

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 11/21/2024
NAME OF PROVIDER OR SUPPLIER Westpark Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Westpark Way Euless, TX 76040	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50948</p> <p>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 one (Resident #35) of sixteen residents reviewed for Reasonable Accommodation of Needs.</p> <p>The facility failed to ensure Resident #35 call light was answered within a reasonable time on 11/20/2024.</p> <p>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.</p> <p>Findings included:</p> <p>During a confidential group interview 6 of 6 residents stated it took the weekday staff 30 minutes-1 hour to respond to the call lights, and the weekend staff 1 hour or more to respond to the call lights.</p> <p>Record review of Resident #35 face sheet dated 11/21/2024 reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included: Dementia (condition characterized by loss of brain functions such as memory loss), chronic obstructive pulmonary disease.</p> <p>Record review of Resident #35's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, she had a Brief Interview for Mental Status (BIMS) score of 99 which indicated the interview was unable to be completed.</p> <p>Interview on 11/20/2024 at 11:20am Resident #35 stated staff do not come quickly when she used her call light. She stated it took staff 30 minutes or so to respond but it has been longer, about 1 hour or so before staff responded to the call light.</p> <p>Observation on 11/20/2024 at 11:23am revealed Resident #35's call light in use.</p> <p>Observation on 11/20/2024 at 11:44am revealed Resident #35's call light in use.</p> <p>Observation on 11/20/2024 at 12:00pm revealed Resident #35's call light in use.</p> <p>Observation on 11/20/2024 at 12:20pm revealed Resident #35's call light in use.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 11/20/2024 at 12:30pm revealed Resident #35's call light no longer in use.</p> <p>Interview on 11/19/2024 at 11:17am with LVN-A, he stated staff was expected to respond to the call lights in a timely manner. He stated all staff can respond to the call lights and assist a resident within their scope of practice. He stated if staff was unable to respond to the call light immediately, the resident should be acknowledged and informed assistance will take place as soon as possible. He stated the risks of the call lights not being answered in a timely manner was considered neglect and the resident could have an emergency such as a fall.</p> <p>Interview on 11/19/2024 at 11:32am with CNA-I, she stated she answered the call lights immediately unless she was assisting another resident. She stated once she was done assisting one resident, she responded to another resident immediately. She stated not answering the call lights immediately is neglect to the resident, and a resident could have fallen, or something happened to the resident.</p> <p>Interview on 11/20/2024 at 8:57am with ADON G, she stated staff was expected to answer the call lights immediately or in a timely manner. She stated if the call lights were not answered in a timely manner is a risk of safety not only to the residents but the facility.</p> <p>Interview on 11/20/2024 at 12:23pm with the DON, she stated all staff can answer the call lights and respond to the resident within their scope of work. She stated the call lights should be answered in a timely manner and as soon as staff sees the call light. She stated answering the call light 30 minutes- 1 hour was not ideal, but staff should respond as soon they can. She stated the risks of the call lights not answered in a timely manner could be potential harm to the resident.</p> <p>Interview on 11/21/2024 at 9:21am with ADM, he stated any staff can respond to the call lights and assist a resident within their job title. He stated staff should respond to the call lights as soon as possible per the facility's the call light policy. She stated the risks of the call lights not answered timely can impact the resident's health.</p> <p>Interview on 11/21/2024 at 12:04pm with ADON H, he stated staff should answer call lights immediately. He stated any staff can answer call lights and assist the resident within the scope of their job title or get help from another staff member that can help. He stated call lights not answered immediately puts residents at risks of an emergency or their needs not met.</p> <p>Record review of the facility's grievances log dated 8/12/2024 and 9/9/2024, reflected concerns from resident council regarding call light not answered in a timely manner.</p> <p>Record review of the facility's Nursing Clinical Routine Procedures: Call Light/Bell dated: revised 8/3/2021, Policy Statement: It is the policy of this facility to provide the resident a means of communication with nursing staff. 1. Answer the light/bell within reasonable time. 2. Listen to the resident's request/need. 3. Respond to the request. If the item is not available or you are unable to assist, explain to the resident and notify the charge nurse for further instructions.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to provide the right to personal privacy which includes accommodations during personal care for one (Resident #1) of fourteen residents reviewed for Privacy.</p> <p>The facility failed to ensure LVN A closed Resident #1's door while checking the resident's blood sugar and while administering insulin on 11/20/2024.</p> <p>This failure could place the residents at risk of not having their personal privacy maintained during medical treatment.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 11/21/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #1 was diagnosed with type 2 diabetes mellitus (high blood sugar) and unspecified dementia (a condition characterized by loss of memory and ability to reason) with agitation.</p> <p>Review of Resident #1's Quarterly MDS Assessment, dated 11/10/2024, reflected the resident scored 99 on her BIMS Summary Score denoting the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated diabetes mellitus and unspecified dementia with agitation as primary medical conditions.</p> <p>Review of Resident #1's Care Plan, dated 10/15/2024, reflected the resident was type 2 diabetic and the interventions were to obtain blood sugars as ordered and administer diabetes medications as ordered. The resident was at risk for impaired cognitive function related to dementia and one of the interventions was reduce any distractions like closing the door.</p> <p>Review of Resident #1's Physician Order, dated 11/13/2024, reflected Insulin Glargine (man-made form of insulin) Solution 100 UNIT/ML. Inject 15 units subcutaneously (under the skin) one time a day for diabetes.</p> <p>(continued on next page)</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with LVN A on 11/20/2024 at 7:49 AM revealed LVN A was preparing to administer Resident's #1 medication. He said he would check the resident's blood sugar first to determine if he needed to hold the resident's insulin. He inserted a test strip to the glucometer, took a push button safety lancet and alcohol wipe from the first drawer of his cart, and went inside the resident's room. Resident #1 was in her wheelchair at the foot of her bed and was visible from the hallway. He told the resident that he was going to check her blood sugar and asked which finger she preferred. The resident shrugged her shoulders. LVN A wiped the resident's right index finger, pricked it with the push button lance, scooped some blood from the finger, and wiped the remaining blood off the finger. While LVN A was checking the resident's blood sugar, a staff passed by the hall. After he was done checking the resident's blood sugar, he went out of the resident's room and said he would prepare for the resident's insulin. LVN A prepared the insulin, went inside the resident's room, wiped the resident's left upper arm, and injected the insulin on the resident's left upper arm. He did not close the door when he checked the blood sugar and administered insulin. He said the door should be closed every time a staff was providing care or administering any treatment. He said checking the blood sugar and administering insulin were forms of treatments, therefore the door should be closed. LVN A stated he forgot to close the door before he did the resident's blood sugar and gave her insulin. He said the door should be closed every time treatment was done to provide privacy and give dignity to the resident. He said he would make sure she closed the door or pulled the privacy curtain every time he would do any treatment.</p> <p>In an interview with Resident #1 on 11/20/2024 at 12:26 PM, Resident #1 stated LVN A always leave the door open every time he came inside the room to give her insulin. The resident's roommate seconded that LVN A did not close the door every time he would administer treatment.</p> <p>In an interview with ADON G on 11/21/2024 at 7:32 AM, ADON G stated the door should be closed or the privacy curtain should be drawn when checking the blood sugar and administering insulin. She said not closing the door or pulling the curtain was a privacy issue. She said other residents, staff, or visitors could see what treatments were being done to a particular resident. She said the resident could be embarrassed that others could see the treatment being done to her. ADON G said the expectation was for the staff to make sure the door was closed, or the curtain was drawn when they were providing any care. She said she would do an in-service about privacy and dignity.</p> <p>In an interview with the DON on 11/21/2024 at 7:49 AM, the DON stated the door should be closed when the blood sugar was checked and when the insulin was administered. She said the purpose of closing the door or pulling the curtain was to provide privacy and dignity for the resident who might be embarrassed if others could see that she was diabetic. The DON said the expectation was for the staff to close the door when providing care or treatment, especially if the resident was visible from the hallway. She said they could also pull the curtain to provide privacy. She said she would do an in-service about the importance of providing privacy and dignity.</p> <p>In an interview with the Administrator on 11/21/2024 at 8:14 AM, the Administrator stated the staff must provide privacy when providing care to prevent embarrassment. He said the expectation was for the staff to close the door during all care provided. He said he would collaborate with the DON to do an in-service about privacy during treatment.</p> <p>Record review of the facility's policy, Dignity and Respect Policy / Procedure - Nursing Administration revised 05/2007 revealed POLICY: It is the policy of this facility that all residents be treated with kindness, dignity, and respect.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PROCEDURES . 4. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 7 (room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7) of 10 resident rooms and the hallway floors reviewed for cleanliness and sanitization.</p> <p>The facility failed to ensure that Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7 were thoroughly cleaned and sanitized.</p> <p>The facility failed to ensure that the facility hallway floors were cleaned.</p> <p>These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.</p> <p>Findings included:</p> <p>An observation on 11/19/24 at 11:14 AM of the facility hallways revealed thick dirt and some reddish stains along the borders of the floor.</p> <p>An observation on 11/19/24 at 11:16 AM of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The air filters were thick with dust. A wall near a mini fridge had a long brownish stain [NAME] vertically up and down the wall. The bathroom floor had light brownish stains around the toilet. The corners of the bathroom floor had thick dirt debris building up. The mini fridge in the resident's bathroom, had reddish stains on the inside, and the small freezer section had a very thick ice buildup, and nothing could be placed in it.</p> <p>An observation on 11/19/24 at 11:21 AM of Resident room [ROOM NUMBER] reflected the bathroom floor had light brownish circle shape stain under the bathroom sink. The bathroom floor had light brownish stains around the toilet. The corners of the bathroom floor had thick dirt debris building up. The doorway floor entering the room had a thick dirt and wax build up.</p> <p>An observation on 11/19/24 at 11:23 AM of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The air filters had thick layers of dust. The doorway floor entering the room had a thick dirt and wax build up. The bathroom floor had thick black dirt along the corners of the floor and behind the toilet.</p> <p>An observation on 11/19/24 at 11:28 AM of Resident room [ROOM NUMBER] reflected the bathroom floor had thick black dirt along the corners of the floor. The corners of the room floor had thick black dirt buildup.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 11/19/24 at 11:33 AM of Resident room [ROOM NUMBER] reflected the air condition unit had a thick dark stain along the top of the unit. The air filters had thick layers of dust. The bathroom floor had thick black dirt along the corners of the floor and around the toilet. The doorway floor entering the room had a thick dirt and wax build up. The corners of the room floor had thick black dirt buildup.</p> <p>An observation on 11/19/24 at 11:39 AM of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The air filters had thick layers of dust. The bathroom floor had thick black dirt along the corners of the floor, under the sink, and around the toilet. The hinges on the toilet seat had thick black dirt on the seat bracket. The doorway floor entering the room had a thick dirt and wax build up.</p> <p>An observation on 11/19/24 at 11:55 AM of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The air filters had thin layers of dust. The bathroom floor had thick brownish stain under the toilet.</p> <p>In an interview on 11/21/24 at 11:50 PM, the Operations Manager was shown photos of the concerns observed in the Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7 and the hallways. He stated he was not made aware of any concerns observed in the rooms. He stated he would meet with the housekeeping supervisor to address the concerns observed. He stated the risk of the resident's room not being thoroughly cleaned is a dignity issue.</p> <p>In an interview on 11/21/24 at 11:53 AM, Housekeeping Supervisor, stated she had been at the facility for 4 years. She stated housekeeping was supposed to clean everything in the room, including the air conditions. She stated they had a floor tech to clean the hall floors. She was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7 and the hallways, and she advised that housekeeping was responsible for ensuring those areas were cleaned. She stated the risk of not cleaning the rooms could result in health problems. She stated the housekeeping assigned to the 400-hall was only at the facility less than a week.</p> <p>In an interview on 11/21/24 at 12:05 PM, Housekeeping A stated she had only been at the facility for 4 days and she cleaned the 400-hall. She stated she was supposed to clean everything from the window to the door. She was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7 and the hallways. She stated that her housekeeping supervisor had just made her aware of the air filters needed to be cleaned. She stated the impact to the resident of the rooms not being thoroughly cleaned was not good for the resident because it was their room, and she would not want to be in a dirty room.</p> <p>Review of the facility's Cleaning (05/2023) revealed Housekeeping is responsible for maintaining equipment and keeping it as bacteria-free as possible. Thoroughly clean resident treatment areas, bathroom fixtures, handwashing facilities and service sink with a detergent.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to ensure each resident received an accurate assessment, reflective of the resident's status for one (Resident #45) of eight residents reviewed for Accuracy of Assessments.</p> <p>The facility failed to ensure Resident #45's Quarterly MDS Assessment, dated 11/10/2024, accurately reflected that Resident #45 was on oxygen therapy.</p> <p>This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health.</p> <p>Findings included:</p> <p>Review of Resident #45's Face Sheet, dated 11/21/2024, revealed the resident was a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with respiratory failure with hypoxia (insufficient amount of oxygen in the body).</p> <p>Review of Resident #45's Quarterly MDS Assessment, dated 11/10/2024, reflected the resident scored 99 on her BIMS Summary Score denoting the resident was unable to complete the interview to determine the BIMS score. Resident #45's Minimum Data Set, Section O - Special Treatments, Procedures, and Programs specified the resident was not on oxygen therapy.</p> <p>Review of Resident #45's Comprehensive Care Plan, dated 11/17/2024, reflected the resident had oxygen therapy related to respiratory illness and one of the interventions was oxygen via nasal cannula continuously.</p> <p>Review of Resident #45's Physician Order, dated 11/27/2023, reflected Apply oxygen via NC up to (4) LPM, to keep saturation at or above 90%. Titrate as indicated.</p> <p>every shift related to ACUTE AND CHRONIC RESPIRATORY FAILURE WITH HYPOXIA.</p> <p>Observation and interview with Resident #45 on 11/19/2024 at 10:55 AM revealed Resident #45 was in her bed, awake. It was noted that the resident was on oxygen therapy at 3 liters per minute via nasal cannula. The nasal cannula was connected to an oxygen concentrator at bedside. She stated she had been using oxygen since last year because she had issues with breathing. She said she would use oxygen at all times, inside the room or outside the room. She said he used portable oxygen when she went out of the room and used the oxygen machine when inside the room.</p> <p>In an interview with LVN A on 11/19/2024 at 11:43 AM, LVN A said Resident #45 had an order for oxygen because of her respiratory issue. He said the resident had an order for continuous oxygen because of her respiratory issue. He said the resident use the oxygen all the time.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with ADON G on 11/21/2024 at 7:32 AM, ADON G stated she was not familiar with the policy for MDS. She said if the MDS assessment represented the minimum data of the resident, then the use of the oxygen should be reflected on the MDS. She said if the resident was using oxygen continuously, it should be reflected in the system to make sure all the needed care was given to the residents. She said accuracy in assessments would help the staff make a correct care plan for the resident. ADON G said if there was no accurate assessment, there could be a confusion with the care needed by the resident, and the resident might not be able to get the treatment needed. She said the expectation was for all the residents would be properly assessed, not only during admission, but every day. She said the best person to explain the process was the MDS Nurse.</p> <p>In an interview with the DON on 11/21/2024 at 7:49 AM, the DON stated if a resident was using oxygen, it should be on the resident's profile. She said the resident should be accurately assessed to provide the needed interventions. If the residents were not properly assessed, the proper care and needs would not be met. The DON said the expectation was the residents were properly assessed not only during admission but every day to see if there was a change in condition, any refusal of care, or resident acting different than usual. She said she would collaborate with the MDS Coordinator to audit MDS assessments and make appropriate changes.</p> <p>In an interview with the Administrator on 11/21/2024 at 8:14 AM, the Administrator stated the MDS should reflect current condition of the resident and not miss the care needed by the resident. He said he was not clinical and would let the DON evaluate the situation and do in-services about assessments.</p> <p>In an interview and observation with the MDS Nurse on 11/21/2024 at 10:37 AM, the MDS Nurse stated the MDS was to have the overall snapshot of the residents' overall conditions. Said if the resident had an order for oxygen and had an active diagnosis, it should be coded on the MDS. He said he would usually visit the resident to do an assessment. He said he might had overlooked it. He said the medical diagnosis, physician order, MDS, and the care plan should be all in-line and should match to provide a clear overview of the resident's current condition. He said, by doing so, accurate goals and interventions would be provided. The MDS Nurse logged on to his computer, searched for Resident #45's profile and saw that the resident had respiratory failure, an order for continuous oxygen since last year and a care plan for oxygen therapy. He said Resident #45's MDS assessment should reflect that she was on oxygen therapy. The MDS Nurse said again that it was an oversight on his part. He said an accurate MDS assessment was important because it would be the basis of the care needed by the resident. If the assessment was not accurate, the current status of the resident would not be correct resulting in possible confusion on the residents' care. He said he would audit the residents' MDS to reflect their current condition.</p> <p>Record review of the facility policy, Resident Assessment and Associated Processes Policy & Procedure revised 12.2023 revealed Policy: It is the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record . These will be comprehensive, accurate, standardized reproducible assessment of each resident.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observations, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 3 residents (Resident #66) reviewed for accident hazards.</p> <p>The facility failed to obtain physician orders or a physician assessment, as of 11/19/24, for Resident #66 for the usage of a scoop mattress prior to installing the mattress to assist in fall prevention.</p> <p>This failure could place residents at risk of accidents and hazards.</p> <p>Findings included:</p> <p>Record review of Resident #66's face sheet, dated 11/21/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #66 had diagnoses which included seizures, syncope and collapse, and muscle weakness.</p> <p>Record review of Resident #66's Quarterly Minimum Data Set (MDS) assessment dated [DATE], reflected, he had a Brief Interview for Mental Status (BIMS) score of 99. ADL care reflected transfers, toileting, and bathing and the resident was totally dependent for assistance.</p> <p>Record review of Resident #66's physician orders, dated 11/19/24, reflected no physician orders for a scoop mattress.</p> <p>An observation on 11/19/24 at 11:49 AM revealed Resident #66 laying on a scoop mattress.</p> <p>In an interview on 11/20/24 at 1:45 PM, the DON was advised Resident #66 was observed laying on a scoop mattress; however, no physician assessment or physician orders were observed on file. The DON stated sometimes family members requested them for the resident so they would attempt to please the family member. She stated no assessment was completed to ensure the scoop mattress was not a risk to the resident. She stated the risk for the resident having the scoop mattress without a physician order or physician assessment could result in the resident injuring himself if he attempted to get out of bed.</p> <p>The facility's policy Fall Management System (12/2023) reflected It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based observation, interview and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection and to restore continence to the extent possible for one of two residents (Resident #6) reviewed for Incontinent Care.</p> <p>The facility failed to ensure CNA C did not use the same wipes used to clean Resident #6's groin (junction between the central part of the body and the thighs) to clean the resident's front part on 11/19/2024.</p> <p>This failure could place residents at risk of cross-contamination and development of urinary tract infections.</p> <p>Findings include:</p> <p>Record review of Resident #6's face sheet, dated 11/21/2024, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and muscle weakness.</p> <p>Record review of Resident #6's Comprehensive MDS Assessment, dated 08/19/2024, reflected the resident was not able to complete a BIMS. The Comprehensive MDS Assessment reflected Resident #6 was always incontinent for both bowel and bladder.</p> <p>Record review of Resident #6's Comprehensive Care Plan, dated 10/28/2024, reflected the resident had occasional to frequent bowel/bladder incontinence related to impaired mobility/cognition and muscle weakness.</p> <p>Observation on 11/19/2024 at 1:14 PM revealed CNA C was about to do incontinent care for Resident #6. The resident was ushered to her room from the activity area and was transferred to her bed. CNA C sanitized her hands, put on a pair of gloves, and prepared the things needed for incontinent care. She pulled the resident's dress up and unfastened the brief. She started to clean the resident's front part using the front to back technique. After cleaning the resident's front part, she rolled the resident and cleaned the resident's bottom. After cleaning the resident's bottom, CNA C took the brief, placed it under the resident, and rolled back the resident. CNA C said she would clean the resident's front part again. She pulled a wipe and started cleaning the left and right sides of the front part. After cleaning the sides, she used the same wipe to clean the middle part of the front side. After cleaning the front part again, she fastened the new brief and transferred the resident back to her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA C on 11/19/2024 at 1:29 PM, CNA C stated she used the front to back technique when she cleaned Resident #6's front part. CNA C said she did clean again the resident's front part after she was done with the resident's bottom. She said she should have thrown the wipe after each use. She said the staff should not use the same wipe to prevent the microorganisms from the sides of the front part to go to the middle of the front part. She said the practice could cause a urinary tract infection. She said she should be mindful of how she did incontinent care because the resident would be at risk for infection. She said they had in-services for incontinent care but was not able to apply it.</p> <p>In an interview with ADON G on 11/21/2024 at 7:32 AM, ADON G stated the wipes should be discarded after every stroke and not be reused because it could cause cross contamination and probable infection. She said the expectation was for the staff to do incontinent care the right way which was using one wipe per stroke and then discard it. She said she would initiate an in-service as soon as the interview was over.</p> <p>In an interview with the DON on 11/21/2024 at 7:49 AM, the DON stated the wipes should be changed with every stroke specially after cleaning the sides of the front part of the resident. She said, sometimes if the wipes were not that soiled, the wipes could be folded, and could be used again. She said but to be on the safe side, the wipes should not be re-used. She said the expectation was for the staff to remember and practice the proper way of incontinent care. She said she would be on top of this issue, would do an in-service, and would personally monitor the staff during incontinent care.</p> <p>In an interview with the Administrator on 11/21/2024 at 8:14 AM, the Administrator stated improper cleaning of the resident could cause infection. He said the expectation was for the staff to do the right procedure. He said he was not a clinician and would let the DON handle the issue.</p> <p>Record review of the facility's policy, Perineal Care Policy/Procedure - Nursing Clinical, revised 07/2013 reflected POLICY: It is the policy of this facility to 1. Cleanse perineum (area between the thighs) . 3. Prevent irritation or infection . The basic infection control-concept for peri care is to wash from the cleanest area to the dirtiest area.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who was fed by enteral means received appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding which included but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for one of two resident (Resident #39) reviewed for feeding tube.</p> <ol style="list-style-type: none"> The facility failed to ensure LVN A used a new syringe during Resident #39's medication administration via g-tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) on 11/20/2024. The facility failed to ensure LVN A put on Resident #39's abdominal binder on 11/20/2024 as per order. <p>These failures could place residents at risk of infection and accidental pulling of the gastrostomy tube.</p> <p>Findings include:</p> <p>Record review of Resident #39's face sheet, dated 11/21/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 was diagnosed with gastrostomy (medical procedure where a tube is inserted into the stomach) status and dysphagia (difficulty in swallowing).</p> <p>Record review of Resident #39's Quarterly MDS Assessment, dated 09/03/2023, reflected the resident had severe impairment in cognition with a BIMS score of 03. The resident was on tube feeding while a resident of the facility.</p> <p>Record review of Resident #39's Quarterly Care Plan, dated 11/13/2024, reflected the resident required tube feeding (delivery of nutrition through a tube inserted in the stomach) related to dysphagia and the interventions were to change enteral (tube feeding) administration set every night and monitor if the tube was dislodged. The care plan did not mention the resident refused to put on the abdominal binder.</p> <p>Record review of Resident #39's Physician Order, dated 06/08/2021, reflected every night shift Change Syringe.</p> <p>Record review of Resident #39's Physician Order, dated 05/06/2024, reflected Apply abdominal binder to secure Gastrostomy tube every shift.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 11/20/2024 at 7:46 AM revealed LVN A was about to administer Resident #39's medication via g-tube. LVN A performed hand hygiene and put on a pair of gloves. He started to prepare the medications by putting each medication in a small plastic cup. After preparing the medications, he crushed the medications one by one and mixed it with 10 ml of water. After mixing the medications, he went inside the resident's room with all the medications and supplies needed. LVN A checked for Resident #39's G-tube placement by connecting a 60 ml piston syringe with plunger (inside the syringe) to the feeding port and introduced air into the abdomen by pushing the plunger of the syringe. After checking for the placement, LVN A pulled the plunger to check for the residual. The residual was noted less than 10 ml. LVN A pushed the gastric content back, detached the syringe, pulled the plunger of the syringe, and attached it again to the feeding port of the g-tube. LVN A poured 30 ml of water into the syringe to flush it and then started to administer the medications one at a time. After administering the medications, he flushed the g-tube with 30 ml of water. LVN A detached the syringe along with the plunger from Resident #39's G-tube, washed it, and placed into a plastic bag. LVN A then put the syringe in the resident's side table. It was noted that the date on the syringe's plastic bag was 11/18/2024. It was also noted another syringe was on the side table dated 11/17/2024. LVN A said he did not notice the date on the syringe was 11/18/2024. He said the syringe was supposed to be changed every 24 hours to prevent infection. He said the night nurse was responsible in changing the syringe, but he was supposed to check before he used it to make sure he was using a new syringe. He said the syringes were replaced every day to prevent infection. He said the residual was checked to ensure the stomach was emptying effectively. It was observed during medication administration that the resident did not have an abdominal binder and there was no abdominal binder inside the resident's room. LVN A said the resident refused to put the binder and the resident was still in her right mind to decide if she wanted the binder or not.</p> <p>In an interview with Resident #39 on 12:22 PM, the resident said nobody had given her a binder or put a binder on her. She said if she needed the binder, she would put it on. She said she was never asked if she wanted the binder or not. She said if the binder was ordered for her, maybe she needed it.</p> <p>In an interview with ADON G on 11/21/2024 at 7:32 AM, ADON G stated the syringe should be changed every day as per order and it was the right thing to do. She said one would never know what was already growing inside the syringe or the plastic bag of the syringe specially if the syringe was placed inside the bag wet. She said if the resident had an order for abdominal binder, the resident should be wearing one to prevent accidental dislodgement of the g-tube. She said there should be one inside the room or if it was in the laundry, there should be another one to replace it if the other abdominal binder was not available. She said sometimes the resident would take it off, but it should be documented, or care planned. She said she already talked to the night nurse from last night and the night nurse admitted she was not able to put a new syringe. Said the staff used the old syringe could not solely blame the other nurse because he failed to check if the syringe was new. She said it was his shift and should own the mistake. She said the expectation was for the syringes to be changed every day and if the resident had an order for an abdominal binder, the resident should be wearing one to prevent accidental pulling og the g-tube She said she would do an in-service about g-tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 11/21/2024 at 7:49 AM, the DON stated the syringes should be replaced every 24 hours to prevent infection. She said if the resident had an order for an abdominal binder, there should be an abdominal binder, basically to prevent the g-tube to be pulled. She said if the resident was refusing it, there should be a documentation that the resident was refusing it. She said the expectation was for the staff to do the right procedure in providing g-tube care. she said she would do an in-service about g-tube care.</p> <p>In an interview with the Administrator on 11/21/2024 at 8:14 AM, the Administrator stated he was not aware about the procedure for tube feeding. He said whatever the policy and procedure for tube feeding was, should be followed to address the medical necessities of the residents. He said he would let the clinicians address the issue.</p> <p>Record review of the facility's policy Gastrostomy Tube Care and Management Policy & Procedure, revised 12/2023 reflected Policy: It is the policy of this facility to provide proper care and maintenance of gastrostomy tubes . Procedure . 6. Avoid excessive pulling or manipulating of the tube . 12. Syringe Storage and Replacement . b. The syringe will be discarded and replaced on a daily basis.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>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 3 of twelve residents (Resident #35, Resident #55 and Resident #45) reviewed for Respiratory Care.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #35's nasal cannula for her oxygen concentrator was properly stored. The facility failed to ensure Resident #55's face mask for his nebulizer was properly stored when not in use. The facility failed to ensure Resident #45's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) at the back of the wheelchair was properly stored. <p>These failures could place residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of Resident #35's face sheet, dated 11/21/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which included Chronic Obstructive Pulmonary Disease with Acute Exacerbation. <p>Record review of Resident #35's Quarterly Minimum Data Set (MDS) assessment dated [DATE], reflected, she had a Brief Interview for Mental Status (BIMS) score of 99. The resident was on oxygen therapy while a resident of the facility.</p> <p>Record review of Resident #35's physician orders, dated 11/19/24, reflected O2 at 4 liters/minute continuous per n/c to keep sats above 95%.</p> <p>Record review of Resident #35's Comprehensive Care Plan, dated 10/14/2024, reflected nasal canula keep inside plastic bag when not in use.</p> <p>An observation on 11/19/24 at 11:53 AM revealed Resident # 35's nasal canula sitting on top of a large pink stuffed rabbit and was unbagged. The resident was not in the room.</p> <p>In an interview and observation on 11/19/24 at 11:58 PM, the DON was shown Resident #35's nasal canula sitting on top of a large pink stuffed rabbit and unbagged. She stated the resident's nasal canula should be bagged when not in use and the risk was infection control.</p> <ol style="list-style-type: none"> Record review of Resident #55's face sheet, dated 11/21/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #55 had a diagnosis which included Chronic Obstructive Pulmonary Disease. <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #55's Quarterly Minimum Data Set (MDS) assessment, dated 9/19/24, reflected, he had a Brief Interview for Mental Status (BIMS) score of 13. The resident was diagnosed with Chronic Obstructive Pulmonary Disease.</p> <p>Record review of Resident #55's physician orders, dated 11/19/24, reflected O2 via NC to keep O2 saturation > 92%.</p> <p>In an interview and observation on 11/19/24, Resident #55 had his oxygen mask sitting on top of his nightstand unbagged. The resident stated he used the oxygen concentrator whenever he had difficulties breathing but had not used it for the past few days.</p> <p>In an interview and observation on 11/19/24 at 12:18 PM, ADON P was shown Resident #55's face mask not in use and unbagged. She stated the resident's breathing mask should be bagged when not in use to avoid the resident from getting an infection.</p> <p>3. Record review of Resident #45's face sheet, dated 11/21/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included respiratory failure with hypoxia (insufficient amount of oxygen in the body).</p> <p>Record review of Resident #45's Quarterly MDS Assessment, dated 11/10/2024, reflected the resident scored 99 on her BIMS Summary Score denoting the resident was unable to complete the interview to determine the BIMS score. Resident #45's Minimum Data Set, Section O - Special Treatments, Procedures, and Programs specified the resident was not on oxygen therapy.</p> <p>Record review of Resident #45's Comprehensive Care Plan, dated 11/17/2024, reflected the resident had oxygen therapy related to respiratory illness and one of the interventions was oxygen via nasal cannula continuously.</p> <p>Record review of Resident #45's Physician Order, dated 11/27/2023, reflected Apply oxygen via NC up to (4) LPM, to keep saturation at or above 90%. Titrate as indicated. every shift related to Acute and Chronic Respiratory Failure with Hypoxia.</p> <p>Observation and interview with Resident #45 on 11/19/2024 at 10:55 AM revealed Resident #45 was in her bed, awake. It was noted the resident had a portable oxygen tank at the back of the resident's wheelchair. A nasal cannula was connected to the portable oxygen tank. The nasal cannula was tangled to the right wheel of the wheelchair with the prongs of the nasal cannula touching the floor. There was no plastic bag at the back of the wheelchair. The resident said she never saw a plastic bag behind her wheelchair.</p> <p>Observation on 11/19/2024 at 11:03 AM revealed CNA E provided incontinent care to Resident #45. During the process of incontinent care, CNA E folded the wheelchair to provide more space at the foot of the bed. She did not notice the nasal cannula was tangled to the wheelchair and the prongs of the nasal cannula touched the floor.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with LVN A on 11/19/2024 at 11:43 AM, LVN A entered the Resident #45's room to attend on the resident. LVN A passed by the resident's wheelchair going to the resident's bedside to administer the powder for the redness to. He did not notice the nasal cannula at the back of the wheelchair was on the floor. After administering the powder, LVN A washed his hands and was about to go out of the room when asked to check the nasal cannula at the back of the wheelchair. He said the nasal cannula was tangled up on the wheel of the wheelchair and the prongs of the nasal cannula was on the floor. He said he did not notice the nasal cannula was on the floor when he did his morning rounds. He said the nasal cannula should be in a bag when the resident was not using it to prevent cross contamination and respiratory infection. He said there was bag at the back of the wheelchair. LVN A disconnected the nasal cannula and said he would get a new one. He said he would also get a bag to put the nasal cannula if the resident was not using it. LVN A said he was responsible to in making sure the nasal cannula was bagged</p> <p>In an interview with CNA E on 11/19/2024 at 11:56 AM, CNA E stated she did not notice Resident #45's nasal cannula was on the floor when she folded the resident's wheelchair. She said if the nasal cannula was on the floor and the staff still put it on the resident's nose, it could cause infection because the dirt from the floor could enter the lungs. She said she would be mindful next time to check if the nasal cannula was in a bag and not on the floor. She said she would notify the nurse to replace the nasal cannula immediately and would also let the nurse know there was no bag for the nasal cannula that was not in use.</p> <p>In an interview with CNA D on 11/19/2024 at 2:27 PM, CNA D said she was the CNA on Resident #45's hall. She said she did not notice the nasal cannula was on the floor. She said if the nasal cannula was on the floor, there could be chance for cross contamination. She said she would check those residents with nasal cannula if they were bagged when not in use.</p> <p>In an interview with ADON G on 11/21/2024 at 7:32 AM, ADON G stated</p> <p>the nasal cannula should be bagged whenever the resident was not using it for infection control and prevention of cross contamination. She said whoever was caring for the resident should check if the nasal cannula was bagged when not in use or needed to be changed because it touched something dirty. She said the expectation was for the nasal cannula to be bagged when the resident was not using it and the staff would check during their rounds that the nasal cannula was bagged. she said she would do an in-service about bagging the nasal cannula when not in use.</p> <p>In an interview with the DON on 11/21/2024 at 7:49 AM, the DON stated the nasal cannula 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 nasal cannula was bagged when the resident was not using it. She said she would conduct an in-service about respiratory care.</p> <p>In an interview with the Administrator on 11/21/2024 at 8:14 AM, 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.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation.</p> <ol style="list-style-type: none"> The facility failed to ensure the ice chest, located on the 400-hall, was cleaned. The facility failed to ensure the food stored in the refrigerator and freezer were labeled with the stored date. The facility failed to ensure that the sugar and flour bins were cleaned. The facility failed to ensure the ice scoop in the facility kitchen was cleaned. The facility failed to ensure the kitchen cooking equipment was cleaned. The facility failed to ensure the tea dispenser had the top placed back once the tea had brewed. <p>These failures could place residents at risk for cross contamination and other air-borne illnesses.</p> <p>Findings included:</p> <p>Observations on 11/19/24 from 9:01 AM to 9:13 AM in the facility's only kitchen reflected:</p> <p>The ice scoop, hanging in a blue plastic holder, had brownish dirt debris along the bottom of the holder.</p> <p>One 9-ounce box of fish filet, located in the refrigerator, did not have a stored date.</p> <p>One plate with a sandwich and potato chips, located in the refrigerator, did not have a stored date.</p> <p>Four 2-pound bags of sliced ham, located in the refrigerator, only displayed the month and day, but there was no year documented.</p> <p>One large bag of sliced turkey, located in the refrigerator, only displayed the month and day, but there was no year documented.</p> <p>One zipped lock bag of croissants, located in the refrigerator, only displayed the month and day, but there was no year documented.</p> <p>Three containers containing a vegetable soup, mixed vegetables, and gravy, located in the refrigerator, was not labeled, and dated.</p> <p>(continued on next page)</p>

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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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>One large container containing diced vegetables, located in the refrigerator, was not labeled, and dated.</p> <p>One zipped lock bag of croissants, located in the refrigerator, only displayed the month and day, but there was no year documented.</p> <p>One zipped locked bag of beef enchilada, located in the freezer, only displayed the month and day, but there was no year documented.</p> <p>Two 4-pound bags of stir fry vegetables, located in the freezer, did not have a stored date.</p> <p>Two 4-pound bags of slice carrots, located in the freezer, did not have a stored date.</p> <p>One large tea dispenser, located in the kitchen area, near the entry, was uncovered and exposed to air-borne contaminants.</p> <p>Two large sheets of chocolate cake, sitting on the serving line table was uncovered.</p> <p>The warming table in the kitchen, had brownish muddy water in it.</p> <p>The fryer in the kitchen was dark and smelled burnt. The inside and outside was heavily stained with grease and dirt [NAME].</p> <p>The ice chest on the 400-hall was sitting on a cart. Both the ice chest and cart had black, brownish, and reddish stains all over them. The inside of the ice chest had a dark grayish stain circling the ice chest, which also contained ice. The inside lid had black dirt stains.</p> <p>In an interview on 11/20/24 at 1:55 PM, the consultant dietitian, was shown the pictures of the concerns observed in the kitchen area and the ice chest. She stated the dietary manager was on leave and she was the assisting with managing the kitchen in his absence. She stated they did not have anyone else designated as a temporary manager of the kitchen area. She stated that everyone was responsible for the areas identified in the kitchen and she could not point me towards any kitchen staff that was solely responsible for the care of the kitchen area. She stated she think they cleaned the kitchen equipment weekly. She stated that she would advise the dietary manager of the concerns observed once he returned. She stated these concerns not being addressed could result in food contamination and residents getting sick.</p> <p>In an interview on 11/21/24 at 11:50 PM, the Operations Manager was shown photos of the concerns observed in the kitchen, and he stated that the consultant dietitian had advised him of the concerns observed in the kitchen. He stated the Dietary Manager was out on leave and was expected to return next week Monday. He stated the risk of the concerns not being addressed could result in residents becoming ill.</p> <p>Record Review of the Facility's policy on Dietary Services and Infection Control dated 2/05/24, revealed It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Provide safe food services for residents and employees All non-food items must be properly labeled and stored away from food products. Dirty equipment should never touch food. All work surfaces, utensils and equipment should be cleaned and sanitized after each use.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.</p> <p>Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES</p> <p>SUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>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 two of eight residents (Resident #6 and Resident #41) reviewed for Infection Control.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure CNA C changed her gloves and performed hand hygiene while providing incontinent care to Resident #6 on 11/19/2024. 2. The facility failed to ensure CNA B changed her gloves and performed hand hygiene while providing incontinent care to Resident #41 on 11/20/2024. 3. The facility failed to ensure CNA C would not place the pericare cleanser that would be used for incontinent care inside her pocket before using it on 11/19/2024. <p>These failures could place residents at risk of cross-contamination and development of infections.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Record review of Resident #6's face sheet, dated 11/21/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnoses which included with dementia (a condition characterized by loss of memory and ability to reason) and muscle weakness. <p>Record review of Resident #6's Comprehensive MDS Assessment, dated 08/19/2024, reflected the resident was not able to complete a BIMS. The Comprehensive MDS Assessment indicated Resident #6 was always incontinent for both bowel and bladder.</p> <p>Record review of Resident #6's Comprehensive Care Plan, dated 10/28/2024, reflected the resident had occasional to frequent bowel/bladder incontinence related to impaired mobility/cognition and muscle weakness.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 11/19/2024 at 1:14 PM revealed CNA C was about to do incontinent care for Resident #6. The resident was ushered to her room from the activity area and was transferred to her bed. CNA C sanitized her hands, put on a pair of gloves, and prepared the things needed for incontinent care. CNA C opened a new brief and placed it beside the resident's right leg. After preparing the new brief, she took a bottle of peri care and skin cleanser from her scrub pants' right-side pocket and put it on top of the new, open brief. She pulled the resident's dress up, unfastened the brief, and pushed it between the resident's thighs. She removed her gloves, sanitized her hands, and put on a new pair of gloves. She started to clean the resident's front part using the front to back technique. During the process of cleaning, the resident's right leg fell on top of the new, open brief. After cleaning the resident's front part, she took off her gloves, sanitized her hands, and put on a new pair of gloves. She rolled the resident and cleaned the resident's bottom. After cleaning the resident's bottom, CNA C took the brief from the resident's side, placed it under the resident, and rolled back the resident. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. She rolled the resident back and cleaned the resident's front part some more. After cleaning the front part of the resident some more, CNA C fixed the brief and then taped it on both sides. She washed her hands.</p> <p>In an interview with CNA C on 11/19/2024 at 1:39 PM, CNA C stated she washed her hands before and after incontinent care. She said she put the bottle of the skin cleanser in her pocket and then placed it on top of the new brief. She said she should not put anything from her pocket on the new brief because her pocket could be dirty. She said she should not put the brief beside the resident's leg until needed because if the resident's leg touched the new brief and any germs from the legs could transfer to the brief. She said she should have changed her gloves after cleaning the resident's bottom and before touching the new brief because her gloves were already soiled from cleaning the bottom. She said her actions could cause cross contamination and infection. She said she had in-services about incontinent care and hand hygiene but failed to practice it.</p> <p>2. Record review of Resident #41's face sheet, dated 11/21/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which included urinary tract infection (infection in any part of the urinary system) and paraplegia (paralysis of the legs and lower part of the body).</p> <p>Record review of Resident #41's Comprehensive MDS Assessment, dated 08/20/2024, reflected the resident scored 99 on her BIMS Summary Score denoting the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment reflected the resident was always incontinent for bladder and bowel.</p> <p>Record review of Resident #41's Comprehensive Care Plan, dated 08/29/2024, reflected the resident had incontinence and one of the interventions was to provide peri care after each incontinent episode.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 11/20/2024 at 9:48 AM revealed CNA B was about to do incontinent care for Resident #41 before her wound care. CNA B entered the resident's room and put on a gown and a pair of gloves, she did not wash her hands before putting on the gown and the gloves. She pulled the resident's overbed table and put everything she needed for incontinent care. she did not sanitize the table before putting the things needed for incontinent care on the overbed table. She unfastened the brief, pushed it between the resident's legs, and cleaned the resident's front part from front to back. She assisted the resident to roll to the left side and started to clean the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief, and threw it in the trash can. She did not pull the old padding and only rolled it towards the middle. She said she was still waiting for the nurse who would do the wound care and then she would transfer the resident to her wheelchair via Hoyer lift. While the resident was still on her side-lying position, CNA B inserted the Hoyer sling beneath the resident, put a new padding on top of the Hoyer sling, and put a new brief on top of the new padding. After putting the new brief on top of the new padding, she unrolled the old padding and put it on top of the new brief. She did not change her gloves before touching the new padding and the new brief. After wound care, CNA B rolled the resident back and fixed the brief. She said hands should be washed before incontinent care but she forgot to do so. She said she should have placed the Hoyer sling, the new padding, and the new brief after wound care so the old padding would not touch the new brief. She said the dirt from the old padding would transfer to the new brief rendering it soiled. She said the gloves should have been changed after cleaning the resident's bottom and before touching the new brief for the same reason. She said her actions could cause infection. She said she had in-services for incontinent care and hand hygiene but failed to apply them.</p> <p>In an interview with ADON G on 11/21/2024 at 7:32 AM, ADON G stated hand hygiene was included in all the procedures of any care. She said the staff should do hand hygiene before care was done, after any care, and in between changing of gloves. She said gloves should be changed after cleaning the residents' bottom, before getting a new brief. She said not changing the gloves after touching soiled items, or after touching soiled body parts could result in cross contamination and probable infections. She said the staff should not place any item from their pocket on the new brief for the reason that the pockets could be dirty. She said the legs should not touch the new brief as well because the legs could also be dirty. She said it would be ideal to just open the brief when incontinent care was done. She said the expectation was for the staff to do hand hygiene before and after every care, after changing their gloves, and when transitioning from a dirty site to a clean site. She said another expectation was not to put anything presumed dirty on the new brief. She said the expectation was for the staff would be mindful when they performed incontinent care to prevent infection. ADON G said she would do in-services about infection control and hand hygiene.</p> <p>In an interview with the DON on 11/21/2024 at 7:49 AM, the DON stated</p> <p>hand hygiene was the most effective way to prevent cross contamination and infection. She said hands should be washed before and after any care. She said</p> <p>gloves should be changed after touching the soiled brief to prevent transfer of microorganisms to any clean items. She also said nothing soiled or presumed soiled should be placed on top of the new brief to prevent transfer of anything dirty. She said the expectation was for the staff to wash their hands before and after any care, change their gloves when going from dirty to clean, and ensure the brief was clean before putting it on the resident. She said she would do an in-service and skills check-off for infection control and hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the Administrator on 11/21/2024 at 8:14 AM, the Administrator stated not washing the hands before any care, not changing the gloves from soiled to clean, and putting anything soiled to the new brief 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.</p> <p>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.</p>		