

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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43815</p> <p>Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 11 residents (Resident #1) reviewed for abuse and/or neglect.</p> <p>The facility failed to protect Resident #1, who was not verbal, from sexual abuse when a confidential interviewee provided video footage of the resident trying to cover her breasts and vaginal area with her hands while CNA A was undressing her and when CNA A had her hands between Resident #1's legs and moved her hand in a fast motion inside the vaginal area for eight (8) minutes and two seconds (.02) after changing her.</p> <p>An IJ was identified on 08/07/24. The IJ template was provided to the facility on [DATE] at 1:30 p.m. While the IJ was removed on 08/09/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on abuse and neglect.</p> <p>This failure could place residents at risk of abuse, neglect, humiliation, and psychosocial harm.</p> <p>Findings include:</p> <p>Record review of Resident #1's admission record, dated 07/25/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included, Dysphagia (difficulty swallowing), Cognitive Communication Deficit (trouble reasoning and making decisions while communicating), Dementia (a group of thinking and social symptoms that interferes with daily functioning), Psychotic Disorder with Delusions (an unshakeable belief in something untrue), Paranoid Schizophrenia (a person feels distrustful and suspicious of other people and acts accordingly), Major Depressive Disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and Muscle Weakness (decreased strength in the muscles).</p> <p>Record review of Resident #1's Modified Admission MDS assessment, dated 02/12/24, this was the most recent comprehensive assessment on file, reflected Resident #1 had no speech. She usually understood and comprehended most conversations. Resident #1 had severe cognitive impairment, the BIMS score was not indicated, Resident #1 was unable to participate. Resident #1 was dependent on staff for all activities of daily living and was incontinent of bowel and bladder.</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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan, dated 01/31/24, reflected Resident #1 was incontinent of bowel and bladder. Staff were to provide incontinent care after each episode. The care plan reflected Resident #1 was totally dependent on staff for all her activities of daily living.</p> <p>Observation on 07/25/24 at 10:38 a.m. the State Surveyor received and reviewed the video provided by a confidential interviewee of the alleged incident involving CNA-A and Resident #1. The video revealed the following:</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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Video dated 7/21/24 at (19:30:00) 7:30 PM, CNA-A entered the room with Resident #1, within camera view CNA-A began to remove the clothes off Resident #1, at (19:30:50) 7:30:50 PM the resident's blouse was completely removed, and CNA-A took the resident to her bed by grabbing her by the right arm. CNA-A used her right hand to turn back the cover on the bed. The resident was observed in the video using her left arm to cover her breast while CNA-A was walking her toward the bed. CNA-A stood the resident by the bed and pulled down the resident's pants before laying the resident on the bed, then reached to grab her feet from the floor and placed her feet in the bed. At (19:31:58) 7:30:58 PM CNA-A put the resident in bed and removed her pants leaving on the adult brief, during this time the resident was watching CNA-A while covering her breast with both of her arms. At (19:32:04) 7:32:04 PM CNA-A unfastened the adult brief of Resident #1 and walked away from the bed out of camera view, while the resident was lying on the bed covering her breast with both of her arms and the open adult brief was open exposing her vaginal area. CNA-A returned to the bedside of the resident at (19:32:38) 7:32:38 PM. When CNA-A returned to the bedside of the resident she returned with adult briefs and wipes. CNA-A was observed using the wipes to clean the resident. While CNA-A was cleaning the resident, Resident#1 was observed holding both of her arms in a bent position covering her breast while shaking her hands in a clasped position in front of her. CNA-A then turned the resident toward the wall and removed the soiled adult brief and bed pad. CNA-A stepped away from the bed again to dispose of the soiled items, as she left the resident lying on the bed completely naked. CNA-A returned to the bedside of the resident, and she placed two clean adult briefs under the resident by turning the resident from side to side. Once the open briefs were under Resident #1, CNA-A moved to the head of the bed and repositioned the pillow under the head of the resident before returning to the middle of the bed and grabbed the gown and shook the gown before she placed the gown over the head of the resident and put her arms inside the gown. At (19:35:19) 7:35:19 PM, while the resident's vaginal area was still uncovered CNA-A used her hands to open the bent legs of the resident and placed her hands in the vaginal area. The resident was observed raising up her right forearm and tapping the left arm of CNA-A while grimacing her face. The resident was observed stretching out her right leg and reaching her right hand toward CNA-A while looking at her. CNA-A was observed looking toward the resident while she had her hands in the open vaginal area of the resident. At (19:35:54) 7:35:54 PM Resident #1 was observed placing her shaking left hand in front of her face, while CNA-A was looking toward her. Resident #1 was observed raising her head slightly off the pillow and patting her left foot on the bed. At (19:36:17) 7:36:17 PM CNA-A continued to have her hands in the vaginal area of the resident when the resident raised her right arm and was moving it toward CNA-A, as CNA-A looked toward the resident. At (19:36:22) 7:36:22 PM CNA-A continued to have her hands in the vaginal area of Resident #1 as CNA-A's right arm was observed to be moving in a fast motion until the resident looked toward something behind CNA-A at (19:36:29) 7:36:29 PM. CNA-A then looked behind her, then she continued to keep her hands in the open vaginal area of the resident until the resident looked behind CNA-A again at (19:36:35) 7:36:35 PM. At (19:36:35) 7:36:35 PM CNA-A stood up as if she was talking to Resident #1. At (19:36:46) 7:36:46 PM CNA-A opened the legs of Resident #1 with her vaginal area still uncovered and then she walked away from the bed off camera. During this time Resident #1 used her hands to cover her open vaginal area. CNA-A returned to the bedside of Resident #1 at (19:36:52) 7:36:52 PM and she moved the hands of the resident, CNA-A leaned over and placed her right hand between the still bent legs of the resident at (19:37:02) 7:37:02 PM and the resident looked behind CNA-A and CNA-A looked at the resident. At (19:37:13) 7:37:13 PM the resident was observed moving her hand and looking behind CNA-A while CNA-A continued to have her hand moving it in a fast motion. At (19:37:24) 7:37:24 PM Resident#1's legs were stretched on the bed while CNA-A's hands were still moving fast in her vaginal area. This action continued in the open vaginal area of the resident until (19:37:32) 7:37:32 PM when CNA-A bent Resident #1's right leg back up before returning her hands to the open vaginal area. At (19:37:55) 7:37:55 PM, CNA-A moved her body closer to the head of the bed of the resident exposing her vaginal area more, CNA-A's right hand was observed on the vagina of Resident #1 moving in a fast motion until (19:38:02) 7:38:02 PM when CNA-A reached down and pulled up both adult briefs and fastened them at (19:38:21) 7:38:21 PM. At (19:38:30) 7:38:30 PM, CNA-A pulled down the gown of Resident #1 then repositioned her in bed. At (19:38:43) 7:38:43 PM, CNA-A covered Resident #1 with the bed covers, lowered the resident's bed, and repositioned her pillow at (19:39:26) 7:39:26 PM</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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A confidential interview revealed it was observed on 07/21/24 in the evening time, the confidential interviewee stated they were not sure of the specific time of the original viewing of the video. The confidential interviewee stated it was observed via video CNA-A was in the bedroom of Resident #1 putting Resident #1 in bed when they touched her inappropriately. The confidential interviewee stated Resident #1 was not verbal. The confidential interviewee stated there was audio on the camera, the interviewee stated when CNA-A entered the room with the resident CNA-A said, Let me lay you down. The confidential interviewee stated there was not much communication after that statement. The confidential interviewee stated after Resident #1's clothes were taken off, and the resident was put on the bed and the incident happened. The confidential interviewee stated the abuse was reported to the Administrator in Training, and law enforcement. The confidential interviewee stated Resident #1 was taken to the hospital for an exam on 07/22/24. The confidential interviewee stated the hospital stated it would take several weeks to receive the results of the exam. The confidential interviewee stated Resident #1 was anxious when her adult brief was changed, and she would grab the hand of the person who was changing her. The confidential interviewee stated it was hard to determine if the incident had caused the resident harm at this time. The confidential interviewee stated the family requested Resident #1 not be visited because she was non-verbal and could not contribute to the investigation. The confidential interviewee they had contacted the police and Resident #1 was removed from the facility on 07/22/24 at 3:50 p.m. The confidential interviewee stated Resident #1 would not be returning to that facility. The confidential interviewee stated the video would be sent via text.</p> <p>In an interview with the Administrator in Training, acting abuse coordinator on 07/25/24 at 9:40 a.m. revealed he was notified of the abuse allegation on 07/22/24 late in the afternoon by the POA of Resident #1 . He stated the POA notified LE prior to coming to the facility. He stated he was told Resident #1 had been abused, he was not given specifics and was told there was a video, but he had not seen the video. He stated while LE and the POA was at the facility they removed Resident #1 from the facility when they left. He stated CNA A last worked 07/21/24 and was suspended on 07/22/24. He stated the facility's investigation was still ongoing at that time. He stated the facility was conducting safe surveys of all the residents and angel rounds (department heads are making rounds on assigned residents) and skin assessments on the two non-verbal residents. He stated the facility conducted an in-service with all staff on 07/22/24. He stated there was not any previous warnings or incidents regarding CNA-A at the facility. He stated CNA-A received the employee of the month for the month of June. He stated several families complimented her work. He stated at that time the facility was not able to verify if the incident had happened because the investigation was still ongoing. He stated the nursing staff was responsible to ensure the CNA's took proper care of the residents, the DON, and then the Administrator.</p> <p>In an interview on 07/24/24 at 12:08 p.m. with Detective from the local PD revealed he went to the facility on [DATE] and he was not provided the information for CNA-A until he returned on 07/23/24. He stated after the facility provided him with the location information of CNA-A an arrest warrant was issued. He stated due to the nature of his investigation he did not want CNA-A to be interviewed by the State Surveyor prior to her arrest.</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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/25/24 at 12:20 p.m., LVN B said the abuse coordinator should be notified immediately after an allegation of abuse was made. She said she could tell the abuse coordinator, the administrator or administrator in training in person or call them. She said she could also tell the DON of an allegation of abuse. She said she was trained on abuse and neglect several times. She said the abuse policy was a topic that was trained frequently. She said when abuse allegedly occurred she would also need to ensure the resident and other residents were kept safe from the person who allegedly did the abuse.</p> <p>During an interview on 07/25/24 at 1:17 p.m., CNA C said if a resident alleged that they were abused then she would need to ensure the resident was safe, report to the abuse coordinator, the administrator and the DON, keep the resident safe, and prevent the person who allegedly did the abuse away from other residents. She said she was in-serviced on all these principals' multiple times.</p> <p>During an interview on 07/25/24 at 2:47 p.m., CNA-D said she had been in-serviced on the facility abuse policy several times. She said if an allegation of abuse was made, they were to immediately report the allegation to the abuse coordinator, the administrator. She said she could also report to the charge nurse and the DON as well as call the abuse coordinator. She said she would also need to ensure the person who did the abuse did not have access to any resident and have them leave the building.</p> <p>In a follow-up interview with the Administrator in training on 07/25/24 at 3:43 p.m., he stated he interviewed CNA-A prior to the State Surveyor's entrance. He stated, CAN-A described and demonstrated the service she provided to Resident #1 as cleaning her and changing her bed and her brief. She stated she did not have any issues with Resident #1. He stated CAN-A did not provide a written statement of the services she provided to Resident #1. The Administrator in training stated the facility had psych services at the facility and they came and talked to the residents whom CNA-A had provided care . He stated psych services noted no concerns for other residents on Hall 500, where Resident #1 resided. He stated CNA-A would be terminated on 07/25/24, now that he knew the allegation was substantiated. He stated the facility became aware of the incident when the POA and police came to the facility on [DATE]. He stated the facility started in-services on abuse with the facility staff on 07/22/24. He stated their abuse and neglect policy required that all residents be protected after an allegation of abuse. He stated they ensured the protection of residents by conducting the safe surveys and angel rounds. He stated the residents were at risk of having their rights violated, risk of no longer being free from abuse, and risk of trauma.</p> <p>Record review of the facility's in-service, dated 03/26/24, reflected CNA A was in-serviced on the facility abuse policy. Abuse policy educated staff on identifying abuse and neglect as well as timeframes associated with reporting abuse and neglect to the State Agency.</p> <p>Record review of the facility in-service, dated 07/22/24, reflected all staff signed they were in-serviced on facility abuse policy.</p> <p>Record review of residents residing on Hall 500 evaluated by Psych services dated 07/23/24 reflected no change made to medication, the psych evaluation was secondary to an incident that occurred with another resident, the incident included inappropriate touching, the residents were emotionally stable and the recent incident did not affect the resident.</p> <p>Record review of CNA A's Date of Hire-01/10/2023</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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Background check completed reflected:</p> <p>01/04/2023-Federal Criminal National-clear, Healthcare Sanctions-clear, Sex Offender-clear</p> <p>01/04/23-Criminal History Conviction Name Search with Department of Public Safety-No search results found</p> <p>01/03/23-Texas Health and Human Services Not listed on the EMR, NAR: Active</p> <p>07/15/23-Employability Status Check Search Results-Not listed on EMR-NAR status: Active; Certification expiration date: 07/03/2025</p> <p>07/22/2024-Criminal History Conviction Name Search Results-No search results found</p> <p>07/23/2024-Employability Status Check Search Results-Nurse</p> <p>Record review of CNA A's Counseling/Disciplinary Notice dated 07/22/24 reflected suspension, pending investigation, subject to discharge, reason why counseling/disciplinary action necessary was due to abuse allegation, notified via phone on 07/22/24.</p> <p>Record review of facility Termination Form dated 7/25/24 to CNA A reflected her last day of work was 07/21/24 and she was involuntary terminated for gross misconduct on 7/25/24.</p> <p>Record review of facility Abuse: Prevention of and Prohibition Against dated 11.2017 revised 12.2023 reflected, The facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use technology that would infringe on the resident's right to personal privacy. Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>An IJ was identified on 08/07/24. The IJ template was provided to the Administrator on 08/07/24 at 1:30 p.m. and a Plan of Removal was requested. The POR was accepted on 08/08/24 at 4:23 p.m.</p> <p>The POR revealed the following:</p> <p>Abuse: Per the information provided in the IJ Template given on 8/7/2024, the facility has started but has not completed in-services with all staff as of 07/25/24.</p> <p>The facility received verbal information alleging that a staff member had touched a resident inappropriately. This allegation was given to the facility by the police and by an HHSC surveyor.</p> <ol style="list-style-type: none"> <li>The Medical Director was notified of the IJ on 08/07/2024 at 2:10 pm.</li> <li>Train the trainer in-servicing was given to the ED, DON, ADON, MDS Nurse and RN/ED Partners by the Clinical Resource. The training included regarding abuse to include resident rights to be free of sexual abuse. Started in-service training on 7/22/2024 on Abuse: Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This was completed on 8/7 /24.</li> </ol> <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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Training and knowledge checks were completed with all staff regarding abuse to include resident rights to be free of sexual abuse. Skills check offs and skin assessments started on pericare [sic] 7/22/2024. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This was completed on 8/7/24. This training was given by the ED, DON, ADON, MDS Nurse Clinical Resource and RN/ED Partners, was initiated on 8/7/24 will be completed on 8/8/24 with all staff prior to the start of their next shift. Staff will not be allowed to work unless they have completed the training and knowledge checks. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. ED, DON and/or Designee will be responsible that all staff are trained before working.</p> <p>4. An ad hoc (a non-scheduled QA meeting) meeting regarding items in the IJ templates will be completed on 8/7/24. Attendees will include the DON, Medical Director, ADON, Clinical Resource, Executive Director and will include the plan of removal items and interventions.</p> <p>5. The ED or designee will verify staff knowledge on abuse prevention with 10 staff weekly using the abuse and neglect knowledge checks. This will be completed weekly after the initial training and knowledge checks completed on 8/8/24.</p> <p>6. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks beginning 8/8/24 or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance.</p> <p>Monitoring of the facility plan of removal was as follows:</p> <p>In an interview on 08/09/24 at 9:30 a.m. with the Administrator in Training revealed he had been trained on 08/07/24 on how to in-service the staff on Abuse: Prevention of and Prohibition Against a resident by staff and they should report abuse/neglect to the administrator or person in charge of the facility at the time the abuse was observed or suspected.</p> <p>In an interview on 08/09/24 at 9:35 a.m. with the Resource Nurse, revealed she had been trained on 08/07/24 on how to in-service the staff on Abuse: Prevention of and Prohibition Against a resident by staff and they should report abuse/neglect to the administrator or person in charge of the facility at the time the abuse was observed or suspected.</p> <p>In an interview on 08/09/24 at 10:50 a.m. Resident #2 revealed she did feel safe in the facility, she stated a few weeks ago a facility staff came by to ask if there had been any issues with any CNA's and she told her there had not been any issues. She stated she knew she could notify the social worker or the administrator if she did not feel safe or was abused.</p> <p>In an interview on 08/09/24 at 11:23 a.m. with RN E revealed she had been in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident, the administrator was the abuse coordinator and should be notified if abuse was suspected.</p> <p>In an interview on 08/09/24 at 11:36 a.m. with Resident #3 revealed stated she did feel safe in the facility, she stated she had been asked by facility staff if she felt safe and if she had any issues with a CNA. She stated she had not had any issues. She stated if she did not feel safe or if she was abused she would tell her son or the administrator.</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  08/09/2024
NAME OF PROVIDER OR SUPPLIER  Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE  900 Westpark Way Euleless, 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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/09/24 at 11:41 a.m. with CNA F revealed he had been in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident, and the administrator was the abuse coordinator and should be notified if abuse was suspected.</p> <p>In an interview on 08/09/24 at 11:45 a.m. with MA G revealed she had been in-serviced that abuse was a willful act, it was never appropriate to have sexual contact with a resident, if she suspected abuse she would notify the abuse coordinator, the administrator, or the DON.</p> <p>In an interview on 08/09/24 at 12:07 p.m. with the Housekeeping Supervisor revealed she had been in-serviced on how to in-service the staff on Abuse: Prevention of and Prohibition Against a resident by staff and they should report abuse/neglect to the administrator or person in charge of the facility at the time the abuse was observed or suspected. She stated she would in-service the staff that abuse was a willful act, it was not appropriate for a staff to have sexual contact with a resident. She stated abuse and neglect should be reported to the administrator, as the abuse and neglect coordinator.</p> <p>In an interview on 08/09/24 at 12:16 p.m. with CNA H revealed she was in-serviced that abuse was a willful act, it was not appropriate for an employee to have sexual contact with a resident. She stated if she suspected or saw abuse she should report to the administrator the abuse coordinator.</p> <p>In an interview on 08/09/24 at 12:22 p.m. with CNA I revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 12:28 p.m. with RN J revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 12:34 p.m. with visiting DON revealed she had been in-serviced on how to in-service the staff on Abuse: Prevention of and Prohibition Against a resident by staff and they should report abuse/neglect to the administrator or person in charge of the facility at the time the abuse was observed or suspected. She stated she would in-service the staff that abuse was a willful act, it was not appropriate for a staff to have sexual contact with a resident. She stated abuse and neglect should be reported to the administrator, as the abuse and neglect coordinator.</p> <p>In an interview on 08/09/24 at 12:51 p.m. with CNA K revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 12:57 p.m. with CNA L revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 1:02 p.m. with RN M revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/09/24 at 1:05 p.m. with the Director of Rehabilitation revealed he had been in-serviced on how to in-service the staff on Abuse: Prevention of and Prohibition Against a resident by staff and they should report abuse/neglect to the administrator or person in charge of the facility at the time the abuse was observed or suspected. He stated he would in-service the staff that abuse was a willful act, it was not appropriate for a staff to have sexual contact with a resident. He stated abuse and neglect should be reported to the administrator, as the abuse and neglect coordinator.</p> <p>In an interview on 08/09/24 at 1:02 p.m. with RN M revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 1:15 p.m. with Therapist N revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 1:23 p.m. with CNA O revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 1:27 p.m. with CNA P revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 1:31 p.m. with CNA Q revealed she was in-serviced that abuse was a willful act, it was never appropriate for an employee to have sexual contact with a resident. Abuse and neglect should be reported to the abuse coordinator, the administrator.</p> <p>In an interview on 08/09/24 at 1:35 p.m. with Resident #4 revealed she stated she had not been touched inappropriately by anyone, she stated she received her medication on time. She stated facility staff asked her a few weeks ago if she was safe. She stated she felt safe living at the facility, she stated if she was abused she could tell her family or the administrator.</p> <p>In an interview on 08/09/24 at 1:42 p.m. with Resident #5 revealed she stated she did feel safe at the facility, she stated if she did not feel safe she could tell her family or the social worker.</p> <p>In an interview on 08/09/24 at 1:50 p.m. with Resident #6 revealed she felt safe in the facility, she stated she had not been touched inappropriately. She stated if she was abused she could notify the nurse or the administrator.</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  08/09/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/09/24 at 2:30 p.m. with the Administrator revealed she had been trained on 08/07/24 on Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. She stated the QA team met and discussed they would ensure new staff were in-serviced and current staff would conduct random knowledge test of staff and it would be documented on form. She stated safety assessments had been completed on the residents. She stated Resident #1 had not returned to the facility since she was removed by the POA on 07/22/24. She stated CNA A was suspended 07/22/24 by phone and she was terminated on 07/25/24.</p> <p>Review of Facility train the trainer in-service dated 8/7/24 revealed the management staff had been in serviced on how to train the staff on Abuse: Prevention of and Prohibition Against by staff policy dated 10. 2022</p> <p>Review of Facility abuse and neglect in-service dated 8/7/24 revealed all facility staff had been in serviced on Abuse: Prevention of and Prohibition Against by staff policy dated 10.2022</p> <p>Record review of Psych services evaluation for Resident's #7, #8, #9, #10, #11, #12, #13, and #14 dated 07/23/14 reflected no change made to medication, the psych evaluation was secondary to an incident that occurred with another resident, the incident included inappropriate touching, the residents were emotionally stable, and the recent incident did not affect the resident.</p> <p>Record review of resident roster provided 08/07/24 reflected Resident #1 was no longer residing at the facility.</p> <p>Record review of Skills checklist-Perineal Care dated 07/22/24 and 07/23/24 reflected CNAs were re-evaluated to ensure they performed proper Perineal Care.</p> <p>Record review of Safe Interviews of facility residents dated 07/22/24 and 07/23/24 reflected residents were assessed for safety.</p> <p>Record review of CNA A's Counseling/Disciplinary Notice dated 07/22/24 reflected suspension, pending investigation, subject to discharge, reason why counseling/disciplinary action necessary was due to abuse allegation, notified via phone on 07/22/24.</p> <p>Record review of facility Termination Form dated 7/25/24 to CNA A reflected her last day of work was 07/21/24 and she was involuntary terminated for gross misconduct on 7/25/24.</p> <p>The administrator was informed the Immediate Jeopardy was removed on 08/09/2024 at 4:23 p.m. the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on abuse and neglect.</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43815</b></p> <p>Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 1 of 11 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to implement policy that prohibited abuse of Resident #1 was sexually abused when a confidential interviewee provided video footage of CNA A undressing Resident #1 as Resident #1 used her crossed arms to cover her breast and CNA A inserted her hands between the legs of Resident #1, moved her hands in a fast motion inside the vaginal area for eight (8) minutes and 2 (.02) seconds after the resident's clothes were taken off.</p> <p>An IJ was identified on 08/07/24. The IJ template was provided to the facility on [DATE] at 1:30 p.m. While the IJ was removed on 08/09/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on abuse and neglect.</p> <p>This failure could place residents at risk for physical harm, psychosocial harm, unsafe environment, and further abuse.</p> <p>Findings included:</p> <p>Record review of facility Abuse: Prevention of and Prohibition Against dated 11.2017 revised 12.2023 reflected, The facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use technology that would infringe on the resident's right to personal privacy. Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>Record review of Resident #1's admission record, dated 07/25/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] Resident #1 had diagnoses which included, Dysphagia (difficulty swallowing), Cognitive Communication Deficit (trouble reasoning and making decisions while communicating), Dementia (a group of thinking and social symptoms that interferes with daily functioning), Psychotic Disorder with Delusions (an unshakeable belief in something untrue), Paranoid Schizophrenia (a person feels distrustful and suspicious of other people and acts accordingly), Major Depressive Disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and Muscle Weakness (decreased strength in the muscles).</p> <p>Record review of Resident #1's Modified Admission MDS assessment, dated 02/12/24, reflected Resident #1 had no speech. She usually understood and comprehended most conversations. Resident #1 had severe cognitive impairment, the BIMS was not indicated, Resident #1 was unable to participate. Resident #1 was dependent on staff for all activities of daily living and was incontinent of bowel and bladder.</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan, dated 01/31/24, reflected Resident #1 was incontinent of bowel and bladder. Staff were to provide incontinent care after each episode. The care plan reflected Resident #1 was totally dependent on staff for all her activities of daily living.</p> <p>Observation on 07/25/24 at 10:38 a.m. the State Surveyor received and reviewed the video provided by a confidential interviewee of the alleged incident involving CNA-A and Resident #1. The video revealed the following:</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Video dated 7/21/24 at (19:30:00) 7:30 PM, CNA-A entered the room with Resident #1, within camera view CNA-A began to remove the clothes off Resident #1, at (19:30:50) 7:30:50 PM the resident's blouse was completely removed, and CNA-A took the resident to her bed by grabbing her by the right arm. CNA-A used her right hand to turn back the cover on the bed. The resident was observed in the video using her left arm to cover her breast while CNA-A was walking her toward the bed. CNA-A stood the resident by the bed and pulled down the resident's pants before laying the resident on the bed, then reached to grab her feet from the floor and placed her feet in the bed. At (19:31:58) 7:30:58 PM CNA-A put the resident in bed and removed her pants leaving on the adult brief, during this time the resident was watching CNA-A while covering her breast with both of her arms. At (19:32:04) 7:32:04 PM CNA-A unfastened the adult brief of Resident #1 and walked away from the bed out of camera view, while the resident was lying on the bed covering her breast with both of her arms and the open adult brief was open exposing her vaginal area. CNA-A returned to the bedside of the resident at (19:32:38) 7:32:38 PM. When CNA-A returned to the bedside of the resident she returned with adult briefs and wipes. CNA-A was observed using the wipes to clean the resident. While CNA-A was cleaning the resident, Resident#1 was observed holding both of her arms in a bent position covering her breast while shaking her hands in a clasped position in front of her. CNA-A then turned the resident toward the wall and removed the soiled adult brief and bed pad. CNA-A stepped away from the bed again to dispose of the soiled items, as she left the resident lying on the bed completely naked. CNA-A returned to the bedside of the resident, and she placed two clean adult briefs under the resident by turning the resident from side to side. Once the open briefs were under Resident #1, CNA-A moved to the head of the bed and repositioned the pillow under the head of the resident before returning to the middle of the bed and grabbed the gown and shook the gown before she placed the gown over the head of the resident and put her arms inside the gown. At (19:35:19) 7:35:19 PM, while the resident's vaginal area was still uncovered CNA-A used her hands to open the bent legs of the resident and placed her hands in the vaginal area. The resident was observed raising up her right forearm and tapping the left arm of CNA-A while grimacing her face. The resident was observed stretching out her right leg and reaching her right hand toward CNA-A while looking at her. CNA-A was observed looking toward the resident while she had her hands in the open vaginal area of the resident. At (19:35:54) 7:35:54 PM Resident #1 was observed placing her shaking left hand in front of her face, while CNA-A was looking toward her. Resident #1 was observed raising her head slightly off the pillow and patting her left foot on the bed. At (19:36:17) 7:36:17 PM CNA-A continued to have her hands in the vaginal area of the resident when the resident raised her right arm and was moving it toward CNA-A, as CNA-A looked toward the resident. At (19:36:22) 7:36:22 PM CNA-A continued to have her hands in the vaginal area of Resident #1 as CNA-A's right arm was observed to be moving in a fast motion until the resident looked toward something behind CNA-A at (19:36:29) 7:36:29 PM. CNA-A then looked behind her, then she continued to keep her hands in the open vaginal area of the resident until the resident looked behind CNA-A again at (19:36:35) 7:36:35 PM. At (19:36:35) 7:36:35 PM CNA-A stood up as if she was talking to Resident #1. At (19:36:46) 7:36:46 PM CNA-A opened the legs of Resident #1 with her vaginal area still uncovered and then she walked away from the bed off camera. During this time Resident #1 used her hands to cover her open vaginal area. CNA-A returned to the bedside of Resident #1 at (19:36:52) 7:36:52 PM and she moved the hands of the resident, CNA-A leaned over and placed her right hand between the still bent legs of the resident at (19:37:02) 7:37:02 PM and the resident looked behind CNA-A and CNA-A looked at the resident. At (19:37:13) 7:37:13 PM the resident was observed moving her hand and looking behind CNA-A while CNA-A continued to have her hand moving it in a fast motion. At (19:37:24) 7:37:24 PM Resident#1's legs were stretched on the bed while CNA-A's hands were still moving fast in her vaginal area. This action continued in the open vaginal area of the resident until (19:37:32) 7:37:32 PM when CNA-A bent Resident #1's right leg back up before returning her hands to the open vaginal area. At (19:37:55) 7:37:55 PM, CNA-A moved her body closer to the head of the bed of the resident exposing her vaginal area more, CNA-A's right hand was observed on the vagina of Resident #1 moving in a fast motion until (19:38:02) 7:38:02 PM when CNA-A reached down and pulled up both adult briefs and fastened them at (19:38:21) 7:38:21 PM. At (19:38:30) 7:38:30 PM, CNA-A pulled down the gown of Resident #1 then repositioned her in bed. At (19:38:43) 7:38:43 PM, CNA-A covered Resident #1 with the bed covers, lowered the resident's bed, and repositioned her pillow at (19:39:26) 7:39:26 PM</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A confidential interview revealed it was observed on 07/21/24 in the evening time, the confidential interviewee stated they were not sure of the specific time of the original viewing of the video. The confidential interviewee stated it was observed via video CNA-A was in the bedroom of Resident #1 putting Resident #1 in bed when they touched her inappropriately. The confidential interviewee stated Resident #1 was not verbal. The confidential interviewee stated there was audio on the camera, the interviewee stated when CNA-A entered the room with the resident CNA-A said, Let me lay you down. The confidential interviewee stated interviewee stated there was not much communication after that statement. The confidential interviewee stated after Resident #1's clothes were taken off, and the resident was put on the bed and the incident happened. The confidential interviewee stated the abuse was reported to the Administrator in Training, and law enforcement. The confidential interviewee stated Resident #1 was taken to the hospital for an exam. The confidential interviewee stated the hospital stated it would take several weeks to receive the results of the exam. The confidential interviewee stated Resident #1 was anxious when her adult brief was changed, and she grabbed the hand of the person who was changing her. The confidential interviewee stated it was hard to determine if the incident had caused the resident harm at this time. The confidential interviewee stated the family requested Resident #1 not be visited because she was non-verbal and could not contribute to the investigation. The confidential interviewee stated the video would be sent via text.</p> <p>In an interview with the Administrator in Training, acting abuse coordinator on 07/25/24 at 9:40 a.m. revealed he was notified of the abuse allegation on 07/22/24 late in the afternoon by the POA of Resident #1 . He stated the POA notified LE prior to coming to the facility. He stated he was told Resident #1 had been abused, he was not given specifics and was told there was a video, but he had not seen the video. He stated while LE and the POA was at the facility they removed Resident #1 from the facility when they left. He stated CNA A last worked 07/21/24 and was suspended on 07/22/24. He stated the facility's investigation was still ongoing at that time. He stated the facility was conducting safe surveys of all the residents and angel rounds (department heads are making rounds on assigned residents) and skin assessments on the two non-verbal residents. He stated the facility conducted an in-service with all staff on 07/22/24. He stated there was not any previous warnings or incidents regarding CNA-A at the facility. He stated CNA-A received the employee of the month for the month of June. He stated several families complimented her work. He stated at that time the facility was not able to verify if the incident had happened because the investigation was still ongoing. He stated the nursing staff was responsible to ensure the CNA's took proper care of the residents, the DON, and then the Administrator.</p> <p>During an interview on 07/25/24 at 12:20 p.m., LVN B said the abuse coordinator should be notified immediately after an allegation of abuse was made. She said she could tell the abuse coordinator, the administrator or administrator in training in person or call them . She said she could also tell the DON of an allegation of abuse. She said she was trained on abuse and neglect several times. She said the abuse policy was a topic that was trained frequently. She said when abuse allegedly occurred she would also need to ensure the resident and other residents were kept safe from the person who allegedly did the abuse.</p> <p>During an interview on 07/25/24 at 1:17 p.m., CNA C said if a resident alleged that they were abused then she would need to ensure the resident was safe, report to the abuse coordinator who was the administrator, and/or the DON . She stated she would keep the resident safe and prevent the person who allegedly did the abuse away from other residents. She said she was in-serviced on all these principals' multiple times.</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/25/24 at 2:47 p.m., CNA-D said she had been in-services on the facility abuse policy several times. She said if an allegation of abuse was made, they were to immediately report the allegation to the abuse coordinator , the administrator. She said she could also report to the charge nurse and the DON as well as call the abuse coordinator. She said she would also need to ensure the person who did the abuse did not have access to any resident and have them leave the building.</p> <p>In a follow-up interview with the Administrator in training on 07/25/24 at 3:43 p.m., he stated he interviewed CNA-A prior to the State Surveyor's entrance. He stated, CAN-A described and demonstrated the service she provided to Resident #1 as cleaning her and changing her bed and her brief. She stated she did not have any issues with Resident #1. He stated CAN-A did not provide a written statement of the services she provided to Resident #1. The Administrator in training stated the facility had psych services at the facility and they came and talked to the residents whom CNA-A had provided care . He stated psych services noted no concerns for other residents on Hall 500, where Resident #1 resided. He stated CNA-A would be terminated on 07/25/24, now that he knew the allegation was substantiated. He stated the facility became aware of the incident when the POA and police came to the facility on [DATE]. He stated the facility started in-services on abuse with the facility staff on 07/22/24. He stated their abuse and neglect policy required that all residents be protected after an allegation of abuse. He stated they ensured the protection of residents by conducting the safe surveys and angel rounds. He stated the residents were at risk of having their rights violated, risk of no longer being free from abuse, and risk of trauma.</p> <p>Record review of the facility's in-service, dated 03/26/24, revealed CNA A was in-serviced on the facility abuse policy. Abuse policy educated staff on identifying abuse and neglect as well as timeframes associated with reporting abuse and neglect to the State Agency.</p> <p>Record review of residents by Psych services dated 07/23/14 reflected no change made to medication, the psych evaluation was secondary to an incident that occurred with another resident, the incident included inappropriate touching, the residents were emotionally stable, and the recent incident did not affect the resident.</p> <p>Record review of the facility in-service, dated 07/22/24, reflected all staff signed they were in-serviced on facility abuse policy.</p> <p>Record review of Psych services evaluation for Resident's #7, #8, #9, #10, #11, #12, #13, and #14 dated 07/23/14 reflected no change made to medication, the psych evaluation was secondary to an incident that occurred with another resident, the incident included inappropriate touching, the residents were emotionally stable, and the recent incident did not affect the resident.</p> <p>Record review of CNA A's Background check completed reflected:</p> <p>01/04/2023-Federal Criminal National-clear, Healthcare Sanctions-clear, Sex Offender-clear</p> <p>01/04/23-Criminal History Conviction Name Search with Department of Public Safety-No search results found</p> <p>01/03/23-Texas Health and Human Services Not listed on the EMR, NAR: Active</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>07/15/23-Employability Status Check Search Results-Not listed on EMR-NAR status: Active; Certification expiration date: 07/03/2025</p> <p>07/22/2024-Criminal History Conviction Name Search Results-No search results found</p> <p>07/23/2024-Employability Status Check Search Results-Nurse</p> <p>Record review of CNA A's Counseling/Disciplinary Notice dated 07/22/24 reflected suspension, pending investigation, subject to discharge, reason why counseling/disciplinary action necessary was due to abuse allegation, notified via phone on 07/22/24.</p> <p>An IJ was identified on 08/07/24. The IJ template was provided to the Administrator on 08/07/24 at 1:30 p.m. and a Plan of Removal was requested. The POR was accepted on 08/08/24 at 4:23 p.m.</p> <p>The POR revealed the following:</p> <p>Develop and Implement Policy: Per the information provided in the IJ Template given on 8/7/2024, the facility has started but has not completed in-services with all staff as of 07/25/24.</p> <p>The facility received verbal information alleging that a staff member had touched a resident inappropriately. This allegation was given to the facility by the police and by an HHSC surveyor. The facility has not been given or reviewed the video where the alleged abuse may have occurred.</p> <ol style="list-style-type: none"> <li>1. The Medical Director was notified of the IJ on 08/07/2024 at 2:10 pm.</li> <li>2. Train the trainer in-servicing was given to the ED, DON, ADON, MOS Nurse and RN/ED Partners by the Clinical Resource. The training included regarding abuse to include resident rights to be free of sexual abuse. Started in-service training on 7/22/2024 on Abuse: Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This was completed on 8/7/24.</li> <li>3. Training and knowledge checks were completed with all staff regarding abuse to include resident rights to be free of sexual abuse. Skills check offs and skin assessments started on peri care 7/22/2024. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This was completed on 8/7/24. This training was given by the ED, DON, ADON, MOS Nurse Clinical Resource and RN/ED Partners, was initiated on 8/7/24 will be completed on 8/8/24 with all staff prior to the start of their next shift. Staff will not be allowed to work unless they have completed the training and knowledge checks. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. ED, DON and/or Designee will be responsible that all staff are trained before working.</li> <li>4. An ad hoc (a non-scheduled QA meeting) meeting regarding items in the IJ templates will be completed on 8/7/24. Attendees will include the DON, Medical Director, ADON, Clinical Resource, Executive Director and will include the plan of removal items and interventions.</li> </ol> <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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5. The ED or designee will verify staff knowledge on abuse prevention with 10 staff weekly using the abuse and neglect knowledge checks. This will be completed weekly after the initial training and knowledge checks completed on 8/8/24.</p> <p>6. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks beginning 8/8/24 or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance.</p> <p>7.</p> <p>Monitoring of the facility plan of removal was as follows:</p> <p>In an interview on 08/09/24 at 9:30 a.m. with the Administrator in Training revealed he had been trained on 08/07/24 on Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. He stated the QA team met and discussed they would ensure new staff were in-serviced and current staff would conduct random knowledge test of staff and it would be documented on form. He stated he was also trained on understanding behavioral symptoms of residents that may increase the risk of abuse was resistance to care, outburst, and difficulty in adjusting to new routines or staff. He stated he had been trained that if abuse or neglect involved an employee he should immediately remove the employee from care of any resident and suspend the employee during the investigation.</p> <p>In an interview on 08/09/24 at 9:35 a.m. with the Resource Nurse, revealed she had been trained on 08/07/24 on Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. She stated the QA team met and discussed they would ensure new staff were in-serviced and current staff would conduct random knowledge test of staff and it would be documented on form. She stated she was trained to recognize the signs of abuse of physical or psychosocial indicators, to inform staff they could report abuse they could do so without fear of reprisal. She stated she was trained to respond immediately to protect the alleged victim of abuse, and the victim should be examined for any injury, by physical examination or psychosocial assessment.</p> <p>In an interview on 08/09/24 at 11:23 a.m. with RN E revealed she was in-serviced on abuse policy that she should ensure all residents were free from neglect and abuse, to identify and assess behaviors that could indicate a resident had been abused was sexually aggressive behavior and saying sexual things. She sated some indicators of abuse would be sudden or unexplained changes in behaviors or activities, fear of a person providing care. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 11:41 a.m. with CNA F revealed his training included identifying and preventing abuse of a resident, how to report abuse and that he could report abuse without fear of retaliation. He sated he was re-in-serviced that they should not take photos of residents. He had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/09/24 at 11:45 a.m. with MA G revealed she stated abuse and neglect policy stated she should intervene in situations of abuse or neglect, she stated signs that a resident had been abused could be the resident acted different around a specific staff, the resident might be withdrawn or act ashamed when staff were providing care. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 12:07 p.m. with the Housekeeping Supervisor revealed she had been trained on 08/07/24 on Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. She stated the QA team met and discussed they would ensure new staff were in-serviced and current staff would conduct random knowledge test of staff and it would be documented on form. She stated abuse prevention policy included verbal aggression, physical aggression, sexual abuse. She stated some signs a resident had been abused would include injuries in an unusual location on the resident, sudden unexplained changes in the resident's behavior such as fear of a person or feeling shame or guilt.</p> <p>In an interview on 08/09/24 at 12:16 p.m. with CNA H revealed she had been given a knowledge assessment regarding abuse and neglect included to report to the administrator. She stated when she received additional in-service on the abuse policy she learned the abused resident should be kept safe from the employee, the resident should receive emotional support and counseling. She stated some signs of abuse would be sudden change in behavior or a resident who would normally participate in activities suddenly did not want to participate.</p> <p>In an interview on 08/09/24 at 12:22 p.m. with CAN I revealed she learned all abuse was not directly observed and possible indicators would be bruises, skin tears, injuries in an unusual location, and unexplained changes in behaviors. She stated she must protect the resident from the perpetrator. she had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 12:28 p.m. with RN J revealed she stated regarding the facility policy on abuse and neglect all personnel, residents, and visitors were encouraged to report incidents and grievances without the fear of retribution, she would supervise the staff to identify and correct any inappropriate or unprofessional behaviors, she stated as a member of the staff she was responsible for ensuring residents were free from abuse, policy indicated that a resident with communication disorders or spoke a different language should be monitored for signs of abuse. She stated she had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 12:34 p.m. with visiting DON revealed she had been trained on 08/09/24 on Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. She stated the QA team met and discussed they would ensure new staff were in-serviced and current staff would conduct random knowledge test of staff and it would be documented on form.</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/09/24 at 12:51 p.m. with CNA K revealed she stated the abuse neglect policy was reviewed with her regarding recognizing signs of abuse, neglect, exploitation such as physical or psychosocial indicators, facility staff were prohibited from taking or keeping photographs of facility residents in any manner that demeaned or humiliated the resident. She stated she should report any reasonable suspicion of a crime against a resident, she should protect the resident. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 12:57 p.m. with CNA L revealed she stated she learned from abuse and neglect policy that she should ensure the residents were safe, she stated some types of abuse of a resident would be verbally aggressive behavior, screaming, cursing, insulting to their race, physically aggressive behavior. She stated a resident who has been abuse might also exhibit the same behaviors. she had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 1:02 p.m. with RN M revealed she received additional training on the abuse policy regarding recognizing signs of abuse and neglect such as physical or psychosocial indicators, abuse and neglect should be reported to the administrator without fear of reprisal, she learned the facility staff was responsible for protecting the residents, they should not take or distribute photos of the residents, and that dementia residents are at a greater risk of abuse. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 1:05 p.m. with the Director of Rehabilitation revealed he would be responsible to protect all the residents, he stated the abuse and neglect policy indicated all personnel, residents, and visitors should be encouraged to report incidents without the fear of retribution, the facility would act to protect the resident and prevent further abuse, the facility should have structures and processes to provide needed care and services for all residents. Residents who require extensive nursing care or totally dependent on staff for provision of care are most vulnerable. He had been trained on 08/07/24 on Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. She stated the QA team met and discussed they would ensure new staff were in-serviced and current staff would conduct random knowledge test of staff and it would be documented on form.</p> <p>In an interview on 08/09/24 at 1:15 p.m. with Therapist N revealed she was re-in-serviced on policy for identification of signs of abuse of a resident that included sudden or unexplained changes in behaviors or activities such as fear of a person or place, learning to identify different types of abuse such as mental/verbal, sexual, and physical, any act that would demean or humiliate a resident. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 1:27 p.m. with CNA O revealed she received addition training on how to prevent abuse or neglect of a resident how to recognize signs that a resident had been abused or neglected either physically or mentally. She stated she could report abuse without reprisal, and she should not take photos of any resident or distribute any resident to cause the resident to be demeaned or humiliated. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</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  08/09/2024
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/09/24 at 1:15 p.m. with CNA P revealed she was re-in-serviced on the facility policy of how to recognize signs of abuse and neglect such as physical or psychosocial indicators, abuse and neglect should be reported without fear of retaliation, vulnerable residents usually had dementia or were cognitively impaired. She sated she learned that some residents with behavioral symptoms would be aggressive reactions outburst or yelling difficulty in adjusting to new routines or staff. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 1:31 p.m. with CNA Q revealed she had been re-trained on the abuse policy that all staff were encouraged to report incidents and abuse without fear of retribution, how to recognize signs of abuse and neglect which were physical or psychosocial, she should not take photos and distribute them of the residents, she stated she learned that residents with dementia or cognitively impaired residents were at greater risk of abuse. She had been given a knowledge assessment regarding abuse and neglect included to report to the administrator.</p> <p>In an interview on 08/09/24 at 2:30 p.m. with the Administrator revealed she had been trained on 08/07/24 on Prevention of and Prohibition Against Sexual Assault and Prevention. Train the trainer in-servicing on training and implementation of abuse and neglect policy and procedures. This training will also be included in the new hire orientation and will be included for PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received this training and knowledge checks. She s [TRUNCATED]</p>