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	12/12/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop a complete care plan that meets all of a resident's needs, with timeframes and actions that can be measured for one of three residents (Resident #2) reviewed for Care Plans. The facility failed to ensure Resident #2's usage of a Nebulizer device was care planned. This failure could place the resident at risk of not receiving the necessary care and services required. Findings include: Record review of Resident #2's Face Sheet, dated 09/243/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included quadriplegia (paralysis). Record review of Resident #2's Quarterly MDS assessment, dated 7/28/25, reflected he had a BIMS score of 14 (intact cognitive response). For ADL care, it reflected the resident required total assistance. Record Review of Resident #2's Physician Orders, dated 9/24/25, reflected Ipratropium -Albuterol Solution 0. 5-2.3 MG/ML 3 ml inhale orally every 4 hours as needed for SOB or wheezing via Nebulizer. Record review of Resident #2's Comprehensive Care Plan, dated 9/11/25, did not reflect a plan of care for the usage of the nebulizer device. In an observation and interview on 09/24/25 at 08:31 AM, Resident #2 was observed to have a nebulizer device. RN P stated the resident used the nebulizer on an as needed basis. In an interview on 09/24/25 at 11:39 AM, ADON A was advised of Resident #2 use of the nebulizer device not being care planned. She stated the ADONs, DON, and the MDS nurse usually completed this task. She stated the resident nebulizer use should have been care planned when the physician order was inputted. She stated if it was not care planned staff may not know that she needed it. In an interview on 09/24/25 at 11:39 AM the MDS nurse stated she had been at the facility since January 2025. She stated Resident #2 used a nebulizer and it should be care planned when the physician order was received. She stated she did not know the resident was using a nebulizer. She stated there should have been a clinical conversation when they had their staff meeting to discuss residents. She stated she would have care planned it during the resident's quarterly assessment, but the last assessment occurred in July 2025, and the physician order was not inputted until August 2025. She stated if the use of the nebulizer was not care planned it could prevent them from providing better care to the resident. In an interview on 09/24/25 at 09:24 AM, the DON was told that Resident #2's use of the nebulizer device was not care planned and she stated it should typically be care planned when they received the physician order. She stated MDS, the DON, and the ADONs updated the care plan. She stated the resident's use of the nebulizer should have been care planned once the physician orders was received on 08/19/25. She stated it should be care planned to make the nursing team aware of the plan of care. She stated an in-service was started today about care planning. Record review of facility's policy, Care Planning (07/2020) reflected It is the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. The resident's plan of care is reviewed and revised on an ongoing basis, quarterly at a minimum and/or as needed with changes in condition.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676029	A. Building B. Wing	12/12/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure each resident is being watched and has assistance devices, when needed, to prevent accidents for one (Resident #1) of five residents reviewed for accident prevention. The facility failed to ensure Residents #1 had physician orders for the scoop mattress on his bed. The facility failed to ensure Resident #1's fall mat was properly positioned while he was in bed. These failures could prevent the resident from having an environment that was free and clear of accidents and hazards. Findings include: Record review of Resident #1's Face Sheet, dated 09/24/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #1's Quarterly MDS assessment, dated 8/20/25, reflected he had a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance and an active diagnosis of muscle weakness. Record review of Resident #1's Comprehensive Care Plan, dated 9/01/25, reflected the resident was a fall risk, with a recent fall occurring on 9/01/25 and interventions included a fall mat placed alongside his bed and a scoop mattress. Record review of Resident #1's physician orders, dated 9/24/25, reflected no physician orders for the scoop mattress. In an observation and interview on 09/24/25 at 08:28 AM Resident #1 was lying in bed. His bed was in a low position, he had a scoop mattress on his bed, and his fall mat was observed leaning against a wall. RN P stated the resident was a fall risk and the fall mat was supposed to be placed next to his bed when he is lying in it. She stated it should be there to reduce any injuries. She was advised the resident did not have physician orders for the scoop mattress and she stated she was not sure if he had physician orders or not but stated she thinks physician orders may be needed for the mattress but was not sure. In an interview on 09/24/25 at 09:24 AM, the DON was advised of Resident #1's fall mat being located against a wall as opposed to being placed alongside his bed while he is lying in it. She stated the resident had not had a fall in quite some time and was no longer considered a high fall risk. She stated if he had an intervention of the fall mat being placed alongside his bed, it should be placed there to avoid injury. She was also advised the resident did not have physician orders for the scoop mattress and she stated the resident should have physician orders for the mattress because it was a device needed for his plan of care. She stated the mattress could be a form of a restraint for the resident. In an interview on 09/24/25 at 11:39 AM ADON A was advised of Resident #1 not having his fall mat placed alongside his bed and the fall mat being observed leaning against a wall. She stated the resident was a fall risk, and an intervention was for him to have a fall mat placed alongside his bed. She stated it was the nursing staff's responsibility to ensure that the fall mat was placed alongside the resident's bed whenever they completed their rounds and when staff placed him back in bed. She stated not placing the fall mat in place could result in him having a more serious injury if it was not in place. She was advised of the resident not having physician orders for the scoop mattress and she stated physician orders should have been requested for the device. Record review of the facility's policy Restraints, Physical (undated) reflected It is the policy of this facility that the resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. To attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

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	12/12/2025

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 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** Based on observations, interviews, 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 of three residents (Resident #2) reviewed for respiratory care. The facility failed to ensure Resident #2's nebulizer mask was properly stored in a bag when not in use on 09/24/25. This failure could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings include: Record review of Resident #2's Face Sheet, dated 09/24/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included quadriplegia (paralysis). Record review of Resident #2's Quarterly MDS assessment, dated 7/28/25, reflected he had a BIMS score of 14 (intact cognitive response). For ADL care, it reflected the resident required total assistance. There was no reference to her need of a breathing device. Record review of Resident #2's Comprehensive Care Plan, dated 9/11/25, did not reflect a plan of care for the usage of the nebulizer device. Record Review of Resident #2's Physician Orders, dated 9/24/25, reflected Ipratropium -Albuterol Solution 0.5-2.3 MG/ML 3 ml inhale orally every 4 hours as needed for SOB or wheezing via Nebulizer. In an observation and interview on 09/24/25 at 08:31 AM, Resident #2 was observed to have a nebulizer. The nebulizer was on top of a nightstand and the mask was located alongside it, unbagged. RN P stated the resident used the nebulizer on an as needed basis and the mask should have been bagged when not in use to avoid infection. She stated she had just started making her rounds and did not have a chance to check for this. In an interview on 09/24/25 at 11:39 AM ADON A stated she had been at the facility for 4 months. She was advised of Resident #2 not having her nebulizer mask bagged when not in use. She stated the mask should have been bagged when not in use. She stated the nurses should check for this whenever they complete their rounds. She stated if the mask was not bagged it could build up bacteria.In an interview on 09/24/25 at 09:24 AM, the DON was advised of Resident #2 not having her nebulizer mask bagged when not in use. She stated the mask should have been bagged when not in use. She stated the nursing staff should check for this whenever they complete their rounds. She stated not bagging the mask could result in the resident getting an infection. She stated she was in-servicing staff on the importance of bagging nasal cannulas and mask when not in use today.Review of the facility's policy Respiratory Nurse Training, 09/2019, reflected It is the policy of this facility to provide a pathway for training of a Respiratory Nurse, who once qualified, can deliver skilled nursing services for respiratory assessment, interventions, resident education, and documentation of the care and treatment provided. Care and interventions provided by a Respiratory Nurse, may be included as skilled nursing services, and coded as such, on the Minimum Data Set (MDS) following Resident Assessment Instrument (RAI) guidelines that only a Respiratory Nurse or therapist's skilled minutes can be counted. The MDS coding guidelines include that:A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws