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	03/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for two (Residents #1 and #2) of eight residents reviewed for medications and pharmacy services. 1. The facility failed to obtain hospital discharge orders and administer Resident #1's seizure medication after his admission to the facility on Friday-03/21/25, resulting in him missing the medication on the evening of 03/21/25 and the morning of 03/22/25. 2. The facility failed to administer Resident #2's long and short acting inhalers related to her COPD after her admission to the facility on Friday-03/21/25 and on Saturday 03/22/25, in accordance with the admission orders. The failure could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status, including seizure activity, respiratory distress, disorientation, physical and emotional discomfort. Findings included: 1. Record review of Resident #1's Face Sheet dated 03/24/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1's active diagnoses included other seizures (a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings and levels of consciousness), congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), type 2 diabetes (a chronic disease characterized by high blood sugar levels), morbid obesity (a severe form of obesity characterized by a significantly excessive body weight that poses serious health risks), hypertension (when the pressure of blood flowing through your blood vessels is consistently too high) and hemiplegia (a condition characterized by paralysis or weakness on one side of the body). Record review of Resident #1's clinical chart reflected no admission MDS assessment was completed as the resident had just admitted to the facility and it was not required to be completed yet. (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's clinical chart reflected no initial 48-hour baseline care plan was completed as the resident had just admitted to the facility and it was not required to be completed yet. Record review of Resident #1's hospital clinicals reflected they were faxed to the facility on [DATE] from the hospital social worker. The hospital clinicals reflected Resident #1 had been admitted to the hospital due to ongoing chest pain for six days resulting in a hypertensive urgency (severely high blood pressure) and a blood pressure of 212/97. Resident #1 admitted to the hospital from his previous facility with the medication Levetiracetam (Keppra) 750 mg two tablets in the morning and before bedtime for treatment of seizure disorder. Record review of Resident #1's clinical chart reflected no evidence of the hospital discharge medication orders on 03/21/25, which was his date of admission. Record review of Resident #1's admission nursing assessment dated [DATE] reflected it was completed at 03/21/25 at 8:40 PM. The assessment reflected Resident #1 had admitted from the hospital and the facility physician was notified of his admission. Resident #1 was assessed to be alert and oriented to time, place and person and all other body systems were evaluated as well with no significant issues documented with the exception of mobility. Resident #1 had paralysis present on his left side and range of motion limitations in his arms, hands, legs and feet. Record review of Resident #1's nursing progress notes post-admission on 03/21/25 on the 2-10pm shift and 10pm-6am shift into Saturday morning (03/22/25) reflected no entry related to his Keppra being given or why it was not given. An observation of Resident #1 on 03/22/25 at 9:35 AM revealed he was calling out from his room and stated he needed to go to the hospital. Upon entering, Resident #1 was observed to be in his bed, not in any obvious physical distress, but upset that he had not been given his Keppra since he admitted from the hospital the day before around 4:00 PM. Resident #1 stated he was worried he would have a seizure and felt he needed to go back to the hospital to ensure the medication level had not dropped in his system. Resident #1 stated one of the nurses (name unknown) told him the hospital had not sent his medications with him and the facility had not received them yet from the pharmacy. Resident #1 voiced concern that he could only miss one dose before he would start to have symptoms and start feeling poorly. He said he had already missed two doses since his admission and he did not remember the hospital administering it to him prior to his discharge time. Resident #1 stated he was not having any seizure like symptoms yet, and he was mostly frustrated that the nurses had not figured out what to do. Review of Resident #1's clinical chart reflected no hospital admission orders from 03/21/25, the date of his admission. Record review of Resident #1's current facility physician's orders dated 03/22/25 reflected, Levetiracetam Oral Tablet 750 MG give 2 tablets by mouth two times a day for Seizure (start 03/22/25). An interview with the charge nurse LVN A on 03/22/25 at 9:45 AM revealed she arrived for the start of her shift (6:00 AM) and began working on the floor when Resident #1 had informed her he had not received his seizure medication. LVN A stated she was currently in the middle of looking into it and did not know anything about it since he was a new admission. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with RN B on 03/22/25 at 9:50 AM revealed there was an e-kit at the facility the nurses could use if a resident admitted with no medications from the hospital, or the facility could call the pharmacy and stat the new meds to the facility which took about two hours and was more expensive. RN B stated there were four new admissions the day prior (03/21/25) and it was busy because they were not all supposed to admit in one day, as some had been postponed from an earlier anticipated admission. RN B stated everyone was having to step in and assist because it was a lot for just one charge nurse to handle. Record review of Resident #1's March 2025 MAR reflected, Levetiracetam Oral Tablet [Keppra] 750 MG-Give 2 tablets by mouth two times a day for Seizure (order date 03/22/2025; order start 03/22/2025). (Note: Keppra is an anti-epileptic drug, also called an anticonvulsant). The Keppra was not initialed as given on his date of admission or the next morning. After investigator intervention, the MAR reflected the first dose was timestamped as administered on 03/22/25 at 11:10 AM. An interview with the ADM on 03/22/25 at 11:50 AM revealed he had just talked with the DON and Resident #1's Keppra medication was still within the time frame to be given without it being considered missed. The ADM stated he did not know why Resident #1 was not given Keppra from the facility's e-kit and would have to look into it. An interview with LVN A on 03/22/25 at 12:03 PM revealed she had just administered Resident #1 his two 750 mg tablets of Keppra from the e-kit based off the hospital orders he came with the day before. LVN A stated when the facility got a new admission, the resident's information got entered into the system and the MD was notified of who the attending physician was. Then the attending physician and the admitting charge nurse would go through the medications for any clarifications, then the charge nurse entered the medication information into the online e-chart. LVN A stated the pharmacy used by the facility had two runs a day for deliveries. The first run came around 3:00 PM and the cutoff to get an order called in was around 11:00 AM-noon. For the second overnight pharmacy delivery run, the order would need to be called in by midnight. LVN A stated stat pharmacy deliveries could happen for emergency medications if needed and the turnaround time would be two hours. LVN A stated with Resident #1, she had to pull the Keppra from the e-kit on 03/22/25 to make sure he was able to get it. LVN A stated the potential harm of not getting a seizure medication was critical because the resident was supposed to have it and could have a seizure if they abstain from it. LVN A stated she did not work the day prior for Resident #1's admission, but all admissions were done as a team and had to be done within 24 hours. She stated if the admitting nurse did not get finished with their admission tasks, the oncoming nurse could complete them. LVN A stated she found out there was an issue because the medication aide passing meds earlier in the morning of 03/22/25 reported to her that Resident #1's Keppra was not in the medication cart. LVN A said she went to talk to Resident #1 and told him she would look into it. After that, LVN A stated Resident #1 called 911 because he got anxious and wanted to go back to the hospital, but the EMTs cancelled the call they arrived because LVN A was able to give him the Keppra from the e-kit and he calmed down. Record review of the facility's e-kit inventory log reflected there were 16 tablets of Keppra available as of 03/22/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with ADON C on 03/24/25 at 11:43 AM revealed he did the admission for Resident #1 the day prior (03/21/25). ADON C stated when Resident #1 arrived from the hospital from the medical transport service, he did not come with all his hospital documentation, which included no discharge medication list. He said when that happened, he called the hospital and talked to someone who said it would get faxed to the facility but it never did and then his shift ended around 11:30 PM and he told the oncoming nurse to look out for them. ADON C stated he found out the next morning (03/22/25) prior to investigator intervention that the orders from the hospital never got faxed over. ADON C stated Resident #1 did not have any seizures since his admission. An interview with the DON on 03/24/25 at 11:45 AM revealed the hospitals usually sent the facility referrals which included medications a resident was being given, but the facility could not use those in lieu of hospital discharge orders for an admission. The DON stated Resident #1 admitted late the night before (03/21/25) so she thought the staff assumed he had taken all his medications at the hospital and they would just start them the next morning. The DON stated normally a hospital faxed discharge orders when asked, but going forward she was going to have the facility marketer get an additional copy of the discharge orders from the case manager once the doctor signs them at the hospital as a backup. The DON stated the hospital always sent a copy in the envelope that comes with a resident, but it would be a backup in case something happened. The DON stated not administering Keppra as ordered could result in the potential for a seizure if they miss a couple of doses. 2. Record review of Resident #2's Face Sheet dated 03/24/25 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2's active diagnoses included chronic obstructive pulmonary disease (a chronic disease that causes airflow obstruction, making it difficult to breathe), acute and chronic respiratory failure with hypoxia (occurs when the lungs cannot adequately provide oxygen to the blood, leading to low oxygen levels), morbid obesity, asthma (a chronic respiratory disease characterized by inflammation and narrowing of the airways, leading to difficulty breathing, coughing, and wheezing), obstructive sleep apnea (a sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep) and dependence on supplemental oxygen. Record review of Resident #2's clinical chart reflected no admission MDS assessment was completed as the resident had just admitted to the facility and it was not required to be completed yet. Record review of Resident #2's clinical chart reflected no initial 48-hour baseline care plan was completed as the resident had just admitted to the facility and it was not required to be completed yet. Record review of Resident #2's admission physician orders initiated 03/21/25 reflected the following inhalers: -Advair Diskus Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT 1 inhalation inhale orally two times a day for Asthma (ordered: 03/21/2025, start date: 03/22/2025); -Atrovent 2.5mg/3ml 1 inhalation inhale orally three times a day for COPD (ordered 03/22/25, start date 03/22/25); -Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT 2 puff inhale orally two times a day for COPD (ordered 03/21/2025, start date: 03/22/2025; discontinued 03/22/2025) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Incruse Ellipta 62.5 MCG/ACT Aerosol Powder, breath activated 1 inhalation once time a day for COPD (Pharmacy Pending confirmation ordered: 03/22/2025, start date: 03/22/2025). Record review of Resident #2's admission nursing assessment [e-signed by RN D] dated 03/21/25 reflected it was completed on 03/21/25 at 9:48 PM. The assessment reflected Resident #2 had admitted from the hospital and the facility physician was notified of her admission. Resident #2 was assessed to be alert and oriented to time, place and person and all other body systems were evaluated as well with no significant issues documented. Resident #2 was noted to have COPD and asthma and was on 4 liters of continuous oxygen. Her lung sounds were clear and she did not have any shortness of breath. Record review of Resident #2's nursing progress notes post-admission on 03/21/25 on the 2-10pm shift and 10pm-6am shift into Saturday morning (03/22/25) reflected no entry related to her physician ordered inhalers being given or why they were not given. An interview with Resident #2 on 03/22/25 at 12:37 PM revealed she was on continuous oxygen via a nasal cannula and concentrator at four liters per minute. Resident #2 admitted to the facility the night prior around 7:30 PM (03/21/25). Resident #2 stated that she had been in the hospital recently for double pneumonia and had previously been in another facility. She said every time a nursing facility had accepted her in the past, they knew ahead of time what medications she needed, But that didn't happen here. Resident #2 stated the facility nurses had been taking her oxygen saturation levels since her admission the night prior and her levels were normal and she had received her nebulizer treatments. Resident #2 stated her inhalers were not at the facility and she had one that was taken routinely every four hours and was short acting. The other was a long-acting inhaler every 12 hours and was a steroid. Resident #2 denied having any difficulty breathing but expressed frustration and concern that the inhalers were not available if she needed them and that her bipap machine was also not available for her on her first night. Record review of Resident #2's March 2025 MAR reflected she was not administered the following inhalants: 1) Incruse Ellipta was not administered on 03/21/25 on the evening shift and twice on 03/22/25 in the AM and PM, 2) Budesonide-Formoterol Fumarate was not administered on the 03/22/25 on the morning and evening shift and discontinued on 03/22/25 ; 3) Advair Diskus was not administered on 03/21/25 on the evening shift; and 4) Atrovent was not administered on the 03/21/25 evening shift, 03/22/25 on the PM shift/midday. An interview with the DON on 03/24/25 at 11:45 AM revealed after investigation intervention, Resident #2 now had all of her inhalers on the medication cart. The DON stated not having the inhalers available for a resident with known respiratory issues could result in an adverse reaction in the lungs, such as the resident having an asthma attack. An interview with ADON C on 03/24/25 at 11:43 AM revealed he was present at the facility during Resident #2's admission on 03/21/25 when Resident #2 admitted to the facility and was the nurse who completed her admission. He stated he had spoken to her on 03/24/25 as she was a new admission and she did not have any concerns about her inhalers anymore as they had all been delivered to the facility and were on the medication cart. ADON C stated a potential problem of not getting medication such as routine inhalants as ordered was it could cause an adverse reaction and the resident could have an asthma attack. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up interview with Resident #2 on 03/24/25 at 12:37 PM revealed she was getting three of the four inhalers ordered by the doctor. She did not know why she did not get the fourth one (note: It had been dc'ed by the MD), but stated she had no breathing issues going without them for the past one to two days and said everything was okay. 3. Review of the facility's policy titled, Administration of Medications dated July 2017, reflected, Procedure .3. Medications must be administered in accordance with the written orders of the attending physician .10. Should a drug be refused, withheld or given other than at the scheduled time, the staff administering must indicate the reason on the MAR. For those utilizing e-MAR, the appropriate code must be entered with any follow up documentation as appropriate for the situation. Review of the facility's policy titled, Nursing Admission Guidelines (not dated), reflected the following tasks to be completed, Review meds for accuracy, .Admit progress note (include from where, with whom and why. Comment of general status of resident, physician notification with verification of medications .