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	02/19/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #3 and Resident #4) of ten residents reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light system in Resident #3 and Resident #4's rooms were in a position that was accessible to the residents on 02/18/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #3 Record review of Resident #3's Face Sheet, dated 02/18/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and unsteadiness on feet. Record review of Resident #3's Comprehensive MDS Assessment, dated 01/25/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The resident required maximal assistance for hygiene, shower, and dressing. Record review of Resident #3's Comprehensive Care Plan, dated 02/05/2025, reflected the resident was at risk for falls related to unstable gait and one of the interventions was to be sure the resident's call light was within reach. Observation and interview on 02/18/2025 at 10:19 AM revealed Resident #3 was in his bed, awake. It was observed that his call light was clipped to the privacy curtain and was not within reach of the resident. The resident only shrugged his shoulders when asked where his call light was. Resident #4 (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 02/19/2025
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F 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of Resident #4's Face Sheet, dated 02/18/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with generalized muscle weakness and difficulty in walking.

Record review of Resident #4's Comprehensive MDS Assessment, dated 01/27/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The resident required assistance in toileting, shower, and dressing.

Record review of Resident #4's Comprehensive Care Plan, dated 02/12/2025, reflected the resident was at risk for falls related to weakness and one of the interventions was to be sure the call light was within reach.

Observation and interview on 02/18/2025 at 10:27 AM, revealed Resident #4 was sitting at the side of his bed. it was observed that his call light was behind his roommate's oxygen concentrator. When asked if he had his call light, the resident searched his bed and said he cannot even find the cord of his call light. The resident stood up and continue to search and he could not find his call light. He said he seldom used the call light but it should be with him just in case he needed it.

Observation and interview with RN D on 02/18/2025 at 10:38 AM, RN D stated call lights should be with the residents all the times because they use the call lights to call for help or assistance if needed. She said anything could happen if the call lights were not with the residents like the resident might fall trying to do things by themselves or get frustrated because they could not call the staff. She said all the staff were responsible in making sure the call lights were within reach of the residents. She also said the call lights were not just for the dependent residents but for the independent residents as well. RN D said Resident #3 was dependent for his activities of daily living such as transfer and bed mobility. RN D went inside Resident #3's room and saw the call light was clipped to the privacy curtain. She took the call light from the privacy curtain and placed it where the Resident #3 could reach it. She went to Resident #4's room but the door was closed. She said she would check Resident #4's call light after She said she did her morning round but did not notice if the call lights were with the residents.

In an interview on 02/18/2025 at 12:31 PM, the ADON stated the call lights should always be accessible to the residents to call the staff for assistance or help. The ADON said the residents used their call lights if they needed to be changed, for a refill of water, or if they needed their tv remote. She said if the call lights were not within reach, the residents would not be able to call the staff and their needs would not be met. The ADON said the expectation was for all the staff to make sure the call lights were within the reach of the residents every time they do their rounds and before leaving the room. The ADON said they would do an in-service about call lights being accessible to the residents.

In an interview on 02/18/2025 at 12:56 PM, the DON stated call lights should be placed where the residents could easily access them. The DON said the call lights were the residents' mode of communication so they could tell the staff they needed something. She said all the staff were responsible in ensuring that the call lights were within reach. The DON said the expectation was for the staff would be mindful that every time they leave the residents' room, the call lights were within reach. The DON said she would conduct an in-service about the call lights. She said she would personally monitor that all the residents' call lights were within reach.

(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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/18/2025 at 1:21 PM, the Administrator stated the call lights should be within reach of the residents. The Administrator said the residents might be having an emergency and staff would not know. The Administrator said the staff should be make sure the call lights were within reach. The Administrator said he would coordinate with the DON regarding call lights. In an interview on 02/18/2025 at 1:39 PM, CNA F stated she did not notice the call lights were not with resident #3 and #4. She said she should have made sure the call lights were accessible to all the resident entrusted to her in case they needed something. She said without the call light, the needs of the resident will not be known and met. Record review of facility's policy Call Light/Bell Policy/ Procedure - Nursing Clinical revised 08/03/2021 revealed POLICY: It is the policy of this facility to provide the resident a means of communication with nursing staff . PROCEDURES . 4. Leave the resident comfortable. Place the call device within resident's reach before leaving room.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on observations, interview, and record review, the facility failed to protect a resident's right to be free from abuse for 1 (Residents #7) of 6 residents reviewed for resident abuse. The facility failed to ensure Resident #7 was free from physical abuse from LVN B during an incident on 01/04/2025 that subsequently required surgery on 01/09/2025. A Past Non Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator on 02/19/2025 at 11:37 AM. The noncompliance began on 01/04/2025 and ended on 01/06/2025. The facility corrected the noncompliance before the investigation began. These failures placed residents at risk for serious injuries, abuse, and serious harm. Findings Included: Review of Resident #7's Face Sheet, dated 02/18/2025 at 1:30 PM, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included schizophrenia, generalized anxiety disorder, osteoporosis, opioid dependence, and anorexia. Review of Resident #7's Quarterly MDS dated [DATE] revealed she was cognitively intact with a BIMS score of 15. She received both scheduled and PRN pain medication. She was prescribed antipsychotics for her mental health. Review of Resident #7's Care Plan, revised 01/22/2025, revealed she had . falls . resulted in ulnar styloid avulsion fracture (bony projection of the wrist) . right wrist fracture . fracture of the olecranon (part of the elbow) . and interventions included to anticipate resident needs, encourage resident to leave splints in place on wrists for proper healing, monitor pain level, educate/encourage resident to wear appropriate footwear, educate/encourage resident to ask for assistance when needed, pharmacy consult to evaluate medications, ensure personal belongings were with resident's reach, enhanced monitoring for pain, bruising, and change in mental status, ensure environment was safe, and therapy evaluation and treatment per orders. Review of Resident #7's Radiology Results Report on 01/06/2025 at 12:41 PM revealed acute fracture of the right elbow and right wrist. Review of Resident #7's Clinical Record from her orthopedic surgery on 01/09/2025, dated 01/10/2025 at 10:00 am revealed Resident #7 presented for outpatient surgery for ORIF left and right wrist and ORIF right elbow . Patient sustained injuries with a previous fall . In interview with Resident #7 on 02/18/2025 at 11:25 AM, she stated that last month, LVN B threw her across the room and slammed her down to the ground. She stated LVN B caused injury to both of her arms and wrists. Resident #7 stated she had to have surgery because of her injuries. She declined further interview at this time and could not provide further detail. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an attempt for a follow up interview with Resident #7 on 02/19/2025 at 12:22 PM, she declined interview at this time. Interview attempted with LVN B on 02/18/2025 at 12:18 PM and 02/19/2025 at 2:00 and 02/19/2025 at 2:30 PM was unsuccessful. Record review of Progress Note by LVN B, dated 01/04/2025 at 8:41 PM revealed, [Resident #7] punched nurse. [LVN B] pushed resident away from her. Resident dramatically fell against the wall and slid to the floor. [LVN B] attempted to assist resident. [Resident #7] refused. [Resident #7] then lied down in the supine position. [CNA A] attempted to assist resident. Resident again refused . In interview with CNA A on 02/18/2025 at 2:28 PM, she stated she worked the time of the incident, but she did not recall the exact time the incident occurred. She stated she was not present for the specific incident but arrived afterward the alleged incident to assist Resident #7 from the floor to her bed. She stated she did not suspect any abuse at this time, and stated Resident #7 did not report any allegations during any time after the interaction. Record review of Progress Note by LVN T, dated 01/05/2025 at 11:15 AM revealed: [Resident #7] called nurse to give her pain pill and noticed bruising in her elbow and wrist asked when that happened, she replied 'it happen last night after the dinner in the hallway' doctor, DON, ADON, family notified, as per doctor's order R elbow, hand, skull X-RAY stat ordered. vitals are stable, call button is in place, nurse is monitoring resident closely. Interview attempted with LVN T at 02/18/2025 at 3:25 was unsuccessful. In interview with DON at 2/18/2025 at 3:00 PM, she stated LVN B was a good nurse and denied any complaints or suspicions of abusive conduct prior to the incident. She stated that LVN B reported to her that she specifically witnessed the resident sit on the floor and that was why LVN B did not report the incident as a fall, accident, or abuse. DON stated that once LVN T noticed bruising on Resident #7's wrists and reported to her the incident, she immediately began interventions. She stated she immediately suspended LVN B, contacted law enforcement, and conducted a thorough investigation with facility's Administrator. DON stated while she did not feel LVN B's action was willful or malicious, she stated LVN B was terminated out of an abundance of caution and her license was referred for further review. In interview with Administrator at 02/18/2025 at 12:43 AM, he stated he immediately suspended LVN B pending investigation, contacted law enforcement, and conducted a thorough investigation after LVN T reported the allegation regarding Resident #7. He stated after he completed his investigation, he stated LVN B reported to him that her actions were defensive, and not willful or malicious. Administrator stated that as a result of his investigation, he concluded her actions were out of line and terminated her employment at the facility. Additionally, he stated he referred her license out of an abundance of caution. Following the incident his leadership team conducted safe-surveys with the residents and multiple in-services related to abuse, neglect, exploitation and employee burnout. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Facility in-services on 02/18/2025 revealed multiple staff were in-serviced on what Abuse and Neglect consist of, policy, protocol and procedures following any suspected abuse, neglect, and/or exploitation, and specifically whom to report to and the timeframe required. Further review revealed complementary Abuse & Neglect Knowledge Check quiz completed by all staff to ensure comprehension of the in-service information provided. In interview with Administrator, DON, ADON, RN D, CAN E, CNA F, CNA A, LVN Z, LMSW, and Activity Director between 02/18/2024 9:00 AM - 3:00 PM revealed staff were knowledgeable on what abuse and neglect consisted of, facility policy, protocol, and procedures, whom to specifically report suspected abuse, neglect, and/or exploitation to and the timeframe required. Review of Facility safe surveys on 02/18/2025 conducted by Administrator on 01/05/2025 revealed no additional allegations of Abuse, Neglect, and/or Exploitation from the residents at the facility. Review of LVN B's In-services, dated 01/06/2025 at 10:57 AM revealed she was in-serviced on Preventing and De-escalating Crisis Situations, on 12/27/2024 and received a 100% on the post-test. Additional in-services included Knowing the Rights of the Residents, Working with Residents with Substance Use Disorder, Tips on Managing Challenging Behaviors, Effective Communication, Pian Management, Fall Prevention, and Abuse, Neglect and Exploitation all completed on 12/27/2024. Review of LVN B's Termination Form dated 01/06/2025 revealed she was involuntarily terminated due to gross misconduct and additional explanation of termination: conclusion of the investigation, employee did not express regret, no remorse. Termination effective immediately and is not rehire-able. A Past Non Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator on 02/19/2025 at 11:37 AM. The noncompliance began on 01/04/2025 and ended on 01/06/2025. The facility corrected the noncompliance before the investigation began. Record review of Facility Policy, Resident Rights and Protections, dated 12/2014, signed by LVN B on 10/23/2024 revealed Our residents are entitled to . be treated with respect and dignity . be free from verbal, sexual, physical, and mental abuse . have a physician and/or representative notified any time a resident is injured in an accident or needs to see a doctor . Review of Facility Policy, Reporting and Preventing Abuse, Neglect and Mistreatment, dated 12/2014, revealed Any person who observes or becomes aware of an incident of resident/patient abuse, neglect or mistreatment . whether alleged, suspected, or observed, must report the incident to the Administrator . immediately. Record review of Facility Policy, Abuse: Prevention and Prohibition Against, dated 11/2017 revealed each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . Physical abuse includes but is not limited to hitting, slapping, pinching, and kicking.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review the facility failed to ensure a resident was incontinent of bladder received services and assistance to prevent urinary tract infections for one (Resident #2) of one resident reviewed for Urinary Incontinence. The facility failed to prevent Resident #2's indwelling urinary Foley catheter (device that drains urine from the urinary bladder) device from contact with the floor on 02/18/2025. This failure could place the resident with indwelling urinary catheter devices at risk for the development of urinary tract infections. Findings included: Review of Resident #2's Face Sheet, dated 02/18/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #2's Quarterly MDS Assessment, dated 12/18/2024, reflected the was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident had an indwelling suprapubic catheter (device inserted into the stomach to the bladder to drain urine). Review of Resident #2's Comprehensive Care Plan, dated 01/20/2025, reflected the resident had a suprapubic catheter related to neurogenic bladder and one of the interventions was to secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. Review of Resident #2's Physician Order, dated 11/14/2024, reflected SUPRAPUBIC CATHETER 16 FR (French scale: measurement system for the size of the catheter)/10 ML TO CLOSED DRAINAGE SYSTEM. DX TO SUPPORT USE: RETENTION. Observation and interview on 02/18/2025 at 10:07 AM, revealed Resident #2 was in his bed, awake. It was observed that his catheter bag was on the floor. The drain valve (used to drain the urine in the catheter bag) of the catheter bag was not secured and was also touching the floor. When asked about his catheter, the resident did not reply. Observation and interview on 02/18/2025 at 10:38 AM, RN D stated the catheter bag should not be on the floor because the floor was definitely dirty. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said the proper care of the catheter was changing it as ordered and making sure the catheter bag was off the floor to prevent infection. She went inside Resident #2's room and saw the catheter bag was on the floor with its drain valve also touching the floor. She said the catheter bag should be secured properly on the railings under the resident's bed so it would not fall on the floor. She said the drainage valve of the catheter should not be left dangling and touching the floor because there was a place in the catheter bag to insert it. She said if the catheter bag was on the floor, germs could enter the bag and multiply upward. She said she would get another catheter bag and replace the one on the floor. In an interview on 02/18/2025 at 12:31 PM, the ADON stated the catheter bag should be off the floor. She said the catheter bag should be below the bladder but not on the floor. ADON said it could cause infection especially for individuals who were immuno-compromised. ADON said the expectation was for the staff to make sure the catheter bag was off the floor when the resident was in the bed or in the wheelchair. In an interview on 02/18/2025 at 12:56 PM, the DON the catheter bag should not be on the floor to prevent infection such as urinary tract infection. The DON said the nurses were responsible in ensuring the catheter was off the floor. The DON added the nurse should start monitoring the catheter bag and should start reminding the staff that every time they would empty the catheter bag, they should make sure that the catheter bag was off the floor. The DON said the expectation was the catheter bags would be off the floor to prevent infection and the staff would ensure they were following the best practice for catheter care. The DON concluded she would do an in-service regarding catheter bags not being on the floor. In an interview on 02/18/2025 at 1:21 PM, the Administrator stated the catheter bag should be off the floor to prevent a potential contamination. The Administrator added the expectation was for the staff to ensure the catheter bag was not on the floor. He said he was not clinical and would let the DON handle the issue about the catheter bag. In an interview on 02/18/2025 at 1:45 PM, CNA E stated she might had missed to check Resident #2's catheter bag during her round. She said she was not aware the resident's catheter bag was on the floor. She said she would check if the resident's catheter bag was hanged on the resident bed's railings. Review of facility policy, Catheter Care, Urinary, 2001 MED-Pass revised January 3, 2023, revealed Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections . Infection Control . 1. Use standard precautions when handling or manipulating the drainage system.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview,' and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care 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 Respiratory Care. The facility failed to ensure Resident #1's face mask for his nebulizer was properly stored when not in use on 02/18/2025. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Record review of Resident #1's Face Sheet, dated 02/18/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #1's Quarterly MDS Assessment, dated 02/07/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident had chronic obstructive pulmonary disease. Record review of Resident #1's Comprehensive Care Plan, dated 02/12/2025, reflected the resident had oxygen therapy related to COPD and one of the interventions was give medications as ordered. Record review of Resident #1's Physician Orders, dated 05/26/2024, reflected Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 1 vial inhale orally via nebulizer every four hours for SOB/Wheezing. Observation and interview with Resident #1 on 02/18/2025 at 10:14 AM, revealed the resident was in her bed, awake. It was observed that a breathing mask was on top of a semi open drawer of the resident's right-side table. The breathing mask was not bagged. The resident said the nurse did not come back when she was done with the breathing treatment that was why she took it off. The resident said nobody told her the breathing mask should be bagged or do the staff come to bag the breathing mask. Observation and interview on 02/18/2025 at 10:38 AM, RN D stated the breathing mask used for nebulization should be bagged when not in use. She said she administered the resident's morning breathing treatment and went back to check if the resident was done with her breathing treatment and saw the resident was not yet done. She said she went back to check if the resident was done with her breathing treatment. She said when she saw the resident was done and checked the resident's O2 saturation. RN D went inside the resident's room and saw the breathing mask was on the drawer and was not bagged. She went out of the room and said she would get a new breathing mask and a plastic bag. she said she did not notice the breathing mask was not bagged when she checked the resident's O2 saturation. She said she should be mindful that the breathing mask was inside a plastic bag and there should always be a plastic bag at bedside for the breathing mask. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/18/2025 at 12:31 PM, the ADON stated the breathing mask should be cleaned after usage and then bagged to prevent cross contamination and infection. She said whoever was caring for the resident should check if the breathing mask was bagged when not in use or needed to be changed because it was exposed or touched something dirty. She said the expectation was for the breathing mask to be bagged when the resident was not using it and the staff would check during their rounds that the breathing was bagged. She said she would do an in-service about bagging the breathing when not in use. In an interview on 02/18/2025 at 12:56 PM, the DON stated the breathing mask was supposed to be in a bag when the resident was not using it to prevent cross contamination and respiratory infections. She said the expectation was for the staff to be mindful and make sure the breathing mask was bagged when the resident was not using it. She said she would conduct an in-service about respiratory care. In an interview on 02/18/2025 at 1:21 PM, the Administrator stated everything the residents were using should be kept clean to prevent infection. He said he was not a clinician but would coordinate with the DON on how to go forward about the issue of respiratory care. Record review of the facility's policy, Departmental (Respiratory Therapy) - Prevention of Infection 2001 MED-PASS, Inc. revised October 2012, reflected Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . 7. Store the circuit in plastic bag, marked with date and resident's name.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based 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 infections for one (Resident #5) of ten residents reviewed for Infection Control. The facility failed to ensure CNA G and COTA G changed their gloves and performed hand hygiene while providing incontinent care to Resident #5 on 02/18/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: Record review of Resident #5's Face sheet, dated 02/18/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with cerebral palsy (a disorder that affects movement and muscle tone due to brain injury). Record review of Resident #5's Comprehensive MDS Assessment, dated 01/25/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident was always incontinent for both bowel and bladder. Record review of Resident #5's Comprehensive Care Plan, dated 12/12/2024, reflected the resident had bowel/bladder incontinence related to impaired mobility and one of the interventions was to wash, rinse and dry perineum. (continued on next page)

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 02/19/2025
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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/18/2025 at 11:02 AM, revealed COTA G and PTA H went inside the room to transfer Resident #5 to her bed. PTA H sanitized her hands from the wall mounted hand sanitizer outside the resident's room and then put on a pair of gloves. COTA G went inside the room while pushing a Hoyer lift. She then put on a pair of gloves without doing hand hygiene. PTA H and COTA G hooked the resident's Hoyer sling and transferred the resident to her bed. COTA G said they would clean the resident up and transfer her again to her electric wheelchair because the resident needed to go somewhere. When the resident was in her bed, COTA G pulled down the resident's pants, unfastened the soiled brief, and pushed it between the resident's thighs. After pushing the soiled brief in between the resident's thighs, COTA G opened a new brief and placed it beside the resident. She did not change her gloves after touching the soiled brief and before touching the new brief. COTA G cleaned the resident's perineal area (area between the legs). After cleaning the perineal area, PTA H and COTA G rolled the resident to her right. COTA G started cleaning the resident's bottom. While COTA G was cleaning the resident's bottom, CNA F entered the room and assisted in cleaning the resident. PTA H stepped back and let CNA F helped COTA G. COTA G continued to clean the resident's bottom. It was observed that the resident had a large bowel movement. While COTA G was cleaning the resident's bottom, her gloves got some feces on it. COTA G took some wipes and just wiped the feces off her gloves. She did not change her gloves when her gloves got soiled. COTA G continued to clean the resident's bottom. When she was done, she pulled the soiled brief and she asked CNA F to get a plastic bag near her so she could throw the soiled brief. CNA F handed over the plastic bag, COTA G threw the soiled brief, and CNA F threw the plastic bag to the trash can. COTA G then took the new brief from the resident's side and put it under the resident. She did not change her gloves before touching the new brief. While COTA G was fixing the brief, CNA F took off her gloves, took the box of gloves from the wall beside the resident's door, and then put on a pair of gloves. CNA F did not sanitize her hands before putting on the new pair of gloves. They rolled back the resident and fixed the brief further. They pulled up the resident's pants and transferred her to her electric wheelchair. In an interview with COTA G on 02/18/2025 at 11:19 AM, COTA G stated she should have changed her gloves after she tucked the soiled brief between the legs of the resident and after she cleaned the bottom of the resident because her gloves were considered dirty. She said touching the new brief with soiled gloves rendered the new brief dirty. She said she should have changed her gloves when feces came in contact with her gloves. She said wiping off the feces from her gloves did not make the gloves clean. She said she should have removed her gloves, washed her hands, and put on a new pair of gloves. She said her actions could cause cross contamination and infection. She said she would be mindful the next she would do incontinent care. She added that she should do hand hygiene before doing any care and before putting on a new pair of gloves, also, to prevent cross contamination. In an interview with CNA F on 02/18/2025 at 11:24 AM, CNA F stated she handed over the plastic bag to COTA G so she could throw the soiled brief and then threw the plastic bag in the trash can. She said should have changed her gloves and sanitized her hands to be sure her gloves were clean. She said she took off her gloves to get the box of gloves but did not sanitize before putting on a new pair of gloves. She said changing of gloves and sanitizing in between changing of gloves would prevent transfer of germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 02/18/2025 at 12:31 PM, the ADON stated hand hygiene should be done before doing any care, like transfer and incontinent care. She said gloves should be changed after tucking the soiled brief and after cleaning the residents' bottom. She also said that if the gloves were soiled during incontinent care, the gloves should be changed and the staff should do hand hygiene. She said not washing the hands before doing care, not changing the gloves after touching soiled items and after being soiled, and not sanitizing the hands in between changing of gloves could result to cross contamination and probable infections. She said the expectation was for the staff to do hand hygiene before and after every care, in between changing of gloves, and after contact with anything soiled. She said another expectation was for the staff to change their gloves after touching anything soiled. ADON said she would do in-services about infection control and hand hygiene. In an interview with the DON on 02/18/2025 at 12:56 PM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. She said hands should be washed before and after any care and hand hygiene should be done in between changing of gloves. She said the gloves should have been changed after tucking the soiled brief, after cleaning the resident's bottom, and when the gloves got feces on them. She said the expectation was for the staff to practice proper procedures to prevent cross contamination and hand hygiene. She said she would do an in-service about infection control and hand hygiene. In an interview with the Administrator on 02/18/2025 at 1:21 PM, the Administrator stated not doing hand hygiene before any care, not changing the gloves from soiled to clean could contribute to cross contamination and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he was not a clinician and would let the DON handle the issue about infection control and hand hygiene. Record review of the facility policy, Hand Hygiene Policy & Procedure, revised 12/2023, reflected Policy: It is the policy of this facility to provide . education . healthcare workers perform hand hygiene, which is one of the most effective measures to prevent the spread of infection . wash hands . b. Before and after direct contact with residents . h. Before moving from a contaminated body site to a clean body site . j. After contact with blood or bodily fluids . m. After removing gloves. Record review of the policy Perineal Care Policy/ Procedure -Nursing Clinical revised 07/2013 revealed POLICY . It is the policy of this facility to . 3. Prevent irritation or infection . PROCEDURES . 5. Wash hands properly.