk for not receiving care consistent with their care plan.</p> <p>Findings included:</p> <p>Review of Resident #1's MDS quarterly assessment dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. She was always incontinent of bladder and bowel. She required the extensive of two staff for incontinence care and bed mobility. Her cognitive status was unable to be determined. Her diagnoses included stroke.</p> <p>Review of Resident #1's Care Plan dated 07/17/20, reflected the resident had an ADL self-care performance deficit related to history of stroke. An intervention was for two staff to assist for bed mobility and toileting.</p> <p>An observation on 01/11/24 at 12:45 PM revealed CNA A was preparing to do incontinence care for Resident #1. Resident #1 was lying in bed and was awake and alert. She had some difficulty with communicating. CNA A provided incontinence care by herself for the resident.</p> <p>An interview on 01/11/24 at 3:15 PM with CNA A revealed Resident #1 was a 2 person assist for incontinence care. She said she had another staff at the door waiting, but then the staff member left. CNA A said she felt comfortable providing incontinence care by herself for Resident #1.</p> <p>An interview on 1/11/24 at 3:00 PM with the DON revealed two staff were not used to provide incontinence care for Resident #1 because the care plan was a guide. The care plan indicated two staff were needed, but the DON said that could change depending on the level of participation during the care of the resident. The DON said some residents might require two staff in the morning and only one staff in the evening.</p> <p>(continued on next page)</p>

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 01/11/2024
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Westpark Way Eules, 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy Comprehensive Resident Centered Care Plan revised January 2022, reflected:</p> <p>Procedure:</p> <p>1.the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care.</p>

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 01/11/2024
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Westpark Way Eules, 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</p> <p>Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for one (Resident #1) of two residents observed for incontinence care.</p> <p>CNA A failed to perform hand hygiene and clean Resident #1's mattress during incontinence care.</p> <p>This failure could place residents at risk for infection during incontinence care.</p> <p>Findings included:</p> <p>Review of Resident #1's MDS quarterly assessment dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. She was always incontinent of bladder and bowel. She required the extensive of two staff for incontinence care and bed mobility. Her cognitive status unable to be determined. Her diagnoses included stroke.</p> <p>Review of Resident #1's Care Plans reflected the following:</p> <p>-04/17/23 History of frequent urinary tract infections related to immobility and incontinence.</p> <p>-07/17/20 ADL self-care performance deficit related to history of stroke. An intervention was for two staff to assist for bed mobility and toileting.</p> <p>An observation on 01/11/24 at 12:45 PM revealed CNA A was preparing to do incontinence care for Resident #1. Resident #1 was lying in bed and was awake and alert. She had some difficulty with communicating. The resident was soiled with urine that had gone through the bed sheets and down to the mattress. CNA A folded down the brief while the resident was lying on her back and cleaned the urine in the peri-area. CNA A turned the resident to her right side and cleaned the urine from the resident's buttocks. CNA A changed her gloves but did not perform hand hygiene. CNA grabbed a clean sheet, mattress pad, and brief and placed them underneath the resident. The CNA did not clean the urine on the mattress. The CNA put the clean brief on the resident.</p> <p>An interview on 01/11/24 at 12:50 PM with CNA A revealed she did not perform hand hygiene because she did not have hand sanitizer with her. She said she did not clean the mattress because it would have been hard for her to do and she would have needed another staff member to help her. CNA A said she had been trained to perform hand hygiene and to clean the mattress. CNA A said hand hygiene and cleaning the mattress were important to prevent infection.</p> <p>An interview on 1/11/24 at 3:00 PM with the DON revealed staff were supposed to perform hand hygiene between glove changes and clean the mattress if it had urine on it. The DON said it was important to prevent infection.</p> <p>Review of the facility's policy Incontinence Care dated March 2017, reflected,</p> <p>(continued on next page)</p>

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 01/11/2024
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Westpark Way Eules, 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>POLICY:</p> <p>It is the policy of this facility to provide incontinence care for those residents requiring assistance with bladder and/or bowel incontinence .</p> <p>6. Remove gloves and wash hands .</p>