STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676029	A. Building B. Wing	02/06/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 11 of 20 resident rooms (room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) and 2 of 2 shower rooms observed for cleanliness. The facility failed to ensure Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11 were thoroughly cleaned and sanitized. The facility failed to ensure two of two shower rooms were thoroughly cleaned and sanitized. This facility failure could place residents at risk of living in an unclean and unsanitary environment, leading to a decreased quality of life.Findings included: During an observation on 02/04/26 at 10:35 a.m. of room [ROOM NUMBER], reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. Observation reflected the bathroom floor had thick dark substances in the corners of the floor and behind the toilet. During an observation on 02/04/26 at 10:37 a.m. of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust covered the front of the unit and between the vents. Observation reflected the bathroom floor had thick dark substances in the corners, behind the toilet, and inside of the toilet bowl were dark stains. Observation reflected the floor had built up dirt in the corners of the door frame and corners of the floor. The door frame had a rust-like substance on the bottom of the frame. During an observation on 02/04/26 at 10:40 a.m. of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had thick dark substances in the corners of the floor and behind the toilet. The entryway of the room floor had a thick yellowish stain. The door frame had a rust-like substance on the bottom of the frame. During an observation on 02/04/26 at 10:44 a.m. of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had thick dark substances in the corners of the floor and behind the toilet. The floor under the sink had thick black dirt. The room floor had built up dirt in the corners of the door frame and corners of the floor. During an observation on 02/04/26 at 10:58 a.m. of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bedside table had a thick rust-like substance all over the lower frame. The bathroom floor had thick dark substances in the corners of the floor and behind the toilet. The floor under the sink had thick black dirt. The room floor had built up dirt in the corners of the door frame and corners of the floor. During an observation on 02/04/26 at 11:04 a.m. of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bedside table had a thick rust-like substance all over the lower frame. The bathroom floor had thick dark substances in the corners of the floor and around the toilet. During an observation on 02/04/26 at 11:07 a.m. of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The room floor had built up dirt in the corners of the door frame and corners of the floor. The bathroom floor had thick dark substances in the corners of the floor, under the sink, and around the toilet. During an observation on 02/04/26 at 11:15 a.m. of room [ROOM NUMBER], reflected the air conditioning unit (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had dark substances all over the center portion of the floor, the corners of the floor, and around the toilet. The shower floor had dark stains near the rear wall and thick dirt around the drain. The room floor had built up dirt in the corners of the door frame and corners of the floor. During an observation on 02/04/26 at 11:19 a.m. of room [ROOM NUMBER], reflected the bathroom floor had dark substances all over the center portion of the floor, the corners of the floor, and around the toilet. The shower floor had dark stains near the rear wall and thick dirt around the drain. The room floor had built up dirt in the corners of the door frame and corners of the floor. During an observation on 02/04/26 at 11:25 a.m. of room [ROOM NUMBER], reflected the bathroom floor had dark substances all over the center portion of the floor, the corners of the floor, and around the toilet.During an observation on 02/04/26 at 11:30 a.m. of room [ROOM NUMBER], reflected the bathroom floor had reddish substances along the edges of the wall, near the shower, behind the toilet, and under the sink. During an observation on 02/06/26 at 10:34 a.m. of the shower room on the 100-hall, reflected the shower floor had dark stains and thick dirt around the drain.During an observation on 02/06/26 at 10:36 a.m. of the shower room on the 100-hall, reflected the shower floor had dark stains and thick dirt around the drain. During an interview on 02/06/26 at 10:58 a.m., Housekeeping A stated she cleaned the 300 and 400 halls. She stated they were to clean everything in the room. She stated they wiped down the air conditioner units, and the bathrooms. She was shown pictures of the concerns observed by the surveyor in the resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11 and the shower rooms. She stated not cleaning the room thoroughly could result in the spread of bacteria. She stated a lot of the stains observed on the floors required something stronger to get the stains up. During an interview on 02/06/26 at 10:58 a.m., Housekeeping N stated she cleaned the 200 - hall, and she cleaned the shower rooms. She stated they are to clean everything in the room. She stated they wiped down the air conditioner units, and the bathrooms. She was shown pictures of the concerns observed by the surveyor in room [ROOM NUMBER], #11, and shower rooms and she stated she cleaned the bathrooms every day and there was an ant problem in the bathrooms. She stated she was not sure what the impact would be to the residents if their rooms were not thoroughly cleaned.During an interview on 02/06/26 at 11:20 a.m., the Housekeeping supervisor was informed and shown pictures of the concerns observed by the surveyor in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11 and the shower rooms, the shower rooms, and the dining room. She stated the housekeeping staff are trained to cleaned from the windows to the front door of the resident rooms, including bathing rooms. She stated the floor tech cleaned the shower rooms, and the dining room floors. She stated they deep cleaned the rooms daily and the floor machines were unable to clean the corners of the floor. She stated maintenance cleaned the vents of the air conditioner units. She stated not thoroughly cleaning the rooms could cause infections.During an interview on 02/06/26 at 11:36 a.m., the Administrator was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11 and the shower rooms. He stated he expected housekeeping to provide a clean environment for the residents. He stated this was the resident's home and it could also cause an infection. Review of the facility's policy on Safe/Comfortable/Homelike Environment, dated 01/2022, revealed, Resident are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics includes cleanliness and order.

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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 observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for six (Residents #16, #26, #59, #85, #107, and #72) of sixteen residents reviewed for respiratory care.1. The facility failed to ensure Resident #16 's nasal cannula was stored properly when not in use on 02/04/2026.2. The facility failed to ensure Resident #26's breathing mask was properly stored when not in use on 02/04/2026. 3. The facility failed to ensure Resident #59's breathing mask was properly stored when not in use on 02/04/2026. 4. The facility failed to ensure Resident #85 's nasal cannula was stored properly when not in use on 02/04/2026.5. The facility failed to ensure Resident #107's nasal cannula was stored properly when not in use on 02/04/2026.6. The facility failed to ensure Resident #72's breathing mask was stored properly when not in use on 02/04/2026.These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: 1. Record review of Resident #16's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive lung disease and respiratory failure (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #16's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 01/14/2026, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 15. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #16's Comprehensive Care Plan, dated 12/02/2025, reflected the resident had oxygen therapy and one of the interventions was O2 at 2 - 5 l/min via nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs).Record review of Resident #16's Physician Order, dated 01/07/2026, reflected Apply oxygen via NC at 3-5 LPM continuous to keep saturation at or above 90% every shift.During an observation and interview on 02/04/2026 at 9:16 AM, revealed Resident #16 was in her bed, awake. It was also observed that a nasal cannula was hanging on the resident's wheelchair and was not bagged. it was also observed that there was no bag at the back of the wheelchair. The resident said she would use the nasal cannula on her wheelchair every time she would go out of her room. She said a staff would be assisting her with her transfer to her wheelchair. She said the staff assisting would be the one replacing her oxygen with the one on her wheelchair and also would take it off when she transferred to her bed. She said she did not see a bag at the back of her wheelchair.2. Record review of Resident #26's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #26's Comprehensive MDS Assessment, dated 01/23/2026, reflected the resident had moderate impairment (resident may need additional support and monitoring) with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #26's Comprehensive Care Plan, dated 02/04/2026, reflected the resident required respiratory therapy as needed and one of the interventions was to administer nebulization (method of delivering medication by converting liquid medication into an inhalable mist) as ordered.Record review of Resident #26's Physician Order, dated 11/14/2025, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 6 hours as needed for SOB or Wheezing via nebulizer (machine used for breathing treatment).An observation on 02/04/2026 at 9:09 AM, revealed Resident #26 was not inside the room. It was observed that a breathing mask (used to receive medications by breathing in mist through nose and mouth) was on top of the resident's shelf. The breathing mask was not bagged.3. Record review of Resident #59's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male who was admitted to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #59's Comprehensive MDS Assessment, dated 11/03/2025, reflected the resident had severe impairment (resident required significant assistance and support in daily life) with a BIMS score of 01. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #59's Comprehensive Care Plan, dated 02/03/2026, reflected the resident had altered respiratory status and one of the interventions was administer nebulization as ordered.Record review of Resident #59's Physician Order, dated 14/17/2025, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally three times a day for SOB/ wheezing.An observation on 02/04/2026 at 9:11 AM, revealed Resident #59 was not inside the room. It was observed that a breathing mask was on the resident's chair. The breathing mask was not bagged.4. Record review of Resident #85's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with asthma (lung disorder caused by narrowing of the airways). Record review of Resident #85's Comprehensive MDS Assessment, dated 11/26/2025, reflected the resident had severe impairment with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident had asthma. Record review of Resident #85's Comprehensive Care Plan, dated 12/02/2025, reflected the resident had oxygen therapy and one of the interventions was O2 at 2 - 4 l/min via nasal cannula.Record review of Resident #85's Physician Order, dated 01/20/2026, reflected Oxygen 2-4 LPM via nasal cannula to keep SpO2 (percentage of the blood that had oxygen) greater than 90% as needed.An observation on 02/04/2026 at 9:13 AM, revealed that Resident #85 was not inside his room. It was observed that a nasal cannula was attached to an oxygen concentrator, the nasal cannula was on the floor and was not bagged.5. Record review of Resident #107's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease and respiratory failure.Record review of Resident #107's Comprehensive MDS Assessment, dated 01/16/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had chronic obstructive pulmonary disease and respiratory failure. Record review of Resident #107's Comprehensive Care Plan, dated 01/18/2026, reflected the resident had COPD and one of the interventions was to give oxygen therapy as ordered. Record review of Resident #107's Physician Order, dated 06/14/2025, reflected Oxygen 2-4 LPM via nasal cannula to keep SpO2 greater than 90% as needed.During an observation and interview on 02/04/2026 at 9:15 AM, revealed Resident #107 was in her bed, awake. It was observed that an oxygen concentrator was at the bedside with a nasal cannula attached to it. The prongs of the nasal cannula was on the floor. She said she would only use it when she needed it. She said nobody checked on her nasal cannula.6. Record review of Resident #72's face sheet, dated 02/04/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with COPD (lung condition that makes it difficult to breathe).Record review of Resident #72's Quarterly MDS Assessment, dated 11/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident received oxygen therapy. Record review of Resident #72's Comprehensive Care Plan, dated 12/29/2025, reflected the resident had COPD. An intervention was to provide breathing treatments as ordered and monitor for effectiveness. Record review of Resident #72's Physician's Order, dated 11/10/2025, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 unit inhale orally two times a day for shortness of breath.During an observation and interview on 02/04/2026 at 9:21 AM, Resident #72 was sitting in a wheelchair in her room. Her nebulizer mask was on the nightstand unbagged. Resident #27 stated she used it every day but had not noticed it in a bag. During an observation and interview on 02/04/2026 at 9:23 AM, LVN F stated the nasal cannula and the breathing masks should be in a bag if the resident was not using them to prevent any respiratory infections. He went inside Resident #26's room and saw the breathing mask on the shelf. He said his breathing treatment was on an as needed basis so the breathing mask (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be bagged. He said he did not notice Resident #26's breathing mask on the resident's shelf. He took the breathing mask and threw it away and said he will just get a new one when Resident #26 would need the breathing treatment. He then went to Resident #59's room and saw the breathing mask on the chair. He said he did not know why the breathing mask was on the chair. He took the breathing mask and threw it away and said he would get a new one because the staff would administer Resident #59's breathing treatment three times a week. He said Residents #85 and Resident #107's oxygen was as needed so their nasal cannula should be bagged. He went to Resident #16's room and saw HK I putting Resident #16's nasal cannula in a bag. He said, maybe she was going around to check if the nasal cannula and the breathing masks was bagged. He said before they were placed inside the bags, they were already dirty and he did not know how long they had been in contact with the shelf, chair, wheelchair, and the floor. He said since he was the charge nurse, then he was responsible in making sure that breathing masks and the nasal cannula was bagged.In an interview on 02/04/2026 at 9:27 AM, HK I stated she checked the rooms of the residents in hall 400 and saw some nasal cannulas that was not bagged. She said she put them in the bags because they should not be exposed. She then said she would tell the nurse to change the nasal cannula that she saw not bagged because they were already dirty. She said the breathing masks and the nasal cannula had already been in contact with something dirty and might cause other respiratory issues.During an observation and interview on 02/04/2026 at 11:02 AM, MDS Nurse H was sitting at a table on Resident #72's hall with her laptop open. She entered Resident #72's room with the surveyor. The nebulizer mask was on the nightstand unbagged. MDS Nurse H stated the nebulizer mask should have been bagged. She stated she would get a new mask and place it in a bag. She stated the Resident #27 had breathing treatments twice a day. She stated it was important to keep the nebulizer mask bagged for infection control purposes. During an interview on 02/05/2026 at 12:18 PM, ADON B stated Resident #72's nebulizer mask should have been bagged when not in use for infection control. He stated the expectation was for all oxygen tubing and nebulizer masks to be bagged when the resident was not using them. During an interview on 02/05/2026 at 12:50 PM, the DON stated Resident #72's nebulizer mask should have been in a bag. She stated when rounding, she reminded residents to call before taking off a mask or oxygen. She stated if a nurse puts on a nebulizer mask for a breathing treatment, the nurse should go back and place the mask in a bag. She stated aides and nurses should notice when rounding if respiratory was bagged. She stated she had provided education to staff. If it's not in a bag, get new tubing or a breathing mask, and place it in a bag. She stated staff also educate residents, when appropriate, to tell staff before removing respiratory items. She stated it was important for infection control. In an interview on 02/06/2026 at 8:11 AM, the DON stated the nasal cannula and the breathing mask should be bagged when not in use to primarily prevent cross contamination and development of infection. She said she had been preaching about this issue and there was still unbagged nasal cannulas and breathing masks observed. She said the expectation was for the staff to scan the rooms of the residents to check the nasal cannulas and the breathing masks. If the order was as needed then the nasal cannula and the breathing masks should be bagged or the staff disconnect them and just get a new one when needed. She said she already started an education pertaining to the issue.In an interview on 02/06/2026 at 8:47 AM, ADON B stated the breathing masks and the nasal cannulas should be stored properly inside a plastic bag if the residents were not using them to prevent cross contamination and respiratory infections. He said the staff was responsible in monitoring if the breathing mask and the nasal cannula was bagged. He said the expectation was for the staff to be mindful and bag the breathing masks and the nasal cannula. He said if the order was PRN, they should be bagged until the residents needed to use them. If the order for the breathing treatment was to administer daily, then the staff should bag them after the treatment was done. If the resident had oxygen on the wheelchair, then the nasal cannula should be bagged. He said the DON already started an in-service about bagging the nasal cannulas and the breathing masks.In an interview on 02/06/2026 at 9:17 AM, the Administrator stated they were vigilant in reminding the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to bag the respiratory paraphernalia that the residents were using. He said the nasal cannulas and the breathing masks should be inside a plastic bag when the resident was not using them to prevent respiratory infections. He said the expectation was for the staff to be mindful that when they do their rounds, they should also check if the nasal cannula and the breathing masks was bagged. He said the DON already started an in-service pertaining to bagging the nasal cannula and the breathing masks. Record review of the facility's policy Oxygen Equipment Policy/Procedure - Nursing Clinical revised May 2017 reflected POLICY: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner . PROCEDURES . 1. Oxygen Tanks, Connectors and Concentrators . E. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms . 2. Nebulizer Equipment Procedures . F. Store, clean, and dry until next use.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medication errors for one (Resident #51) of six residents reviewed for significant medication errors.The facility failed to ensure Resident #51's propranolol (blood pressure medication) was administered as ordered on 02/05/2026.This failure could place residents at risk for not receiving the therapeutic effect of their medications as ordered by the physician. Findings included:Review of Resident #51's Face sheet, dated 02/05/2026, reflected a [AGE] year-old female who admitted on [DATE]. She was diagnosed with hypertension (elevated blood pressure). Resident #51 was on hospice care services. Record review of Resident #51's MDS Assessment, dated 01/06/2026, reflected severe cognitive impairment with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had hypertension.Record review of Resident #51's Comprehensive Care Plan, dated 01/19/2026, reflected the resident had hypertension and one of the interventions was to administer anti-hypertensive medication as ordered. Review of Resident #51's Physician's Order, dated 12/31/2025, reflected to administer Propranolol 20 mg by mouth two times a day for hypertension. Review of Resident #51's medication administration record revealed she did not receive the morning dose of Propranolol on 02/05/2026.During an observation and interview on 02/05/2026 at 8:37 AM, MA G stated she did not see Resident #51's Propranolol in the medication cart. She stated she would check the emergency kit. MA G returned to her medication cart and stated the medication was not in the emergency kit. MA G stated she spoke with ADON A who was going to call the hospice nurse about the medication. During an interview on 02/05/2026 at 12:38 PM, ADON A stated she called hospice and was told the medication would be delivered that afternoon. She stated staff should order medication 3 or 4 days prior to running out of medication. She stated it was important to ensure medications were re-ordered on time so residents did not miss a dose.During an interview on 02/05/2026 at 12:50 PM, the DON stated staff should reorder medication before the last pill was given. She stated she would follow up with staff regarding the medication. She stated there had not been any issues with residents running out of a medication. She stated it was important to ensure residents received medication as ordered. Record review of the facility's policy Medication Administration, revised 08/31/2023, reflected It is the policy of this facility that medication shall be administered as prescribed by the attending physician.Medications are reordered when supplies are needed or supply has been exhausted. Medications will be available using the resident's supply in cart of if needed, through the emergency medication supply in the facility.

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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 store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for ten (Resident #10, #18, #21, #31, #53, #73, #98, #102, #103, and #68) of twenty-eight residents reviewed for medication storage. 1. The facility failed to ensure Resident #10 did not have an anti-fungal cream on top of her bedside table on 02/04/2026.2. The facility failed to ensure Resident #102's zinc oxide was not left inside the resident's room on 02/04/2026.3. The facility failed to ensure Resident #103's zinc oxide was not left inside the resident's room on 02/04/2026.4. The facility failed to ensure Resident #21 did not have containers of zinc oxide on the resident's shelf on 02/04/2026.5. The facility failed to ensure Resident #73's zinc oxide was not left inside the resident's room on 02/04/2026.6. The facility failed to ensure Resident #18 did not have a bottle of nasal spray on top of her overbed table on 02/04/2026.7. The facility failed to ensure Resident #31's insulin pen was not left on top of the cart unattended on 02/04/2026.8. The facility failed to ensure RN D did not leave a container of wound cleanser and skin barrier on top of her cart unattended on 02/05/2026,9. The facility failed to ensure Resident #103's liquid Lorazepam, with instruction Refrigerate, was not stored inside the cart's lock box on 02/06/2026. 10. The facility failed to ensure Resident #53's insulin had date when it was opened to determine if it was past its shelf life on 02/06/2026.11. The facility failed to ensure Resident #98?s insulin had a date when it was opened to determine if it was past its shelf life on 02/06/2026.12. The facility failed to ensure Resident #103?s insulin had a date when it was opened to determine if it was past its shelf life on 02/06/2026. 13. The facility failed to ensure a bottle of over-the-counter peroxide was not in Resident #68's room on 02/04/2026.These failures could place residents at risk of not receiving the full benefit of the medications, misuse of medications that could lead to adverse reactions or overdose.Findings include: 1. Record review of Resident #10's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia and diabetes mellitus (high blood sugar).Record review of Resident #10's Comprehensive MDS Assessment, dated 12/19/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had dementia and diabetes mellitus. Record review of Resident #10's Comprehensive Care Plan, dated 12/20/2025, reflected the resident had an impaired cognitive function and thought process, and diabetes mellitus and the interventions for both were to administer medications as ordered.Record review of Resident #10's Physician Order on 02/04/2026 reflected that the resident did not have an order for anti-fungi cream.An observation on 02/04/2026 at 9:20 AM, revealed Resident #10 was not inside her room. It was observed that a tube of antifungal cream was on top of her side table.2. Record review of Resident #102's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia and muscle weakness.Record review of Resident #102's Comprehensive MDS Assessment, dated 12/02/2025, reflected the resident had severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated the resident was frequently incontinent for bladder and bowel. Record review of Resident #102's Comprehensive Care Plan, dated 12/01/2025, reflected the resident had an impaired cognitive function and thought process and one of the interventions was to administer dementia medications. The plan also indicated that the resident had bladder and bowel incontinence and one of the goals was the resident would be free from skin breakdown.During an observation and interview on 02/04/2026 at 9:06 AM, revealed Resident #102 was in her bed, awake. It was observed that there were a tube and a sachet of zinc oxide (medicated cream used to prevent skin irritation) on top of her side (continued on next page)

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	676029	A. Building B. Wing	02/06/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	table.During an observation and interview on 02/04/2026 at 9:23 AM, LVN F stated zinc oxide was a form of medication applied topically to prevent any skin issues. He said it should not be inside the room because confused residents might consume it. He said the cream should be stored in the cart and just put some in a cup for use. He said the cup should be disposed after use. He said the anti-fungal cream should not be also inside the room of the resident for the same reason. He went inside Residents #10 and #102's room and took the zinc oxide and the anti-fungal. He said he did not know why the medications were inside the rooms.3. Record review of Resident #103's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obesity and delusional disorder.Record review of Resident #103's Comprehensive MDS Assessment, dated 01/06/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel.Record review of Resident #103's Comprehensive Care Plan, dated 01/13/2026, reflected the resident had an impaired cognitive function and thought process and one of the interventions was to administer medication for delusional disorder. The plan also indicated that the resident had bladder and bowel incontinence and one of the goals was the resident would be free from skin breakdown.During an observation and interview on 02/04/2026 at 11:26 AM, revealed Resident #103 was in his bed, awake. It was observed that two cups with white cream were on top of the resident's side table. The resident said the staff used them whenever they changed his brief. He said he did not know how long the cups of cream were in his side table and who left them there. He said the cream looked like toothpaste.During an observation and interview on 02/04/2026 at 11:38 AM, CNA J stated she saw the cups of white cream when she did her morning rounds but it did not occur to her that the cream should not be there. She said she should have thrown it away because residents could eat them. She said the white cream would be barrier creams and most probably it would be the nurse that left them. She picked up the cups of cream and threw them away. She then went to LVN F.In an interview on 02/05/2026 at 11:40 AM, LVN F stated he did not leave the cups of barrier creams inside Resident #103's room. He said it might be the night nurse.4. Record review of Resident #21's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness.Record review of Resident #21's Comprehensive MDS Assessment, dated 11/07/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident was always incontinent for bladder and bowel. Record review of Resident #21's Comprehensive Care Plan, dated 12/04/2025, reflected the resident had bladder and bowel incontinence and one of the goal was the resident would be free from skin breakdown.During an observation and interview on 02/04/2026 at 9:43 AM, revealed Resident #21 was not inside her room. It was observed that two containers of zinc oxide were on the resident's shelf. 5. Record review of Resident #73's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with dementia and muscle weakness.Record review of Resident #73's Comprehensive MDS Assessment, dated 01/08/2026, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had dementia and muscle weakness. Record review of Resident #73's Comprehensive Care Plan, dated 07/30/2025, reflected the resident was at risk for impaired cognitive function and thought process and one of the interventions was to provide with necessary cues. The plan also indicated that the resident was dependent on staff related to disease process and one of the interventions was to assist with ADLs.During an observation and interview on 02/04/2026 at 9:43 AM, revealed Resident #73 was in his bed, awake. It was observed that a cup of white cream was on top of the resident overbed table. When asked what the cream was for, the resident did not reply.In an interview on 02/04/2026 at 9:52 AM, CNA L stated the cream in the cup was a skin barrier. She said it should not be left inside the rooms of the residents, especially on the table where they eat, because the resident might mistake it as sauce or dips and eat them. She said she did not know who left the cup with barrier (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cream on the resident's overbed table. She went inside Resident #73's room and said she would throw it away. She said she would also ask the nurse where to put Resident #21's skin barrier.6. Record review of Resident #18's Face Sheet, dated 02/04/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with cerebral infarction (blockage in the blood vessels of the brain) and cognitive communication deficit (impaired ability to communicate).Record review of Resident #18's Comprehensive MDS Assessment, dated 12/02/2025, reflected the resident had severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated the resident had cerebral infarction and cognitive communication deficit.Record review of Resident #18's Comprehensive Care Plan, dated 12/02/2025, reflected the resident had history of cerebral vascular accident (blood supply to the brain was interrupted) and one of the interventions was to administer medications as ordered.Record review of Resident #18's Physician Order on 02/04/2026 reflected that the resident did not have an order for a nasal spray.An observation on 02/04/2026 at 9:37 AM, revealed Resident #18 was not inside the room. It was observed that a container of nasal spray was on top of the resident's overbed table.7. Record review of Resident #31's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus.Record review of Resident #31's Comprehensive MDS Assessment, dated 12/30/2026, reflected the resident had severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #31's Comprehensive Care Plan, dated 01/28/2026, reflected had diabetes and one of the interventions was to administer medications as ordered. Record review of Resident #31's Physician Order, dated 10/22/2025, reflected Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 43 unit subcutaneously (administer under the skin) two times a day for DM.An observation on 02/04/2026 at 9:35 AM, revealed an insulin pen was on top of a cart unattended. The insulin pen was under a laptop but could still be seen from the hallway.During an observation and interview on 02/04/2026 at 9:40 AM, RN C stated she answered a call light that was why she stepped away from her cart. She said she should have secured the insulin pen before answering a call light because a resident might get hold of it and use. She said the resident might be allergic to it or misuse the insulin pen. She took the insulin pen and put it inside her cart. She said medications should be inside the residents' room for their safety. She said residents might misuse the medication or they might be overdosed if they were the one giving the medications to themselves. She went inside Resident #18's room and saw the nasal spray. She said she did not notice the nasal spray when she checked on the resident. She said she would wait for the resident to come back to her room so she could talk to her and explain why there should be no medications inside the room. She logged on to her computer and said there was no for the nasal spray. She said she would request for an order as soon as she assessed that the resident needed it. She said if the nasal spray would remain then the nasal should be in the cart and the staff should be one administering the nasal spray. 8. Observation on 02/05/2026 at 8:33 AM, revealed a bottle of wound cleanser and barrier cream was on top of an unattended cart parked in the hallway of the wander unit. It was observed that several residents were walking down the hallway.In an interview on 02/05/2026 at 11:45 AM, RN D stated the resident should have no access to the wound cleanser and barriers creams because the residents might take them and consume them. She said she should have placed the wound cleanser and the barrier cream inside the cart before leaving her cart. She said she would put the wound cleanser and barrier cream inside the cart.In an interview on 02/06/2026 at 8:11 AM, the DON stated zinc oxide, anti-fungal cream and nasal spray should not be left inside the residents' rooms to prevent accidental ingestion. She said if the medications were left at bedside, there was a possibility that other residents might get hold of the medications and consume them. She said the insulin pen, wound cleanser, and barrier creams should not be left on top of the carts unattended for the same reason. She said the expectations were for the staff to always scan the residents' rooms to make sure there were no medications inside the residents' room, they were not (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leaving zinc oxide inside the room, and they were not leaving any medications on top of the carts. She said she already started an in-service about no medications inside the rooms of the residents and not leaving any medication on top of the cart unattended. She said they would also educate the family members about the medications that they were bringing to the facilityIn an interview on 02/06/2026 at 8:47 AM, ADON B stated zinc oxide was a form of medicated cream and should not be left inside the resident's room because confused resident might consume it and might cause allergic or adverse reactions. He said an anti-fungal cream should not be also inside the resident's room for the same reason. He said wound cleansers and skin barriers should not be left on top of the cart, specially inside the wander unit, because residents might get and hide them, and them use them, eat, the, or drink them. He said the DON started an in-service about the issue.In an interview on 02/06/2026 at 8:54 AM, ADON A stated the insulin pen should have been secured first before the staff answered the call light. She said resident might get hold of it and misuse it. She said there should be no nasal spray inside the resident's room because the staff should be the one administering it. She said the resident might be using it every hour and nobody would know. She said they would also educate the family that if they were bringing any medication, they should give it to the staff first and the staff would be the one administering them.In an interview on 02/06/2026 at 9:17 AM, the Administrator stated the expectation was for the staff to be mindful not to leave zinc oxides inside the residents' rooms or on top of the carts to prevent accidental consumption. He said he was not a clinician and would let the DON take a lead about the issue.9. Record review of Resident #103's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with anxiety disorder (intense or excessive fear or worry).Record review of Resident #103's Comprehensive MDS Assessment, dated 01/06/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had anxiety and was taking anti-anxiety medication.Record review of Resident #103's Comprehensive Care Plan, dated 01/13/2026, reflected the resident had anxiety and one of the interventions was to give anti-anxiety medications.Record review of Resident #103's Physician Order, dated 01/05/2026, reflected Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Anxiety Agitation AND Give 0.5 ml by mouth every 2 hours as needed for Anxiety AND Give 0.75 ml by mouth every 2 hours as needed for Anxiety AND Give 1 ml by mouth every 2 hours as needed for Anxiety.10. Record review of Resident #53's Face Sheet, dated 02/06/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar).Record review of Resident #53's Comprehensive MDS Assessment, dated 01/28/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin.Record review of Resident #53's Comprehensive Care Plan, dated 11/27/2025, reflected the resident had diabetes mellitus and one of the interventions was to give medications as ordered.Record review of Resident #53's Physician's Order, dated 01/22/2026, reflected Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 52 unit subcutaneously at bedtime for Hyperglycemia (too much sugar in the blood).Record review of Resident #53's Physician's Order, dated 01/22/2026, reflected (Insulin Glargine) Inject 52 unit subcutaneously one time a day for DM related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE.11. Record review of Resident #98's Face Sheet, dated 02/06/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus.Record review of Resident #98's Comprehensive MDS Assessment, dated 12/31/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin.Record review of Resident #98's Comprehensive Care Plan, dated 11/22/2025, reflected the resident had diabetes mellitus and one of the interventions was to give medications as ordered.Record review of Resident #98's Physician's Order, dated 03/03/2025, reflected Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inject 15 unit subcutaneously with meals for DM Hold for BS less than 150.12. Record review of Resident #103's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus.Record review of Resident #103's Comprehensive MDS Assessment, dated 01/06/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin.Record review of Resident #103's Comprehensive Care Plan, dated 01/13/2026, reflected the resident had diabetes mellitus and one of the interventions was to give medications as ordered.Record review of Resident #103's Physician's Order, dated 01/01/2026, reflected Humulin R 100 UNIT/ML Solution Inject as per sliding scale: if 151 - 200 = 2; 201 -250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401+ = 12 notify hospice, subcutaneously four times a day for DM related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA.An observation on 02/06/2026 at 10:52 AM revealed that there were three insulins inside the cart that did not have a date to when they were opened. It was also observed that a liquid lorazepam was stored inside the locked box of the cart.During an observation and interview on 02/06/2026 at 11:02 AM, RN D looked at the boxes of the insulins for the dates and said there were no dates. She took the bottles one by one and said there were no dates also on the bottles of the insulins. She said the insulins should have dates on when they were opened because most of the insulins had a shelf life twenty-eight day. She said after twenty-eight days, the insulin should be discarded because they become less effective. She said since there were no dates, the insulins would be presumed less effective. She said Lorazepam's should be stored inside the refrigerator and not inside the cart. She said they would only get the lorazepam when they are about to use it. She said the Lorazepam was already in the cart when counted the narcotics at around 6:00 AM. She said the lorazepam was a PRN and did not know when was the last time it was used. She read the instruction at the back of the bottle of the lorazepam and said the instruction said to refrigerate. She segregated the insulins and said would get new ones. She said she would also put the lorazepam inside the refrigerator.During an observation and interview on 02/06/2026 at 11:06 AM, ADON A stated the insulins should have a date when they were opened because insulins lose its effectiveness once exposed to air rendering them ineffective. She said, once opened, insulins were usually used only for twenty-eight days. She said since the insulins were not dated, then the staff would not know if they needed to dispose them or not. She said they would also audit the cart to check if the insulins had opened date on them. She said the liquid lorazepam should be stored inside the refrigerator inside the medication room and not inside the locked box of the carts. She said the lorazepam might lose its effectiveness as well. She said they include in their in-service about the insulins and the lorazepam.In an interview on 02/06/2026 at 11:15 AM, the DON stated she was made aware about the undated insulin and the lorazepam inside the locked cart. She said insulins should be dated to know when to dispose them. She said the liquid lorazepam should not be stored in the locked box and should be in the refrigerator. She said the staff should only get the lorazepam when they administer it and then put it back after administering it. She said the effectiveness of the lorazepam would be compromised. She said the expectation was that the staff would put dates on the insulin and store the lorazepam inside the refrigerator. She said she would add about the dating the insulins and storing lorazepam in their inservice.In an interview on 02/06/2026 at 12:45 PM, the Administrator stated he was not a clinician and would let the DON take the lead about the issues about the medications. 13. Record review of Resident #68's face sheet, dated 02/04/2026, reflected an [AGE] year-old female who admitted to the facility on [DATE]. She was diagnosed with dementia. Record review of Resident #68's Quarterly MDS Assessment, dated 11/03/2025, indicated severe cognitive impairment with a BIMS score of 7. She required assistance with showers. Record review of Resident #68's Comprehensive Care Plan, dated 02/03/2026, reflected she was at risk for impaired cognitive function or impaired thought processes related to dementia. An intervention was to provide supervision/assistance with all decision making, with assistance from family. Record Review of Resident #68's Physician's Orders revealed there was no (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order to use peroxide. During an observation and interview on 02/04/2026 at 10:38 AM, Resident #68 was lying on her bed. There was a bottle of peroxide on her bedside table. Resident #68 stated it had been there a while but she did not know why. She stated she did not remember if she had ever used it. During an observation and interview on 02/04/2026 at 10:53 AM, MDS Nurse H was sitting at a table in the hall. She stated she was unsure why resident had peroxide on her bedside table. She picked up the bottom of peroxide and stated she would put it in the medication cart. She stated she if had seen it earlier, she would have removed it. She stated the resident did not have an order for it. She stated families bring in items and do not think to ask staff. She stated they would need to educate the family. She stated the resident was confused. She stated they do not want anything at the bedside that could be harmful. During an interview on 02/05/2026 at 12:18 PM, ADON B stated peroxide should not be left in Resident #68's room or any other residents' rooms. He stated it was a medication. He stated aides and nurse should be observant when rounding to ensure items like that were not left in a resident's room. He stated the family would be notified the resident could not have peroxide in her room. He stated staff members were expected to monitor to ensure family members had not brought something residents should not have in their room. He stated a confused resident might think it's juice in a bottle and drink it. During an interview on 02/05/2026 at 12:50 PM, the DON stated Resident #68 should not have peroxide in her room. She stated staff removed it and called the family. She stated they left a message but had not received a return call. She stated they will be reminded about what not to bring. She stated staff was educated that if they saw something that should not be in a resident's room to remove it and tell the nurse. She stated some of their residents had dementia and may accidentally swallow it.Record review of the facility's policy, Medication Access and Storage/Drug Destruction Policy/Procedure - Nursing Clinical revised July 2023 reflected POLICY: It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . PROCEDURES . Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications . Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring.Record review of the facility's policy, Medication Labeling and Storage 2001 MED-PASS, Inc. revised February 2023 reflected Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls . Policy Interpretation and Implementation . Medication Storage . 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Record review of the facility's policy, Physician Orders Policy/Procedure - Nursing Clinical revised July 2022 reflected POLICY: It is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs . PROCEDURES: 1. No drugs or biologicals shall be administered except upon the order of a person lawfullyauthorized to prescribe for and treat human illnesses.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's for one of one kitchen reviewed for food and nutrition services. The Dietary Manager failed to wear a beard cover in the kitchen while prepared food was present.The facility failed to ensure dietary staff properly labeled and dated stored food received by vendors.The facility failed to ensure stored food in the freezer was concealed from air-borne contaminants.The facility failed to ensure the tea dispenser was covered. The facility failed to ensure the following were thoroughly cleaned and/or sanitized: ice machine and ice scoop in the kitchen, sugar and flour bins, the serving table, serving table had a sanitizer container (red bucket) for sanitization, the dining room ice dispenser, the dining room counter and sink, and the ice chest on the 300-hall.These failures could place residents at risk of exposure to food contamination and illness. Findings included:Observations on 02/04/26 from 9:06 a.m. to 9:12 a.m. in the facility's only kitchen revealed: The Dietary Manager was observed walking around the kitchen area, near prepared and uncovered food with no beard cover. The DM3's beard was approximately a quarter of an inch in length. One freezer bag of frozen chicken nuggets, located in the freezer, was not labeled with the date stored. Two large white storage bins, located in the dry storage area, containing sugar and flour had brownish stains along the outside and inside of the bins. Packages of hamburger buns and croissants, located in the walk-in cooler, were not labeled with the date stored. Four packages of deli meat, located in the walk-in cooler, were not dated with the month, day, and year it was stored upon receipt from the vendor. Two packages of grilled mixed vegetables, located in the freezer, were not dated with the month, day, and year it was stored upon receipt from the vendor. Two packages of sliced zucchini squash, located in the freezer, were not dated with the month, day, and year it was stored upon receipt from the vendor. One large package of tater tots, located in the freezer, were not dated with the month, day, and year it was stored upon receipt from the vendor. The package also had a 1 inch in diameter sized hole, exposing the food to air-borne contaminants. Thirteen large pitchers of tea and juices, located in the walk-in cooler, were uncovered and exposed to air-borne contaminants. One large tea dispenser, located in the kitchen area, had tea in it, but it did not have a lid placed on the top of the dispenser to avoid air-borne contaminants. An ice machine, located in the kitchen had stains along the inside panel wall of the ice machine. The ice machine scoop holder, hanging on the wall, had brown dirt particles on the inside bottom of the holder. Three large steam trays on the serving table had brownish stains along the walls of the units and water inside of them had light brownish particles floating in it. The ice dispenser in the dining area had thick white substances all over the outside of the unit and the tray area had thick black dirt along the bottom of it. The bottom legs had a thick rust-like substance. The dining room counter and sink had brownish stains and white substances on and around the faucet area. During an interview and observation on 02/04/26 at 09:05 a.m., the Dietary Manager was observed walking around the kitchen area, while food was prepared and he did not have a beard cover. The DM3 had a beard that was at least a quarter of an inch in length. The DM3 stated no food was being prepared in the kitchen area; however, there were at least two large pans of cake near him, a large tea dispenser uncovered, and large pitchers of juices within his vicinity. The DM3 was shown the large tea dispenser, filled with tea, uncovered. He stated his team prepared the tea at about 7:00 a.m He stated it was his responsibility to ensure the items had the stored date when received from the venders. He states the bag of tater tots needed to be properly sealed to avoid contamination. The DM3 stated the storage bins and the serving table were cleaned weekly. He stated it was his responsibility to ensure they were cleaned. The DM3 was shown the inside of the ice scoop holder and the insides of the ice machine and he stated the items were cleaned once a week. He stated he and his team were responsible for cleaning the drink counter area and Housekeeping was responsible for cleaning the (continued on next page)

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	676029	A. Building B. Wing	02/06/2026

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor. He stated not addressing these areas could result in food contamination.During an observation on 02/04/26 at 10:50 a.m., an ice chest, located on the 300-hall, had light brownish stains all over the lower portion of the chest, which contained ice. During an interview and observation on 02/04/26 at 11:01 a.m., the DM3 was shown the inside of the ice chest located on the 300-hall. He stated he and his team sprayed out the ice chest daily before filling it with ice. He stated ice could not have germs, so the dirty ice chest did not have a negative impact on residents. The DM3 took the ice chest and brought it back clean and the stains were gone. During an interview and observation on 02/05/26 at 11:30 a.m., the [NAME] was plating residents' lunch at the serving table. There was no sanitizer container (red bucket) observed to clean and sanitize the table. The DM stated the red bucket with sanitizing fluid to keep the table clean and sanitized while serving the resident's food. During an interview on 02/06/26 at 11:36 a.m., the Administrator was shown pictures of the concerns observed by the surveyor in the kitchen and dining area. He stated they should be labeling and dating the food properly, following kitchen sanitation, and keeping food safe. He stated the concerns observed could cause health complications to the residents. He stated this was the resident's home and it could also cause an infection.Record Review of the Facility's policy titled Dietary Services, dated 10/2007, revealed, It is the policy of this facility that the food services shall be maintained in a clean and sanitary manner. All kitchen, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. Ice, which is used in connection with food and drinks, shall be from a sanitary source and shall be handled and dispersed in a sanitary manner. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD Texas Chapter 228 Retail Food adopts the U.S FDA Food Code. 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. 3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepare.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three (Residents #10, #150 and #60) of fifteen residents reviewed for infection control. 1. The facility failed to ensure CNA K wore a gown while changing Resident #10's linen, who was on enhanced barrier precautions due to having a g-tube, on 02/03/2026. 2. The facility failed to ensure RN E wore a gown when disconnecting Resident #150's antibiotic via PICC line, who was on enhanced barrier protection, on 02/05/2026.3. The facility failed to ensure MA G removed her gloves and performed hand hygiene between checking Resident #60's blood pressure and using the laptop on her medication cart on 02/04/2026. These failures could place residents at risk of cross-contamination and development and spread of infections.Findings include:1. Record review of Resident #10's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing).Record review of Resident #10's Comprehensive MDS Assessment, dated 12/19/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. Record review of Resident #10's Comprehensive Care Plan, dated 12/20/2025, reflected the resident had a peg tube (procedure to place a feeding tube in the stomach), (a flexible feeding tube inserted directly to the stomach) and one of the interventions was to check patency and g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) placement.Record review of Resident #10's Physician Order, dated 09/28/2025, reflected Enteral Feed Order every shift FLUSH G-TUBE WITH 30-50 ML OF WATER.Record review of Resident #10's Physician Order, dated 01/21/2026, reflected Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: Implanted feeding device every shift.An observation on 02/04/2026 at 10:41 AM, revealed CNA K was inside Resident #10's room and was changing the resident's beddings. She was not wearing a gown when she changed the linens. The resident had a g-tube and there was a sign outside the resident's door indicating that the resident was on EBP and a gown was required when changing the linens.In an interview on 02/04/2026 at 10:48 AM CNA K stated she was not aware she still needed to wear a gown when she was changing Resident #10's linen even though the resident was not in her bed. Then she said, Come to think of it, the resident still had a g-tube and something from the g-tube might leak to the linens and into the bed. She said she should still wear a gown because when she was changing the linens, she would lean over the mattress of the resident. She said the gown was to prevent cross contamination.2. Record review of Resident #150's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection).Record review of Resident #150's Comprehensive MDS Assessment, dated 02/06/2026, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had pneumonia.Record review of Resident #150's Comprehensive Care Plan, dated 02/02/2026, reflected that the resident had pneumonia and one of the interventions was to administer medications as ordered.Record review of Resident #150's Physician Order, dated 02/02/2026, reflected Meropenem Intravenous Solution Reconstituted 1 GM (Meropenem) Use 1 gram intravenously (administering fluids or medications directly into a vein) every 8 hours for PNA for 3 Days.Record review of Resident #150's Physician Order, dated 02/03/2026, reflected PICC (tubing inserted into a vein for long-term intravenous therapy) LINE FLUSHING: FLUSH WITH 10 CC 0.9 % NS IV SOLUTION BEFORE EACH MEDS ADMINISTRATION. FLUSH WITH 10 CC 0.9 % NS IV SOLUTION AND 5 CC HEPARIN LOCK FLUSH SOLUTION AFTER EACH MEDS ADMINISTRATION.An observation on 02/05/2026 at 8:15 AM, revealed RN E was about to disconnect Resident #150's IV via her PICC (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	line. She went inside the room, washed her hands, put on a pair of gloves, and started to disconnect the resident's IV. After she disconnected the IV, she flushed the PICC line. She did not wear a gown while disconnecting the IV and while flushing the PICC line. There was a sign outside the resident's door indicating that the resident was on EBP and PPE was required during device care and use of the central line.In an interview on 02/05/2026 at 8:26 AM, RN E stated she knew she was supposed to wear a gown in disconnecting the IV to prevent spread of infection. She said she did not know why she forgot to wear a gown.In an interview on 02/06/2026 at 8:11 AM, the DON stated if a resident had a g-tube and was not in her bed, the staff did not need to wear a gown when changing the resident's linen. She said when connecting or disconnecting an IV, the staff should have worn a gown because residents with IVs was on EBP and PPE was required. She said the enhanced barrier precautions added an extra barrier of protection and was important to help prevent cross-contamination and infection. She said she already started an in-service about infection control.In an interview on 02/06/2026 at 8:47 AM, ADON B stated he was the infection preventionist of the facility. He said if a staff was changing the linens of a resident with a g-tube, the staff should still wear a gown even though the resident was not inside the room because there could be leaks from the g-tube that could adhere to bed that could have contact with the scrubs of the staff. He said every resident that was on EBP had a sign outside of their rooms to remind the staff that they needed to wear a gown and gloves every time they had contact with the resident. He said EBP was for residents on dialysis, with a catheter, wound, IV, g-tube and anything that required a dressing. He stated most of the residents were elderly and some were immunocompromised. He said EBP was implemented to protect the residents from cross contamination and probable infection. He said the DON already started an in-service about infection control and he would closely monitor the staffs' adherence to the policy of infection control.In an interview on 02/06/2026 at 9:17 AM, the Administrator stated he was not a clinician, but he knew that if there was an EBP sign outside the resident's room, then the staff should wear a gown in addition to the gloves. He said would let the DON take the lead about the issue.3. Record review of Resident #60's Face Sheet, dated 02/06/2026, reflected a [AGE] year-old female who admitted on [DATE]. The resident was diagnosed with hypertension (elevated blood pressure) and diabetes (the body does not use insulin effectively causing the blood sugar level to rise).Record review of Resident #60's Quarterly MDS Assessment, dated 12/02/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 7. The Quarterly MDS Assessment indicated that the resident required assistance with all self-care needs. Record review of Resident #5's Comprehensive Care Plan, dated 02/01/2026, reflected the resident had difficulty breathing related to nasal congestion. An intervention was to monitor for signs of respiratory distress and report to the doctor as needed. During an observation and interview on 02/05/2026 at 8:23 AM, MA G was observed in Resident #60's room. She had on gloves and placed an electronic blood pressure cuff on Resident #60's wrist. After obtaining a blood pressure reading, MA G exited returned to medication cart just outside the resident's door. MA G did not remove her gloves before entering the vital signs in the laptop on the medication cart. She removed her gloves, used hand sanitizer, and applied clean gloves prior to sanitizing the blood pressure cuff. MA G removed the gloves and used hand sanitizer. MG A stated she should have removed her gloves before touching the laptop to prevent cross contamination and infection. During an interview on 02/05/2026 at 12:18 PM, ADON B stated MA G should not have left with room with gloves on to prevent contamination. He stated that was part of infection control. He stated staff should also not wear gloves from one room to another. He stated once you are finished, remove your gloves and sanitize the hands. He stated the facility had already provided in-service training to staff on hand washing and donning (putting on) and doffing (taking off) gloves. Record review of the facility's policy Infection Control IPCP Standard and Transmission-Based Precautions revised March 2024 reflected Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . 3. Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through the use of gown and gloves during high-contact resident care activities that provideopportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident . c. Examples of high-contact resident care activities requiring gown and glove use for EnhancedBarrier Precautions include . v. Changing linens . vii. Device care or use: central vascular line.Record review of the facility's Infection Control policy, revised March 2024, reflected It is the policy of this facility to implement infection control measures to prevent the spread of communicable disease and conditions.b. Personal protective equipment.Don PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting the patient room.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for two direct care staff (RN D and MA G) and one (Crash Cart) of four carts reviewed for other environmental conditions.1. The facility failed to ensure that the drawers of the crash cart was not easily opened when not in use on 02/05/2026.2. The facility failed to ensure that RN D did not leave a container of germicidal wipes on top of the treatment cart at the wander unit unattended on 02/05/2026. 3. The facility failed to ensure MA G did not leave a container of germicidal wipes on top of her cart unattended on 02/05/2026.These failures could prevent the residents from having an environment that was safe for the residents, staff, and public. Findings include:1. An observation on 02/05/2026 at 8:15 AM revealed a crash cart was parked at the entry of hall 100. The drawers of the crash cart was not secured and could easily be opened. The first drawer had a [NAME] screwdriver and the other drawers had tubing in them.In an interview on 02/05/2026 at 8:17 AM, the Administrator stated that what he knew was the crash cart should not be locked.In an interview on 02/05/2026 at 8:18 AM, the DON said that they do not lock the crash cart.In an interview on 02/05/2026 at 2:16 PM, ADON A stated the crash cart should be easily accessed by the staff in cases of emergency but at the same time secured enough that when not in use, the residents would not be able to open the drawers. She said the residents might be able to get some equipment or supplies from the crash cart and harm themselves and others. She said resident might get hold of the [NAME] screwdriver and use it to hurt himself or others or might be able to get some tubing and put it around his neck. She said the crash cart had a flap at the side to secure the drawers. The staff just needed to flip the flap in order to use the crash cart.2. During an observation on 02/05/2026 at 8:33 a.m., a container of germicidal wipes (substance that destroys germs and microorganism) was on top of an unattended cart parked in a hallway inside the memory care unit. It was observed that several residents were walking down the hallway.During an interview on 02/05/2026 at 11:45 a.m., RN D stated that she went inside one of the resident's rooms to assess a wound. She said she should have placed the germicidal wipes inside the cart before leaving the cart because there were confused residents and they might use them to clean their faces and eyes that could result in irritations. She said she would put the germicidal wipes inside the cart.3. An observation on 02/05/2026 at 10:13 AM revealed a container of germicidal wipes was on top of a cart parked in a hallway. The cart was facing the hallway and was unattended. It was observed that several residents were walking down the hallway.During an observation and interview on 02/05/2026 at 10:15 AM, MA G stated she walked away from her cart because the DON called her. She said they use the germicidal wipes to clean the cart. She said she should have secured the germicidal wipes before leaving the cart because residents might use it improperly or even eat it. She said the container of germicidal wipes should be locked inside the cart. she took the container of germicidal wipes and put it on the last drawer of the cart.In an interview on 02/06/2026 at 8:11 AM, the DON stated the germicidal wipes should be locked inside the carts and not left on top of the carts unattended. She said it should be secured inside the carts so that the residents would not be able to access the wipes that had chemicals on them. She said she was not sure what chemical was on the wipes but considering the wipes were used to disinfect, then the wipes could be harmful to the residents. She said confused resident might get hold of the wipes and wipe their face and body that could result to irritations. She said the expectation was for the staff to be mindful and never leave the germicidal wipes on top of the carts unattended. She said on the same token, the crash cart should be secured that resident would not be able to open the drawers for safety. She said they already took the screwdriver and made sure the drawers were secured. She said she already started an in-service about not leaving the germicidal wipes on top of the carts unattended and making sure the crash cart (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was secured.In an interview on 02/06/2026 at 8:47 AM, ADON B stated the germicidal wipes should be stored inside the cart for safety reasons. He said residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, and skin. He said it might cause irritation and toxicity. She said anything that indicated Keep out of reach of children. should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. He said the DON already started an in-service about not leaving the germicidal wipes on top of the carts.In an interview on 02/06/2026 at 9:17 AM, the Administrator stated the germicidal wipes should be placed somewhere not accessible to the residents. He said if the wipes had chemicals in them that could be harmful when consumed or had contact with the eyes. He said, as for the crash cart, they would make sure the residents would not be able to open the drawers. He said the DON already started an in-service about germicidal wipes and the crash cart.Record review of the facility's policy Medication Access and Storage/Drug Destruction Policy/Procedure - Nursing Clinical revised July 2023 reflected Potentially harmful substances (e.g., urine test reagent tablets, household poisons,cleaning supplies, disinfectants) are clearly identified and stored in a locked areaseparately from medications.Record review of Safety Data Sheet (SDS) on 01/21/2026 reflected Safety Data Sheet Medline Micro-Kill Two Germicidal Wipes . Section 2. Hazards Identification . Classification . acute toxicity - oral . eye irritant . flammable liquids . Hazard Statements: Causes serious eye irritation . Flammable liquid and vapor . May cause drowsiness or dizziness . Storage: Keep out of the reach of children.Policy for securing the crash cart requested on 02/05/2026 at 9:13 AM via email to the Administrator.In an interview on 02/06/2026 at 12:45 PM, the Administrator stated the facility did not have a policy for securing the crash cart.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 #6) of fourteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #6's room was in a position that was accessible to the resident on 02/04/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Record review of Resident #6's Face Sheet, dated 02/04/2026, reflected a [AGE] year-old male who initially admitted to the facility on [DATE]. The resident was diagnosed with cerebral palsy (affects body movement and muscle coordination due to brain injury or malformation). Record review of Resident #6's Comprehensive MDS Assessment (tool used to measure health status), dated 11/20/2025, reflected intact cognition with a BIMS (tool used to measure cognitive status) score of 15. The Quarterly MDS Assessment indicated the resident required staff assistance with mobility and self-care needs. Record review of Resident #6's Comprehensive Care Plan, dated 12/19/2025, reflected the resident was at risk for fall r/t impaired transition during transfers and is able to use slide board for transfers. One intervention was to ensure the resident had a working and reachable call light. During an observation and interview on 02/04/2026 at 9:07 AM, Resident #6 was lying in bed asleep. A fall mat was placed next to his bed. The resident's nightstand was approximately 18 to the right of his bed. The top drawer of the nightstand was open, and the call light was draped across the drawer and hung over the side of the drawer that was closest to the bed. The call light was not within the resident's reach. The Assistant Business Office Manager was in the hall checking on the residents and came to Resident #6's room. She pulled on the call light cord, which barely touched the sheet on the resident's mattress, and stated that was as far as the call light would reach. She stated it was important to the resident to be able to call staff for assistance. During an interview on 02/04/2026 at 1:35 PM, RN C stated she had seen maintenance in the resident's room that morning but did not know if it was related to the call light. She stated she did not notice the call light was not in the resident's reach. She stated the resident may want a drink or something and he could not reach the call light. She stated Resident #6 was at risk for falls. RN C stated if the resident cannot reach the call light, he cannot communicate his needs. During an interview on 02/04/2026 at 1:40 PM, CNA L stated during her initial round, she did not notice the call light was not close enough for the resident to reach. She stated it was important for the call light to be within reach because he depended on her for care. She stated that was the point of having a call light.During an interview on 02/05/2026 at 12:18 PM, the ADON stated the call lights were different lengths. He stated the expectation was for the call light to be placed where the resident did not have to stretch his arm to reach it. He stated it was important for all residents to be able to reach their call light to ensure care was not delayed. He stated someone might need to go to the restroom, and it could be degrading to the resident if they could not wait and had an accident. He stated some residents may try to get up without help if they cannot reach their call light. During an interview on 02/05/2026 at 12:50 PM, the DON stated the residents' call lights should always be in reach to call for assistance if needed and for their safety. During an interview on 02/06/2026 at 10:35 AM, the Administrator stated the roommate in Resident #6's room had a longer call light so they swapped them. He stated it was important for Resident #6's call light to be in reach in case he needed to reach out for help. Record review of the facility's policy, revised 08/03/2021, reflected It is the policy of this facility to provide the resident a means of communication with nursing staff.Place the call device within resident's reach before leaving room.

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	676029	A. Building B. Wing	02/06/2026

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

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the State Mental Health Authority to inform them of a significant change in mental condition for two (Residents #2 and #3) of eight residents reviewed for Preadmissions Screening and Annual Resident Review (PASRR).1. The facility failed to notify the SMHA to ensure Resident #2 received a new PASRR level 1 screening following identification of his diagnosis of major depressive disorder on 06/20/2017, delusional disorder on 04/15/2021, and dementia on 01/08/2023.2. The facility failed to notify the SMHA to ensure Resident #3 received a new PASRR level 1 screening following identification of his diagnoses of bipolar disorder, major depressive disorder, and generalized anxiety disorder on 11/14/2023.These failures could place the residents at risk of not receiving the care and services they need in the most appropriate setting, when a significant change in their status occurs.Findings included:1. Review of Resident #2's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosis with major depressive disorder (persistent feeling of sadness or loss of interest) on 06/20/2017, delusional disorder (brain disorder were an individual who have delusional thoughts) on 04/15/2021, and dementia (a condition characterized by loss of memory and ability to reason) on 01/08/2023.Record review of Resident #2's Comprehensive Care Plan reflected the resident's care plan for depression was initiated on 11/22/2017, care plan for occasional hallucinations was initiated on 04/14/2021, care plan for impaired cognitive function was initiated on 10/18/2023, and care plan for mood problem was initiated on 07/23/2024.Record review of Resident #2's PASSR Level 1 Screening, dated 12/26/2016, reflected the resident was negative for mental illness, intellectual disability, and developmental disability when he was admitted to the facility.Record review of Resident #2's Documents on 02/05/2026 reflected the resident did not have a PASSR II, PE, or a new PASSR I.During an observation and interview on 02/04/2026 at 9:38 AM revealed Resident #2 was in his wheelchair, awake. He said he just had his breakfast and was feeling ok. He said he had a good sleep, and he said he was ready for the day. The resident then started rolling himself out of the room.2. Review of Resident #3's Face Sheet, dated 02/05/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosis with major depressive disorder and bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows) on 11/14/2023.Record review of Resident #3's Comprehensive Care Plan reflected the resident's care plan for bipolar disorder was initiated on 11/15/2023.Record review of Resident #3's PASSR Level 1 Screening, dated 11/14/2023, reflected the resident was negative for mental illness, intellectual disability, and developmental disability when he was admitted to the facility.Record review of Resident #3's Documents on 02/05/2026 reflected the resident did not have a PASSR II, PE, or a new PASSR I.During an observation and interview on 02/04/2026 at 9:46 AM revealed Resident #3 was in his bed, awake. He said he was feeling okay and would like to sleep some more.During an observation and interview on 02/05/2026 at 11:44 a.m., the MDS Nurse said she was responsible in doing the PASSR of the residents if needed. She stated that a PASSR level I was required to all individual seeking placement in a nursing facility. She said that PASSR level I were done to identify individuals with mental illness, intellectual disability, and developmental disability, and to ensure right placement and access to specialized services. She said if a resident was PASSR positive, meaning the resident was diagnosed with any mental illness or had indicators for intellectual and developmental disability, then a PASSR level II should be done to determine if the resident needed any specialized services. She said if a resident was PASSR I negative and during resident's stay in the facility was diagnosed with a new mental illness such as depression, anxiety, dementia, bipolar disorder, and delusional disorder, then a new PASSR I should have been done again for the same reason. She logged on to her computer and looked at Resident #2's (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	profile. She said Resident #2 was PASSR negative when he was admitted to the facility but was diagnosed with major depressive disorder on 06/20/2017, delusional disorder on 04/15/2021, and dementia on 01/08/2023. She then checked if the there was a new PASSR I that was done and she said there was none. She then checked on Resident #3's profile. She said Resident #3 was diagnosed with bipolar disorder six days after admission. She said, same with Resident #2, a new PASSR I should have been done. She said both residents' issue with PASSR was before she was hired but said it was not an excuse and she should have done an audit when she took over. She said she would start the process and would also audit the PASSRs of the other residents.In an interview on 02/06/2026 at 8:11 AM, the DON stated she was not familiar with PASSR. She said she knew Resident #2 and Resident #3 had mental illnesses.In an interview on 02/06/2026 at 8:47 AM, ADON B stated Resident #2 and Resident #3 were taking psychotropic medications. He said he had no idea how PASSR worked.In an interview on 02/06/2026 at 9:17 AM, the Administrator stated there should be a process in place to determine if a new PASSR was need as soon as a new mental illness was diagnosed. He said he would personally coordinate with the MDS Nurse to determine where the break in communication was. Policy for PASSR requested on 02/05/2026 at 1:58 PM via email to the Administrator.In an interview on 02/06/2026 at 12:45 PM, the Administrator stated the facility did not have a policy for PASSR but would use the one from state.Review of the facility's Resident Assessment Instrument (RAI Version MDS 3.0) A1500: PASSR dated April 2012 Page A-16 reflected, Individuals who have or are suspected to have MI, or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through level II PASSR determination, those residents covered by Level II PASSR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State . Review of the facility's Resident Assessment Instrument Manual (RAI Version MDS 3.0) A1500: PASSR Planning for Care dated April 2012 Page A-17 reflected, The nursing home is required to provide all other care and services appropriate for the resident's medical condition .that should be addressed in the plan of care .

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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 2 of 12 residents (Resident #22 and #36) reviewed for care plan. The facility failed to ensure Resident #22's care plan reflected a plan of care for the cancer lesion on her forehead. The facility failed to ensure Resident #36's Comprehensive Care Plan reflected the resident had a midline intravenous catheter for antibiotic administration.These failures could place residents at risk of their needs not being met. Findings included:Record review of Resident #22's Face Sheet, dated 02/05/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #22 had paralysis on the left side of her body. Record review of Resident #22's Quarterly MDS Assessment, dated 10/18/25, reflected Resident #22 resident's BIM indicated a moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had an active diagnosis of paralysis on the left side of her body. Record review of Resident #22's Comprehensive Care Plan, dated 02/05/26, which was after the facility was informed of the exclusion of an intervention for the wound doctor's weekly skin assessment, reflected for actual skin impairment to forehead, Wound Care MD to evaluate and treat weekly until wound resolved. During an interview on 02/05/26 at 12:20 p.m., ADON A stated Resident #22 was required to receive weekly skin assessments from the Wound Care Doctor. She stated she did not think this needed to be care planned for the resident, but she would add it to her interventions. She stated the resident had a cancer lesion on her forehead and had this diagnosis for a while. She stated the care plan included the interventions needed to properly care for the resident. During an interview on 02/05/26 at 01:45 p.m., ADON A, RN D, the DON, and Clinical Nurse, the DON stated the resident had a cancer lesion on her forehead, and stated the resident received weekly head-to-toe assessments for pressure ulcers and the nursing staff checked her skin for the condition of the cancer lesion as well. ADON A stated a Wound Doctor was scheduled to assess the resident weekly to monitor the lesion to ensure it did not worsen. The DON stated the resident should have the cancer lesion care planned to ensure the resident received the care. The DON stated it was the ADON's and DON's responsibility to ensure the care plan was updated. Record review of Resident #36's face sheet, dated 02/05/2026, reflected a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. She was diagnosed with neuromuscular dysfunction of the bladder (damage to the nervous system that causes bladder problems). Record review of Resident #36's Quarterly MDS Assessment, dated 02/05/2026, reflected intact cognition with a BIMS score of 15. Section O (Special Treatments, Procedures, and Programs) indicated Resident #36 received intravenous medications. Record review of Resident #36's face sheet, dated 02/05/2026, reflected a [AGE] year-old female (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who initially admitted to the facility on [DATE] and readmitted on [DATE]. She was diagnosed with neuromuscular dysfunction of the bladder (damage to the nervous system that causes bladder problems). Record review of Resident #36's Quarterly MDS Assessment, dated 02/05/2026, reflected intact cognition with a BIMS score of 15. Section O (Special Treatments, Procedures, and Programs) indicated Resident #36 received intravenous medications. Record review of Resident #36's Comprehensive Care Plan, dated 12/10/2025, did not reflect a midline (long, flexible catheter inserted into a vein in the upper arm for treatments that last longer than a few days) for IV antibiotics. Record review of Resident #36's Physician's Orders, dated 01/29/2026, reflected an order for Cefepime (antibiotic) 1 gm/50 ml intravenously two times a day for 7 days for a urinary tract infection. During an interview on 02/04/2026 at 11:02 AM, MDS Nurse H stated Resident #36 had an iv for antibiotics. She stated the resident was out of the facility for an appointment. During an observation on 02/04/2026 at 12:45 PM, a staff member was observed taking Resident #36 to her room in her wheelchair. She told the resident she would ask the kitchen staff to bring her lunch. When the surveyor entered the room, Resident #36 was sitting in her wheelchair. She stated she was doing ok and denied having any concerns. A staff member brought a lunch tray to Resident #36, and the surveyor exited the room. During an interview on 02/05/2026 at 11:44 AM, ADON B stated Resident #36 received the last dose of iv antibiotics the previous day. He stated he should have added the midline to the resident's care plan. ADON B immediately updated the care plan and stated it was important to monitor the resident for complications and signs of infection. During an interview on 02/05/2026 at 12:50 PM, the DON stated the midline should have been included in the resident's care plan to ensure the interdisciplinary team was on the same page. She stated the MDS Nurse and Infection Preventionist (ADON B) were responsible for ensuring the mid-line for antibiotics was included in the care plan. During an interview on 02/06/2026 at 12:20 PM, the MDS Nurse H stated the midline for antibiotics should have been included in Resident #36's care plan. She stated the interdisciplinary team discussed clinical changes during morning meetings and ADON B normally added that it to a resident's care plan. She stated it was important for the care plan to reflect a resident's complete plan of care. 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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 8 residents (Resident #114) reviewed for ADL care. The facility failed to ensure Resident #114 received any scheduled showers for January 2026 and no indication of refusal. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem.Findings included: Record review of Resident #114's Face Sheet, dated 02/05/26, reflected a 48 -year-old male who was admitted to the facility on [DATE]. Resident #114 had a diagnosis of morbid obesity. Record review of Resident #114's MDS Assessment, dated 11/25/25, reflected the resident's BIM (12) indicated a moderate cognitive impairment. The MDS Assessment reflected the resident had active diagnoses of morbid obesity and paraplegia (paralysis of lower body). The resident required maximal assistance for ADL care. Record review of Resident #114's Comprehensive Care Plan, dated 11/20/25, reflected the resident had an ADL self-care deficit and the resident was totally dependent on staff to provide ADL care. There was no mention of the resident refusing showers.Record review of Resident #114's Progress notes for the month of January 2026, reflected no documentation of resident refusing showers.During an observation and interview on 02/04/2026 at 10:43 a.m., Resident #114 stated he was not receiving his showers, and he had not refused them. He stated he sometimes received bed baths but wanted showers. During an interview and record review on 02/05/26 at 1:30 p.m., ADON A provided showers sheets for the month of January 2026 and stated that was all the shower sheets for every resident. Record review of the shower sheets revealed no shower sheets for Resident #114. ADON A was informed there were no shower sheets found for Resident #114, and she stated she would try to find them. She stated Resident #114 often refused showers. She stated the CNA who provided care to the resident was running late today and was not available. She stated the resident was scheduled to receive his showers on Tuesday, Thursday, and Saturday by the evening CNA. During an interview on 02/05/26 at 2:00 p.m., RN A stated she was the charge nurse for the 300-hall. She stated Resident #114 slept in a B bed and his showers were provided by the evening staff. RN A stated she did not know if he was receiving his showers. She stated if the resident was not receiving his showers he could have skin breakdown.During an interview and record review on 02/06/26 at 9:00 a.m., the ADON A stated Resident #114 received bed baths and often refused showers. She stated if a resident refused a shower, the charge nurse must attempt to persuade the resident into taking a shower, and if they were unsuccessful, the ADON would attempt to persuade the resident. She stated they would also contact the resident's RP emergency contact to persuade the resident into taking a shower. She stated if the resident did not receive his showers, he could have skin breakdown. ADON A provided a stack of shower sheets for Resident #114 and stated they were stored somewhere else and were found last night. ADON A provided Resident #114's shower sheets indicating the following: 01/02/26 (shower), 01/03/26 (bed bath), 01/05/26 (shower), 01/06/26 (bed bath), 01/07/26 (bed bath), 01/08/26 (bed bath), 01/09/26 (bed bath), 01/10/26 (shower), 01/12/26 (bed bath), 01/13/26 (bed bath), 01/14/26 (bed bath), 01/15/26 (shower), 01/16/26 (shower), 01/17/26 (shower), 01/19/26 (nothing marked), 01/20/26 (bed bath), 01/22/26 (bed bath), 01/24/26 (refused bed bath), 01/31/26 (bed bath). In an interview on 02/06/26 at 10:00 a.m., Resident #114 was asked if he received showers on the dates referenced on the shower sheets, and he stated he did not receive any showers nor did he receive all the bed baths mentioned. He could not verify which bed baths were received.In an interview on 02/06/26 at 10:02 AM, the DON stated Resident #114 often refused showers. She stated if a resident refused showers, the charge nurse should attempt to persuade the resident to take a shower and if they still refused, they were to contact the RP and document the refusal. She stated if the resident had not received showers he could have skin impairment. She (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they had to search for his shower sheets because they were not placed with the others. Record review of the facility's policy titled Showers/Bed baths, dated 05/2022, revealed, It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. Showers and bed baths will be provided to residents in accordance with the resident's shower schedule provided. 2. If a resident is unable to be showered on their scheduled day related to room changes or appointments, will attempt to reschedule. 3. Shower and bed baths will be documented on shower sheet and/or medical record 4. Charge nurse and/or ADON to review and sign. If resident has areas of concerns nurse/ADON to further investigate as needed and document as necessary.

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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 observation, interview, and record review, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1 of 6 residents (Resident #114) reviewed for hazards. The facility failed to ensure Resident #114 did not have a bottle of rubbing alcohol in his room on 02/04/26.This failure could prevent the residents from having an environment that was free from hazards. Findings include:Record review of Resident #114's Face Sheet, dated 02/05/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #114 had a diagnosis of major depressive disorder. Record review of Resident #114's MDS Assessment, dated 11/25/25, reflected the resident's BIM (12) indicated a moderate cognitive impairment. The MDS Assessment reflected the resident had an active diagnosis of schizophrenia.In an observation on 02/04/2026 at 10:43 AM, Resident #114 was observed with a bottle of rubbing alcohol on his bedside table.During an interview on 02/04/26 at 2:24 PM, RN C She stated the resident was not allowed to have the chemical in his room because it was not safe for him because he could drink it. She stated the nursing staff should check to ensure residents did not have unsafe chemicals in their rooms.In an interview on 02/06/26 at 10:02 AM, the DON stated the resident could not have possession of the item because he could ingest it. She stated they removed the item and provided him with alcohol free wipes. Record review of Safety Data Sheet (SDS) on 01/21/2026 reflected Safety Data SheetMedline Micro-Kill Two Germicidal Wipes . Section 2. Hazards Identification . Classification . acute toxicity - oral . eye irritant . flammable liquids . Hazard Statements: Causes serious eye irritation . Flammable liquid and vapor . May cause drowsiness or dizziness . Storage: Keep out of the reach of children.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for two (Resident #16 and Resident #32) of sixteen residents and one (Nurse's Cart) of two carts reviewed for pharmaceutical services. 1. The facility failed to dispose of an over-the-counter gas relief dated 12/2025.2. The facility failed to dispose of Resident #16's expired Linzess capsules dated 12/2025.3. The facility failed to dispose of Resident #32's expired Clonidine tablets with discard after date of 04/30/2024.These failures could place residents at risk of not receiving the medication's full therapeutic benefits and possible adverse reactions when taken. Findings included:An observation of the nurse's cart on 02/06/2026 at 10:52 AM, revealed the following:-Linzess capsules for Resident #16 with an expiration date of 12/2025, -Clonidine tablets for Resident #32 with a discard after date of 04/30/2024, and -Gas Relief over-the-counter with an expiration date of 12/2025. Record review of Resident #16's Face Sheet, dated 02/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with rheumatoid arthritis (swelling of the joints). Record review of Resident #16's Comprehensive MDS Assessment, dated 01/14/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had rheumatoid arthritis and was occasionally in pain. Record review of Resident #16's Comprehensive Care Plan, dated 12/02/2025, reflected the resident had chronic pain and one of the interventions was administer medications as ordered.Record review of Resident #16's Physician Order, dated 01/07/2026, reflected Percocet (pain medication that could cause constipation) Oral Tablet 10-325 MG (Oxycodone w/Acetaminophen) Give 1 tablet by mouth every 6 hours for pain hold for sedation.Record review of Resident #16's Physician Order on 02/05/2026 reflected the resident did not have an order for Linzess (constipation medication) capsules.Record review of Resident #32's Face Sheet, dated 02/06/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure).Record review of Resident #32's Comprehensive MDS Assessment, dated 12/30/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had hypertension.Record review of Resident #32's Comprehensive Care Plan, dated 01/29/2026, reflected the resident had hypertension and one of the interventions was to give anti-hypertensive medications.Record review of Resident #32's Physician's Order, dated 11/24/2025, reflected Clonidine HCl Oral Tablet 0.1 MG (Clonidine HCl) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for B/P less than 110/60.During an observation and interview on 02/06/2026 at 11:02 AM, RN D read the expiration dates of the medications in question and said the medications were already expired. She stated that expired medications should not be inside the carts so that staff administering the medications would not mistakenly use the expired ones. She said, when the medications were already expired, the effectiveness of the medication could be less or there could be adverse reactions from the expired medication. She said the medications were PRNs and she did not use any of them. She said Resident #32 had blister pack (a type of packaging in which a product is sealed in plastic, often with a cardboard backing) for her clonidine and they did not use the ones in the plastic bottle. She said Resident #16 did not take the Linzess anymore. She said, since she was one of the nurses using the cart, then she was also responsible in checking the medications inside the carts.During an observation and interview on 02/06/2026 at 11:06 AM, ADON A stated there should not be expired medication inside the carts. She said the nurses and medication aides was responsible in ensuring there was no expired medications. She said she was also responsible in checking and auditing the carts for expired medications. She said they would also audit the other carts for expired medications. (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	02/06/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She took the expired medications and undated insulins and said she would dispose of them. She also said she would start an in-service about checking the carts for expired medications.In an interview on 02/06/2026 at 11:15 AM, the DON stated she was made aware about the expired medications. She said expired medications could be less potent or could cause adverse effects depending on the medication. She said the nurses and the medication aides was responsible in checking their carts for expired medications. She said the ADONs was responsible in going behind the nurses and the medications aides and she was responsible in checking if the ADONs was checking the carts. She said ADON A was already preparing the in-service with regards to disposing expired medications accordingly.In an interview on 02/06/2026 at 12:45 PM, the Administrator stated he was not a clinician and would let the DON take the lead about the expired medications. He said, but one thing was for sure, expired medication should not be inside the cart and should not be used. He said they already started an in-service regarding the expired medication.Record review of the facility's policy Medication Access and Storage/Drug Destruction Policy/Procedure - Nursing Clinical revised July 2023 reflected Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676029	A. Building B. Wing	02/06/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow policies and procedures to ensure that each resident or the resident's representative had the opportunity to refuse immunization for 1 of 6 residents (Resident #33) reviewed for vaccinations. The facility failed to ensure Resident #33 did not receive the influenza vaccination on 10/17/25. This failure could place residents at risk of having an adverse reaction and suffering harm.Findings included: Record review of Resident #33's Face Sheet, dated 02/05/26, reflected a [AGE] year-old female admitted [DATE]. Resident #33 had diagnoses of dementia (cognitive decline) and anemia (low red blood cells). Record review of Resident #33's Quarterly MDS Assessment, dated 11/20/25, reflected the resident's BIM (3) indicated a severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnosis of dementia. Record review of Resident #33's Immunization detail regarding the Influenza Vaccine, dated 10/17/25, reflected Family refused.Record Review of Resident #33's Progress Notes on 10/18/25, revealed, Resident received influenza vaccine and tolerated well without allergy reaction, resident vitals within normal limits. During an interview on 02/06/26 at 8:30 a.m., Resident #33's RP stated she told the nursing staff not to give Resident #33 the influenza vaccine and later found out she was given one anyway. She stated she did not want the resident to receive a shot because she was concerned about her having an allergic reaction.During an interview on 02/06/26 at 09:50 AM, ADON A and the DON stated Resident #33 was accidently given the Influenza vaccine on 10/17/26 because she and another resident had the same last name. She stated someone from state had investigated the allegations and they were not cited for it. She stated the resident could have had an allergic reaction to the shot. She stated they completed an in-service with the nursing staff to verify consent and having a second person verify the resident was to receive the vaccination in the future.Record review of the facility's policy titled, Medication Administration, dated 08/31/23, reflected, It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Identification of the resident must be made prior to administering medication to the resident.