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	04/01/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 4 residents (Resident #1 and #5) reviewed for dignity.CNA E was observed standing over Resident #1 feeding her while the resident was lying in bed.Resident #5 was observed lying in bed and her catheter bag could be observed hanging from her bed without a privacy bag.These deficient practices could place residents at risk of not feeling as if they were being treated with dignity, privacy, and respect.Findings include:Record review of Resident #1's Face Sheet, dated 04/01/26, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included difficulty swallowing.Record review of Resident #1's Quarterly MDS assessment, dated 02/26/26, reflected a BIMS score of 00 (severe cognitive impairment). The resident had an active diagnosis of difficulty swallowing. The resident's ADL indicated the resident received maximum assistance with feeding.Record review of Resident #1's Comprehensive Care Plan, dated 03/09/26, reflected the resident had a nutritional problem; however, there was no intervention indicating the resident required assisted feeding. During an interview and observation on 04/01/26 at 08:24 a.m., CNA E was observed standing over Resident #1 feeding her while the resident was lying in bed. She stated staff was expected to be sitting down while feeding the resident. She stated the chair was too low. She stated they should be at eye level to observe the resident to ensure no swallowing issues.During an interview on 04/01/26 at 09:50 a.m., the DON was informed by the Investigator of CNA E feeding Resident #1 while standing over her. She stated the CNA should be sitting down while feeding residents to monitor their eating and swallowing to ensure no concerns. She stated it was also a dignity concern.Record review of Resident #5's Face Sheet, dated 04/01/26, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included a weak bladder.Record review of Resident #5's Quarterly MDS assessment, dated 03/27/26, reflected a BIMS score of 11 (moderate impairment). The resident had a diagnosis requiring the use of an indwelling catheter. Record review of Resident #5's Comprehensive Care Plan, dated 04/01/26, reflected the resident had a plan of care for an indwelling catheter.During an observation on 04/01/26 at 08:31 a.m., Resident #5 was observed lying in bed, her catheter bag could be observed from the hallway hanging from her bed, and no privacy bag was covering it.During an interview and observation on 04/01/26 at 08:33 a.m., the MDS Nurse observed Resident #5 not having a privacy bag over her catheter bag. She stated the resident needed a privacy bag to cover the catheter bag for her dignity. She stated it was the nursing staffs' responsibility to ensure the resident had a privacy bag.During an interview on 04/01/26 at 10:30 a.m., the DON was informed by the Investigator of Resident #5's catheter bag not having a privacy bag. She stated the resident needed a privacy bag to cover the catheter bag for her dignity. She stated the resident had one yesterday and she was not sure what happened.Review of the facility's policy on Resident Rights (07/13/2017) revealed As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States.

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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 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 observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 1 of 6 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan reflected an intervention which included assisted feeding. This failure could place residents at risk of their needs not being met. Findings include:Record review of Resident #1's Face Sheet, dated 04/01/26, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included difficulty swallowing.Record review of Resident #1's Quarterly MDS assessment, dated 02/26/26, reflected a BIMS score of 00 (severe cognitive impairment). The resident had an active diagnosis of difficulty swallowing. The resident's ADL indicated the resident received maximum assistance with feeding.Record review of Resident #1's Comprehensive Care Plan, dated 03/09/26, reflected the resident had a nutritional problem; however, there was no intervention indicating the resident required assisted feeding. During an interview and observation on 04/01/26 at 08:24 a.m., CNA E was observed feeding Resident #1 while the resident was lying in bed. She stated the resident required staff to feed her because she was unable to feed herself.During an interview on 04/01/26 at 10:30 a.m., the DON was informed by the Investigator of Resident #1 not having an intervention for assisted feeding. She stated the resident had a change of condition and now required assistance with her feeding. She stated she could not recall when the resident had a change in condition. She stated the intervention of assist feeding needed to be on the resident's care plan because it was part of her plan of care and if it was not on it, she may not receive the appropriate care. She stated it was the MDS Nurse, ADON, and DON's responsibility to update care plans.During an interview on 04/01/26 at 10:30 a.m., the MDS Nurse was informed by the Surveyor of Resident #1 not having an intervention for assisted feeding. She stated she was unaware of the resident requiring assistance with her feeding. She stated updating the residents' care plans was a collaborative effort between her, the ADON , and DON.Record review of facility's policy, Comprehensive Care Planning, undated, reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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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 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 that residents' environment remained free of accident hazards as was possible for 2 of 12 residents (Residents #6, and #8) reviewed for accident prevention. The facility failed to ensure Resident #6's fall mat was placed alongside her bed while she was lying in it on [DATE].The facility failed to ensure Resident #8 did not have a can of Lysol Spray in his room on [DATE].These failures could prevent residents from having an environment that was free from hazards. Findings include:Record review of Resident #6's Face Sheet, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included fall history.Record review of Resident #6's Quarterly MDS assessment, dated [DATE], reflected a BIMS score of 6 (severe cognitive impairment). The resident had active diagnoses of lack of coordination and unsteadiness on feet.Record review of Resident #6's Comprehensive Care Plan, dated [DATE], reflected the resident was a fall risk and an intervention included to have a fall mat at bedside. During an observation on [DATE] at 08:24 a.m., Resident #6 was observed lying in bed and her fall mat was observed away from her bed and not placed alongside her bed. During an interview and observation on [DATE] at 09:45 a.m., CNA C was informed by the Investigator of Resident #6 observed lying in bed, her fall mat was observed away from her bed and not placed alongside her bed. Her bed was also in a raised position. She stated the resident was a fall risk and needed the fall mat placed alongside her bed for fall prevention. She stated the resident raised her bed and did not allow staff to lower it.During an interview on [DATE] at 12:32 p.m., the DON was informed by the Investigator of Resident #6's lying in bed and her fall mat was observed away from her bed and not alongside her bed. She was also informed of the resident's bed not being in the lowest position. She stated the resident was a fall risk and needed the fall mat placed alongside her bed to protect her from injury if she fell out of bed. She stated the resident often raised her bed. Record review of Resident #8's Face Sheet, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included mental disorder and lack of coordination. Record review of Resident #8's MDS Assessment, dated [DATE], revealed the resident's BIMS score of 14 indicated intact cognitive function with minimal to no impairment.Record Review of Resident #8's undated care plan revealed, has an altered respiratory status related to cough with intervention to Administer medication/puffers as ordered. Monitor for effectiveness and side effects.Record Review of Resident #8's Active physician's orders on [DATE] revealed an order for Albuterol-Budesonide Inhalation Aerosol 90-80 MCG/ACT (Albuterol-Budesonide) 2 puff inhale orally every 4 hours as needed for wheezing.During an observation on [DATE] at 8:45 a.m., Resident #8 was observed with a can of Lysol Spray on his bedside table. During an interview on [DATE] at 10:00 a.m. with RN A, she stated residents should not have Lysol sprays in their rooms, she stated that all staff were responsible for making sure any harmful items were removed from residents' room. She stated that having Lysol spray in the room if used could exacerbate respiratory issues for other residents or even poison them. During an interview on [DATE] at 10:10 a.m. with CNA K, she stated Lysol sprays should not be in the resident's room, it should be removed by any staff member who finds it and reports to the nurse. She stated that if used could cause injury or burns if oxygen was in use.During an interview on [DATE] at 10:25 a.m. with CNA M, she stated Lysol spray should not be in resident's possession, she stated that CNAs and housekeeping should report to the nurse if they find such things. She stated that if used it could cause an allergic reaction to residents who have allergies.During an interview on [DATE] at 10:40 a.m. with Med Tech A, she stated Lysol should not be in resident room, they are not allowed to have such items in their rooms. She stated that if any staff member finds such items, it should be removed and reported to the nurse. She stated that the risk to any resident who gets it sprayed on them could cause an allergic reaction, it could make (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory issues worse and cause trouble breathing.During an interview on [DATE] at 10:50 a.m. with LVN D, he stated Lysol spray should not be in the residents' room for any reason and if the resident representative brings it in, they need to be educated not to bring such items into the facility. He stated that everyone is responsible for making sure that any items not allowed should not be in resident rooms. He stated that the risk of having the Lysol spray could be allergic reaction by the residents and it could be expired or even contaminated. During an interview on [DATE] at 11:10 a.m. with the DON, she stated residents should not have Lysol sprays in their rooms, she stated that Resident #8 goes out on medical pass and buys them, and that they are unable to stop him. She stated that they will continue to educate him about the risk of having such sprays. She stated that all staff take part in angel rounds and will continue to monitor and educate Resident #8. She stated that the risk of having such sprays could cause or worsen respiratory issues.Review of the facility's policy on Resident Rights ([DATE]) revealed As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States. You have a right to a safe, clean, comfortable and homelike environment, and use of your personal belongings to the extent possible, including but not limited to receiving treatment and supports for daily living safely.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 5 of 7 residents (Resident #7, #9,#11, #12 and #13) reviewed for respiratory care. The facility failed to ensure Resident #7's Nasal cannula connected to the oxygen tank was properly stored on 04/01/26. The facility failed to ensure Resident #9's suction tip was properly stored on 04/01/26. The facility failed to ensure Resident #11's Nasal cannula connected to the oxygen concentrator was properly stored on 04/01/26. The facility failed to ensure Resident #12's Nasal cannula connected to the oxygen concentrator was properly stored on 04/01/26. The facility failed to ensure Resident #13's Oxygen humidified bottle was connected to the oxygen concentrator and dated on 04/01/26. These failures could place the residents at risk of respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #7's Face Sheet, dated 04/01/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included Chronic Respiratory failure (low oxygen or high carbon dioxide in levels in the blood) and Type 2 Diabetes (High blood sugar). Record Review of Resident #7's undated care plan revealed, the resident is at risk for impaired cognitive function / Dementia (A progressive loss of memory, reasoning and communication skills) or impaired thought process. Record Review of Resident #7's Active physician's orders on 04/01/26 revealed an order for CHANGE O2 TUBING & HUMIDIFIER BOTTLE every night shift every Sun, no orders for Alka Seltzer or Nasal saline spray were noted. Record review of Resident #9's Face Sheet, dated 04/01/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis that includes Dementia (A progressive loss of memory, reasoning and communication skills). Record review of Resident #9's MDS Assessment, dated 01/16/26, revealed the resident's BIMS score of 6 indicated severe cognitive impairment. The MDS Assessment reflected that the resident had an active diagnosis of Dementia. Record Review of Resident #9's undated care plan revealed, the resident had Oxygen therapy related to disease process, with intervention to monitor for signs and symptoms of respiratory distress and report to physician as needed. Record Review of Resident #9's physician's order dated 01/22/26 revealed Oxygen AT 2-4 L/MIN VIA NC PRN as needed for shortness of breath. Record review of Resident #11's Face Sheet, dated 04/01/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis that includes Chronic Obstructive pulmonary disease (a progressive, long-term lung disease that makes it hard to breathe). Record review of Resident #11's MDS Assessment, dated 01/16/26, revealed the resident's BIMS score of 15 indicated no cognitive impairment. The MDS Assessment reflected that the resident had an active diagnosis of COPD. Record Review of Resident #11's undated care plan revealed, has COPD (a progressive, long-term lung disease that makes it hard to breathe), with intervention to give oxygen therapy as ordered by the physician. Record Review of Resident #11's physician's order dated 11/28/25 revealed to elevate head of bed due to shortness of breath while laying flat every shift related to COPD. Record review of Resident #12's Face Sheet, dated 04/01/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis that include COPD, Acute and chronic respiratory failure (Acute failure happens suddenly (minutes to hours) due to injury or illness. Chronic failure develops slowly over time (months/years) due to long-term diseases). Record review of Resident #12's MDS Assessment, dated 01/30/26, revealed the resident's BIMS score of 13 indicated no cognitive impairment. The MDS Assessment reflected that the resident had active diagnoses of COPD and respiratory failure. Record Review of Resident #12's undated care plan revealed, he has altered respiratory status and oxygen therapy with intervention to monitor for signs and symptoms of respiratory distress and report to physician as needed. Record Review of Resident #12's physician's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orders dated 01/14/26 revealed, apply oxygen via NC at 2-4LPM, to keep saturation at or above 90%. Titrate as indicated as needed. Record review of Resident #13's Face Sheet, dated 04/01/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that include Acute and chronic respiratory failure and Heart failure (condition in which the heart cannot pump blood well enough to meet the body's needs). Record review of Resident #13's MDS Assessment, dated 01/06/26, revealed the resident's BIMS Score of 15 indicated no cognitive impairment. The MDS Assessment reflected that the resident had active diagnoses of heart failure and respiratory failure. Record Review of Resident #13's undated care plan revealed, the resident has a terminal prognosis related to Acute/chronic respiratory failure, has oxygen therapy related to respiratory illness with intervention to monitor for signs and symptoms of respiratory distress and report to physician as needed. Record Review of Resident #13's physician's orders dated 01/02/26 revealed CHANGE O2 TUBING & HUMIDIFIER BOTTLE every night shift every Sun, O2 AT 2-4L/MIN VIA NC as needed for SOB, RESPIRATORY DISTRESS, CYANOSIS (bluish or purplish discoloration of the skin, lips, or fingernails caused by a lack of oxygen in the blood), and LABORED BREATHING. During an observation on 04/01/26 at 8:35 a.m. Residents #7's nasal cannula connected to oxygen tank was noted hanging on his wheelchair while the resident was in bed with another nasal cannula connected to the oxygen concentrator. During an observation on 04/01/26 at 8:45 a.m., Resident #9's suction machine tip was connected to the suction machine and was not bagged. During an observation on 04/01/26 at 8:40 a.m., Resident #11's nasal cannula connected to the oxygen concentrator was lying on the floor. During an observation and interview on 04/01/26 at 8:43 a.m., Resident #12 was laying in bed awake with his nasal cannula connected to the oxygen concentrator and hanging on his chair. He stated he usually hangs it on this chair when not in use and it is not bagged most times. During an observation on 04/01/26 at 8:55 a.m., Resident #13's Oxygen concentrator humidifier bottle was sitting on the nightstand, not connected to the machine, it was 1/4 full with an open crack on the top right corner. During an interview on 04/01/26 at 10:00 a.m. with RN A, she stated that all nasal cannulas, nebulizer masks and suction tips should be bagged and dated and changed weekly according to the facility policy. She stated the nurses were responsible to change, date and bag the items and the CNAs are responsible for notifying the nurses if they see it not bagged and exposed. She stated the risk of not storing the nasal cannulas and nebulizer masks properly could be infection caused by germs that can make respiratory issues worse. During an interview on 04/01/26 at 10:10 a.m. with CNA K, she stated that the nasal cannulas should be stored in a bag and dated, she stated the CNAs and nurses are responsible for making sure they were bagged and dated. She stated if the nasal cannula is not bagged, it will become contaminated and result in an infection to the residents. During an interview on 04/01/26 at 10:25 a.m. with CNA M she stated that the nasal cannula should be bagged and dated. She stated that she should report to the nurse whenever she sees it not bagged. She stated that the nasal cannula not being bagged could result in contamination and infection. During an interview on 04/01/26 at 10:40 a.m. with Med Tech A, she stated that the nasal cannula and nebulizer mask should always be bagged when not in use and it should be dated. She stated it is the responsibility of everyone to notify the nurse if they see it not bagged and dated. She stated the risk of not having the nasal cannula and nebulizer mask in a bag could result in them getting dirty, the residents could inhale germs from them and get sick with an infection. During an interview on 04/01/26 at 10:50 a.m. with LVN D, he stated that the facility policy is that all nasal cannulas and nebulizer masks should be always bagged, dated and changed weekly and as needed if dirty or soiled. He stated that everyone is responsible for making sure they are stored properly. He stated that if they are not bagged, they will collect dust and pose a risk for infection. He stated the Oxygen humidifier bottles are changed and dated weekly and as needed if empty. During an interview on 04/01/26 at 11:00 a.m. with the DON, she stated that the oxygen humidifier bottle, nasal cannula and humidifier mask are dated and changed weekly and as needed if empty or soiled. She stated that everyone is responsible for making sure they are stored in a bag and dated. She stated the nurses round as often (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as possible and managers do an angel round on all residents every 2-3 hours. She stated she does not know why the oxygen humidifier bottle was on the table and cracked and not connected to the oxygen concentrator. She stated that it should be changed when the water level is low. She stated the risk of not storing respiratory equipment's properly could result in infections. The Facility's Oxygen Equipment Policy Dated 05/17 revealed: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner and to use disposable pre-filled humidifiers, tubing, masks and cannulas for residents receiving oxygen. This equipment is to be discarded after use. The facility will maintain clean tanks, connectors and concentrators. PROCEDURES: 1. Oxygen Tanks, Connectors and Concentrators A. Oxygen tanks, connectors and concentrators must be cleaned after use B. Gauges must be cleaned after use as follows: 1. Remove gauge from tank2. Clean gauge with disinfectant. Allow to dry thoroughly3. Place clean gauge in oxygen storage area C. Pre-filled humidifiers, when used, are to be dated and replaced every ten (7) days, according to manufacturer recommendation, or as needed 1. Tubing should be replaced every week2. Masks should be replaced every week3. Cannulas should be replaced every week4. Oxygen concentrator filters will be cleaned with water and detergent every week or according to manufacturers recommendations D. Oxygen masks, nasal cannulas, and tubing will be used for one resident only. When used continuously or intermittently, tubing will be routinely changed to prevent the build-up of respiratory secretions, mucous, and bacterial growth. E. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms. It will not be covered tightly. F. Gauges should be cleaned after oxygen therapy is discontinued 1. Remove gauge from tank2. Clean gauge with disinfectant. Allow to dry thoroughly3. Place gauge in oxygen storage area 2. Nebulizer Equipment Procedures A. Nebulizer equipment generates aerosols small enough to be readily deposited in the lungs. Careful technique is required to prevent infecting the resident B. Medication will be added to the nebulizer immediately before use C. After each treatment, take the nebulizer apart and discard all unused medication. Rinse all parts thoroughly with warm water and air dry D. Daily dismantle entire breathing assembly including all hoses, wash with warm soapy water, rinse well and ensure parts are dry, including inside of hoses E. Reassemble pieces F. Store, clean, and dry until next use 3. Room Air Humidifier A. Use of these in facilities is discouraged by CDC. These may technically be called nebulizers since they aerosolize droplets, are difficult to thoroughly cleanse of microorganisms, and are not safe to use in a facility 4. Emergency Resuscitation Devices A. Mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable. B. Disposable resuscitation equipment is recommended. It should be used once and disposed of.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys 3 of 7 residents (Residents #1, #7, and #10) reviewed for hazards. The facility failed to ensure Resident #1 did not have a bottle of Lumify eye drop in her room on 04/01/26 The facility failed to ensure Resident #7 did not have a pack of Alka Seltzer and saline nose spray in his room on 04/01/26 The facility failed to ensure Resident #10 did not have a jar of Vicks Vapor rub in her room on 04/01/26 These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions.Findings include: Record review of Resident #1's Face Sheet, dated 04/01/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnosis that include Limitation of activity due to disability, Primary generalize Osteoarthritis and generalized muscle weakness. Record review of Resident #1's MDS Assessment, dated 02/06/26, revealed the resident's BIMS score of 7 indicated severe cognitive impairment. Record Review of Resident #1's undated care plan revealed, she has impaired cognition with intervention to Give step by step instructions one at a time as needed to support cognitive function. Record Review of Resident #1's Active physician's orders on 04/01/26 revealed no orders for Lumify eyedrops Record review of Resident #7's Face Sheet, dated 04/01/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. with diagnosis that includes Chronic Respiratory failure (low oxygen or high carbon dioxide in levels in the blood), Type 2 Diabetes (High blood sugar) Record Review of Resident #7's undated care plan revealed, the resident is at risk for impaired cognitive function / Dementia (A progressive loss of memory, reasoning and communication skills) or impaired thought process. Record Review of Resident #7's Active physician's orders on 04/01/26 revealed and order for CHANGE O2 TUBING &HUMIDIFIER BOTTLE every night shift every Sun, no orders for Alka Seltzer or Nasal saline spray were noted. Record review of Resident #10's Face Sheet, dated 04/01/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. with diagnosis that includes Dementia (A progressive loss of memory, reasoning and communication skills), intellectual disability. Record review of Resident #10's MDS Assessment, dated 03/10/26, revealed the resident's BIMS score of 13 indicated intact cognitive status. The MDS Assessment reflected that the resident had an active diagnosis of Dementia. Record Review of Resident #10's undated care plan revealed, resident is at risk for impaired visual function related to macular Degeneration (Damage to the center of the retina of the eye). Record Review of Resident #10's active physician's orders on 04/01/26 revealed No order for Vicks Vapor rub. During an observation and interview on 04/01/26 at 8:30 a.m., Vicks vapor rub was noted in Residents # 10's plastic chest of drawers, when asked if the nurses knew she had it, she did not respond to the question and waved her hand for me to leave the room. During an observation on 04/01/26 at 8:35 a.m. Alka Seltzer was and Nasal Saline spray was noted on Residents #7's over the bed table. During an observation on 04/01/26 at 8:50 a.m., Resident #1 asleep in bed with a bottle of Lumify eyedrops was noted on her bedside table. During an interview on 04/01/26 at 10:00 a.m. with RN A, she stated that all medications should be secured for residents' safety. She stated that if residents have medications in their possession, it could interact with prescribed medications and cause undesirable side effects and potentially cause an overdose. She stated that the CNA's and nurses are responsible for checking and making sure that the residents have no medications in their possession. During an interview on 04/01/26 at 10:10 a.m. with CNA K, she stated that medications should not be in residents' room, she stated that if she finds any medications in residents' possession, she removes it reports to the nurse charge. She stated that (continued on next page)

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	04/01/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents can harm themselves with the medication by taking too much of it if not supervised. During an interview on 04/01/26 at 10:25 a.m. with CNA M, she stated that residents should not have medications on them, she stated she reports to the nurse if she finds any medications with the residents. She stated that the risk of the residents having medications. During an interview on 04/01/26 at 10:40 a.m. with Med Tech A, she stated that residents' medications should not be in their possession, that it should be on the medication cart. She stated that everyone is responsible for making sure if they find any medication in resident's possession to report to the nurse in charge. She stated that the risk of residents having medication and taking it without supervision will result in overdose, wrong medication being given, another resident could get hold of it and have an adverse reaction. During an interview on 04/01/26 at 10:50 a.m. with LVN D, he stated that residents are not allowed to medicate, he stated that all medications need an order and approval by the physician. He stated that the nurses are responsible for making sure that residents are not in possession of medications. He stated that residents could have an allergic reaction to medication. During an interview on 04/01/26 at 11:10 a.m. with the DON, she stated that the facility policy does not allow residents to have medications on them, all medications are administered by the nurses or medication Techs. She stated that every staff member is responsible for making sure no resident has personal medication in their possession. She stated that the risk could be duplication in therapy which could result in an overdose.