

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  Western Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  512 Draper Dr Temple, TX 76504	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47065</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that each resident had the right to a safe, clean, comfortable, and homelike environment for 2 (Residents #1 and #2) of 15 residents reviewed for clean rooms.</p> <p>The facility failed to ensure Resident #1's and #2's rooms were clean and did not have a foul odors on 01/17/25.</p> <p>This deficient practice could place residents at risk of a diminished quality of life.</p> <p>Findings include:</p> <p>Review of Resident #1's admission record, dated 01/22/25, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses including unspecified nontraumatic intracerebral hemorrhage (a type of stroke that occurs when blood pools in the brain without trauma), other specified cardiac arrhythmias (abnormal heart rhythms), anoxic brain damage (occurs when the brain is completely deprived of oxygen), aphasia (loss of ability to understand and express speech), dysphasia (difficulty speaking), and weakness.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 12/31/24, reflected a BIMS of 4, indicating a severe cognitive impairment. Section GG (Functional Abilities and Goals) reflected she was dependent and required total staff assistance on all ADLs.</p> <p>Review of Resident #1's care plan, dated 01/13/25, reflected she had a wound to her sacrum and required tube feeding. Resident #1 also had impaired cognitive function and psychosocial well-being problems.</p> <p>Review of Resident #2's admission record, dated 01/17/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses including hypomagnesemia (a condition where there was too little magnesium in the blood), dysarthria (a speech disorder that made it difficult to clearly speak), unqualified visual loss in both eyes, adjustment disorder with mixed anxiety and depressed mood, blindness in one unspecified eye, and age-related physical debility.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's quarterly MDS assessment, dated 11/20/24, reflected he had an 8 a BIMS score of 8 out of 15, which indicated he had moderate cognitive impairment. Resident #2 was dependent on toileting and showering, required partial/moderate assistance with dressing, bed mobility and personal hygiene, and supervision/touching assistance with eating and oral hygiene.</p> <p>Review of Resident #2's care plan, dated 12/24/24, reflected he was blind.</p> <p>An observation of Resident #1's room on 01/17/25 at 9:53 a.m. found the inside of her room smelled of vomit. The floor had dried up spills. Resident #1's bedside table also had wet spills. Resident #21 was asleep.</p> <p>An observation of the hallway where Resident #1 resided on 01/17/25 at 9:56 a.m. found the hallway in front of her room smelled of vomit. HK A was cleaning another resident's room that was across from Resident #1's room.</p> <p>During an interview on 01/17/25 at 9:56 a.m., HK A stated she was re-educated about her job duties daily by the HS. HK A stated she cleaned and deep cleaned residents' rooms twice daily. HK A stated she documented on cleaning sheets whenever she cleaned residents' rooms daily. HK A stated the HS would spot check residents' rooms and her cleaning sheets daily. HK A stated she smelled the vomit odor in the hallway that was coming from Resident #1's room. HK A stated she often received foul odor complaints from residents and family members. HK A stated she notified the HS whenever she received complaints about foul odors. HK A stated she most recently notified the HS about the foul odor complaint a while back. HK A stated the HS told her to keep using the same cleaning products in her housekeeping cart whenever she notified the HS about the foul odor complaints. HK A stated she did not know what to do with the foul odors most of the time. HK A stated she knew it was important to keep the facility and residents' rooms clean and odorless and said, To maintain a healthy clean environment. HK A did not believe the foul odors could affect the residents .</p> <p>Review of HK A's Deep Clean Sheets, dated 11/05/24, 11/06/24, 11/15/24, 11/18/24, 11/18/24, 11/20/24, 11/22/24, 12/03/24, 12/03/24, 12/16/24, 12/23/24, 12/31/24, 12/31/24, 2 for 01/01/25, 2 for 01/02/25, 01/03/25, 01/06/25, 01/07/25, 01/09/25, and 01/13/25, reflected her name, date, and room number. None of the deep clean sheets that HK A filled out and provided the surveyor from her housekeeping cart indicated Resident #1's room received a deep cleaning. A deep clean sheet, dated 12/16/24 and 01/02/25, had Resident #2's room listed. Additionally, the check off the following areas completed section was blank on all of HK A's deep clean sheets.</p> <p>During an interview on 01/17/25 at 10:07 a.m., HK A stated the HS was supposed to sign off on her deep clean sheets after the HS spot checks the residents' rooms when asked why the check off section was blank on all her deep clean sheets.</p> <p>During an observation and interview on 01/17/25 at 10:42 a.m., Resident #2's room was two rooms next to Resident #1's room. The outside and inside of Resident #2's room smelled of urine and feces. There were crumpled up papers and dried up spills on Resident #2's room floor. Resident #2 stated he smelled the urine, feces, and vomit odors in his room and the hallway in front of his room. Resident #2 said, The facility smelled like that daily. Resident #2 stated he notified staff of the foul odors and said, They would do nothing. Resident #2 said, Housekeeping do not ever come around to my room. I have to smell this every damn day. Resident #2 stated the foul odors he smelled daily also aggravated him daily .</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An attempt to interview Resident #1 was made on 01/17/25 at 10:49 a.m. Resident #1 was unable to answer any questions.</p> <p>During an observation of Resident #2's room and the hallway outside Resident #2's room on 01/17/25 at 11:24 a.m., Resident #2's room and the hallway were in the same condition and had the same odors as the observation on 01/17/25 at 10:42 a.m .</p> <p>During an interview on 01/17/25 at 11:40 a.m., HK B, who was working on a hallway next to Residents #1 and #2's hallway, stated he was given orientation training two days ago on how to perform his job duties. HK B stated he cleaned residents' rooms once daily. HK B stated he was not required to document whenever he cleaned residents' rooms. HK B stated he deep cleaned residents' rooms according to the cleaning schedule. HK B stated he did not receive any complaints about foul odors and/or uncleaned rooms. HK B stated he would immediately clean the residents' rooms and report to the HS if he received complaints about foul odors and/or uncleaned rooms. HK B stated the HS checked behind him to ensure residents' rooms were cleaned every 20-30 minutes. HK B stated he knew it was important to keep the facility and residents' rooms clean and odorless and said, That way it's not contagious.</p> <p>During an interview on 01/17/25 at 1:01 p.m., CNA C stated she received complaints from residents and families about foul odors and uncleaned residents' rooms daily. CNA C stated she notified Housekeeping whenever she received complaints about the foul odors and uncleaned residents' rooms. CNA C stated she noticed the foul odors outside and inside Resident #1's and #2's room and the lack of cleanliness in Resident #1's and Resident #2's room. CNA C stated Housekeeping supposedly cleaned residents' rooms daily.</p> <p>During an interview on 01/17/25 at 4:24 p.m., the DMHK stated she oversaw the facility's housekeeping department for 2 years. The DMHK stated housekeepers cleaned residents' rooms once daily and twice daily if the rooms were still dirty during her spot check. The DMHK stated housekeepers documented deep cleanings they completed daily on deep clean sheets. The DMHK stated the HS notified the ADM whenever there were physical environment and housekeeping concerns. The DMHK stated the HS quit last Thursday (01/09/25). The DMHK stated she directly received physical environment and housekeeping concerns and complaints from 01/09/25 through 01/17/25. The DMHK stated she did not receive any complaints or concerns about foul odors and uncleaned residents' rooms. The DMHK stated she observed the foul odor coming from Resident #1's room when she took over the facility's housekeeping department on 01/09/25. The DMHK stated Resident #1's room smelled of vomit, urine, and feces. The DMHK could not recall if she smelled the same odors in Resident #2's room. The DMHK stated she never spoke with Resident #1 about the foul odors coming from her room and did not know why. The DMHK stated she asked the nursing staff who worked on the hallway and at the nursing station near Resident #1's room about the foul odors and they told her that they also smelled the odors and that it was normal. The DMHK could not indicate who the nursing staff members were and when she spoke with them about the foul odors from Resident #1's room. The DMHK stated she cleaned Resident #1's room sometime last week (sometime between 01/06/25 through 01/10/25). The DMHK stated she knew it was important to keep the facility and residents' rooms clean and odorless and said, So residents felt comfortable because it was their home.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/22/25 at 11:39 a.m., Resident #1's RP stated he visited Resident #1 anytime he was in town. Resident #1's RP stated he most recently visited Resident #1 last Sunday (01/19/25). Resident #1's RP stated he observed Resident #1's room had urine, feces and vomit odors and was uncleaned. Resident #1's RP stated there were times that Resident #1's room smelled of urine and feces because the nurses had not come and changed Resident #1. Resident #1's RP could not recall when he most recently smelled the urine and feces odors in Resident #1's room. Resident #1's RP stated Resident #1's room smelled of vomit due to her vomiting at times during her peg tube feedings. Resident #1's RP could not recall when he most recently smelled the vomit odor in Resident #1's room. Resident #1's RP stated he did not observe housekeeping staff clean Resident #1's room since 12/20/24. Resident #1's RP stated he did not file a grievance or report his concerns about the odors and lack of cleanliness in Resident #1's room because he did not want to get anyone in trouble.</p> <p>During an interview on 01//22/25 at 1:33 p.m., LVN D stated housekeeping cleaned residents' rooms once daily. LVN D stated she received complaints about the foul odors from Residents #1 and #2's hall. LVN D stated she smelled body odor and urine in Resident #1's room. LVN D stated she observed the foul odors from Resident #1's room on 1-2 occasions. LVN D stated she most recently observed the foul odors from Resident #1's room back in October 2024. LVN D stated she could not recall if she observed the foul odors from Resident #2's room. LVN D stated she would alert housekeeping whenever she received complaints about the foul odors. LVN D stated she would also ensure the CNAs performed brief changes, took out residents' food trays, and took out the trash whenever she smelled foul odors. LVN D stated Resident #1's room had foul odors despite cleaning Resident #1's linens and changing Resident #1's briefs. LVN D stated the foul odors from Resident #1's room were constantly brought up during morning meetings. LVN D stated she knew it was important to keep the facility and residents' rooms clean and odorless and said, For residents' rooms to be clean, and safety. It is a huge issue and concern. If there was clutter or a mess, residents could slip and fall. It is also the resident's home. Residents lived here. We would be denying residents if we let them live in filth.</p> <p>During an interview on 01/22/24 at 5:38 p.m., the ADON stated she received complaints about the foul odors coming from Resident #1's room from staff. The ADON stated she could not recall if she received any complaints about the foul odors coming from Resident #2's room. The ADON stated staff tried to upkeep Resident #1's room whenever there were foul odors, or it was dirty. The ADON stated CNAs and nurses would try and clean Resident #1's room and notify the housekeeping staff to deep clean the room. The ADON stated she could not recall when Resident #1's room was most recently deep cleaned. The ADON stated housekeeping staff cleaned residents' rooms daily. The ADON stated Resident #1 did barf a lot due to her peg tube and had poor bowel movements. The ADON stated she knew it was important to keep the facility and residents' rooms clean and odorless and said, For their health and dignity. So, there is no insects. To make sure they (residents) are not ingesting anything old.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/22/24 at 6:39 p.m., the DON stated housekeeping staff cleaned residents' rooms daily. The DON explained the facility outsourced the housekeeping department to a third-party entity. The DON stated she did not know how housekeeping staff divided and cleaned residents' rooms. The DON stated rounds were conducted daily on residents' rooms and given to the ADM. The DON stated staff discussed whenever there was an odor during morning meetings. The DON stated if she smelled an odor, she was trained to investigate the origins of the foul odor, discard any food material, and check residents for incontinence. The DON said she had not received any concerns or grievances about foul odors from Residents #1's and #2's hallway. The DON stated she observed the foul odors from Resident #1's room. The DON stated she could not recall if she observed foul odors from Resident #2's room. The DON stated she knew it was important to keep the facility and residents' rooms clean and odorless and said, Because it must be a pleasant, homelike environment. It is their (resident's) home. No one wants their home to stink. It is already hard enough to adjust to living with other people. Residents are also sensitive to odors and clutter. It is a resident's right. To live in a clean environment, not a foul-smelling environment. It would also be an infection control issue. If there was a smell, it might be an infection.</p> <p>During an interview on 01/22/25 at 7:36 p.m., the ADM stated the housekeepers cleaned residents' rooms once daily. The ADM stated the HS left employment sometime last week. The ADM stated he did not receive any grievances and concerns from residents and families about foul odors and uncleaned rooms. The ADM stated he occasionally had staff complain about the foul odors coming from Resident #1's room. The ADM stated he could not recall if he received grievances and concerns about Resident #2's room. The ADM stated he was unsure if Resident #1's room's foul odors came from Resident #1's peg tube. The ADM stated housekeeping staff also deep cleaned Resident #1's room. The ADM stated he knew it was important to keep the facility and residents' rooms clean and odorless and said, This is their home. We try to make it as accommodating as possible. We also do not want to disturb other residents with the odors.</p> <p>Review of the facility's Deep Clean Schedule that HK A provided the surveyor, dated November 2024, reflected Resident #2's room was required to be deep cleaned every fourth day of the month. Resident #1's room was required to be deep cleaned every 30th day of the month.</p> <p>Review of the facility's Daily Clean Requirements for Residents #1 and #2's hall, undated, reflected that housekeeping staff were required to vacuum and wipe down the handrails in their way in and out the hallway. Housekeeping staff were also required to always check the binder for deep cleans and focus areas for cleaning the rooms.</p> <p>Review of the facility's Daily Rounds sheets, dated 01/02/25, 01/07/25, 01/10/25, and 01/13/25, reflected Resident #1's and #2's rooms were checked by the ADON, who indicated on the sheets that the rooms were clean and there were no odors. There were no other dates provided and included.</p> <p>Review of the facility's Homelike Environment policy, revised February 2021, reflected the following:</p> <p>Policy Statement: Residents are provided with a safe, clean, comfortable, and homelike environment .</p> <p>Policy Interpretation and Implementation:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.2. The community team members and management maximize, to the extent possible, the characteristics of the community that reflect a personalized, homelike setting. These characteristics include:</p> <p>a. clean, sanitary, and orderly environment .</p> <p>3. The community team members and management minimize, to the extent possible, the characteristics of the community that reflected a depersonalized, institutional setting. These characteristics include:</p> <p>.b. institutional odors .</p> <p>Review of the facility's Resident Rights policy, revised December 2016, reflected the following:</p> <p>Policy Statement: Team members shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>a. a dignified existence.</p> <p>b. be treated with respect, kindness, and dignity .</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065</b></p> <p>Based on interview and record review, the facility failed to ensure each resident had the right to be free from misappropriation of property for 6 of 10 residents ( Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, and Resident #15) reviewed for misappropriation of property.</p> <p>The facility failed to prevent the misappropriation of Resident #10's Oxycodone (a schedule II controlled opioid medication used to treat moderate to severe pain) taking taken during the days of 10/17/24 through 10/21/24, and Residents #11, #12, #13, #14 and #15's hydrocodone/APAP tablets (a schedule II controlled opioid medication used to treat pain) taken on unknown dates.</p> <p>This failure placed residents at risk for not receiving prescribed medications for pain relief.</p> <p>Findings included:</p> <p>1. Review of Resident #10's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, stage 5 (kidney failure), congestive heart failure (heart cannot pump an adequate amount of blood for circulation), femur fracture (broken thighbone) and pain unspecified (uncertain cause)</p> <p>Review of Resident #10's Annual MDS assessment, dated 11/20/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 12 which indicated moderate cognitive impairment.</p> <p>Review of Resident #10's care plan reflected a focused area, revised on 1/16/2024, of generalized pain related to a femur fracture. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #10's Order Summary Report, viewed on 1/17/2025, reflected the resident was ordered 1 oxycodone tablet, 5mg by mouth every 8 hours PRN for pain; Ordered 12/7/2023.</p> <p>Review of Resident #10's MAR for October 2024 reflected a PRN oxycodone tablet was not requested during the month.</p> <p>2. Review of Resident #11's admission record, undated, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Diagnoses included DM II, pain in unspecified knee, HTN (high blood pressure) and heart failure.</p> <p>Review of Resident #11's Quarterly MDS assessment, dated 10/17/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 15 which indicated cognition was intact.</p> <p>Review of Resident #11's care plan reflected a focused area, revised on 1/15/2025, of generalized pain related to a femur fracture. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #11's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 10-325mg by mouth every 6 hours PRN for pain; Ordered 3/13/2024.</p> <p>Review of Resident #11's MAR for October reflected prn hydrocodone-acetaminophen tablets had been given 12 times from 10/1/2024 until 10/21/2024.</p> <p>3. Review of Resident #12's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, stage 5 (kidney failure), disorder of bone (medical conditions affecting the bones), HTN and chronic pain.</p> <p>Review of Resident #12's quarterly MDS assessment, dated 12/2/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 15 which indicated cognition was intact.</p> <p>Review of Resident #12's care plan reflected a focused area, revised on 3/3/2024, of generalized pain related to a femur fracture. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included anticipate the resident's need for pain relief and respond immediately.</p> <p>Review of Resident #12's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 5-325mg by mouth every 8 hours PRN for pain; Ordered 2/16/2024.</p> <p>Review of Resident #12's MAR for October reflected PRN hydrocodone-acetaminophen tablets had been given 5 times from 10/1/2024 through 10/21/2024.</p> <p>4. Review of Resident #13's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE], with an original admission of 10/21/2022. Diagnoses included heart failure, DM II, and unspecified pain .</p> <p>Review of Resident #13's care plan reflected a focused area, revised on 8/13/2024, of pain. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #13's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 5-325mg by mouth every 6 hours PRN for pain; Ordered 5/6/2024.</p> <p>Review of Resident #13's MAR for October 2024 reflected prn hydrocodone-acetaminophen tablets had been given 26 times from 10/1/2024 through 10/21/2024.</p> <p>5. Review of Resident #14's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE], with an original admitted [DATE]. Diagnoses included unspecified fractured neck (fracture of any of the seven cervical vertebrae in the neck), dementia (gradual decline of brain functions) and chronic pain syndrome.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #14's quarterly MDS assessment, dated 10/18/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 12 which indicated moderate cognitive impairment.</p> <p>Review of Resident #14's care plan reflected a focused area, revised on 9/9/2024, of chronic pain. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #14's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 10-325mg by mouth every 8 hours PRN for pain; Ordered 8/16/2024, updated 10/16/2024 to include PRN for moderate or greater pain.</p> <p>Review of Resident #14's MAR for October reflected PRN hydrocodone-acetaminophen tablets had been given 13 times from 10/1/2024 through 10/21/2024.</p> <p>6. Review of Resident #15's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE], with an original admitted [DATE]. Diagnoses included idiopathic aseptic necrosis of right and left femur (unknown cause of a bone disease causing bone death due to lack of adequate blood supply, in the thigh bone), dementia (gradual decline of brain functions) and pain cause unspecified.</p> <p>Review of Resident #15's care plan reflected a focused area, revised on 12/12/2024, of right leg pain. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #14's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 10-325mg by mouth every 12 hours PRN for pain; Ordered 8/16/2024, updated 10/16/2024 to include PRN for moderate or greater pain.</p> <p>Review of Resident #14's MAR for October reflected PRN hydrocodone-acetaminophen tablets had been given 4 times from 10/1/2024 through 10/21/2024.</p> <p>Review of the facility provided investigation report, dated 10/29/2024, reflected on 10/21/2024, visiting hospice nurse, RN L, notified facility staff Resident #10's Oxycodone blister pack and the narcotic count sheet for the medication were missing. RN L reported the blister pack and the count sheet had been in the cart the week prior when she visited the facility. The facility DON began an investigation. The report notes Resident #10's Oxycodone were not located; the facility began drug testing the nursing staff who had access to the cart in which the drug had been located. Overnight nurse, RN M, was the final nurse needing to be drug tested. The other three nurses who had access to the cart had tested negative for the presence of oxycodone. RN M was scheduled to be tested prior to her shift; the DON arranged for LVN O to be available to work if the drug test results were positive for RN M. LVN O mentioned to the DON that a similar situation had occurred at a sister facility. LVN O stated RN M had worked at the sister facility and was suspected of being the one to take the narcotics missing. LVN O described that the blister packs containing narcotics had been slit in the back and replaced with a similar looking non-narcotic pill and put back in the cart. The report noted RN M was suspended pending the investigation. All medication cart blister packs were inspected for alterations. The facility discovered the Residents #11, #12, #13, #14 and #15 had hydrocodone blister packs containing methocarbamol (a non-narcotic muscle relaxant) in place of hydrocodone pills.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility RN M's personnel file revealed she was hired on 08/12/2024 and her employment was terminated on 10/25/2024. RN M had received training on Abuse, Neglect and Exploitation on 9/13/2024. RN M's file contained a current RN nursing license with an expiration date of 9/30/2026.</p> <p>During an interview on 01/17/2025 at 12:21pm and 1/18/2025 at 3:42pm with the facility DON revealed she had been notified by LVN N that Hospice nurse, RN L, was at the facility and had reported she was unable to find Resident #10's PRN Oxycodone or the count sheet. The DON stated it was initially believed that the Oxycodone had been placed in a different cart than the PRN cart. She stated Resident #10 also had a blister pack of scheduled Oxycodone which she received as scheduled daily twice a day, in the schedule medications cart and was not missing. On 10/22/2024 all carts were checked, and the medication was not found. The DON stated she then started the drug testing of all nurses that had access to the PRN cart and discovered from LVN O that RN M had a history of working at a sister facility where narcotic medications had also been stolen. LVN O had described that narcotic blister packs had been tampered with and replace with a medication that looked similar. The DON stated that after the drug test, which was negative for narcotics, RN M was suspended. A search of all narcotics in all medication carts with a focus on whether the foil backing on the blister packs had been tampered with and if the pills were as labeled on the packs. The DON stated the additional missing narcotics were then found, the count sheets corresponding to the medication remained. The DON stated it had not been easy to detect the tampering as the foil was cut along the edge of the bubble and the medication was substituted with methocarbamol which looks the same other than the pill imprint. The DON stated since the RN M's urine tested negative, and the tampering was so hard to detect she wonders if it was being done to resale the narcotics on the street, but she does not have evidence of this theory. The DON stated since the misappropriation occurred, she had implemented a process in which she or an ADON were notified daily by the pharmacy of the facility narcotic reconciliation report and one of them has checked all carts daily and will continue to do so.</p> <p>During an interview on 01/18/2025 at 12:58pm with hospice RN L revealed each hospice nurse when they visit a facility is required to do a narcotic count. She had been visiting Resident #10, so she was counting the residents' narcotics. RN L stated she had been unable to locate Resident #10's PRN Oxycodone blister pack and the corresponding count sheet. She stated the previous hospice nurse that visited on 10/17/2024 had documented there was 29 tablets left in a blister pack and the count sheet had the correct count. RN L stated she notified the facility nurse who was working at the time, and she had also looked for the blister pack. When it was not found the facility DON was notified by the facility nurse and she had called her hospice supervisor to notify of the missing drug. RN L stated she had never experienced missing medications at the facility prior to this so she assumed the blister pack had been misplaced.</p> <p>During an interview on 01/18/2025 at 3:25pm with LVN O revealed she had worked at another facility owned by the same company. She stated she knew RN M had also worked at the facility as an agency nurse. She had not known her well but when she was called in to work and RN M came in, she had recognized her. LVN O stated the sister facility had not known for certain that missing drugs were caused by RN M, but they had requested she not be sent back to the facility from the Agency.</p> <p>During an interview on 01/22/2025 at 12:21pm with the facility MD revealed he had been notified of the missing medication for Resident #10 then again notified of the other residents possibly having received a muscle relaxant in place of the narcotic ordered. The MD stated assessments were completed on all residents involved that as with any medication there can be adverse reactions and or side effects, none were found.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy Identifying Exploitation, Theft and Misappropriation of Resident Property, dated 4/2021, revealed misappropriation of resident property meant the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. According to the document, an example of misappropriation of property included, drug diversion (taking the resident's medication ).</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47065</p> <p>Based on interviews and record reviews, the facility failed to ensure the resident environment remained as free of accident hazards as is possible for 1 (Resident #8) of 15 residents reviewed for accidents and hazards.</p> <p>The facility failed to ensure CNA G performed appropriate incontinent care on Resident #8 when she asked her to hold onto the bed, which subsequently led to Resident #8 losing grip of the bed, falling to the ground, and sustaining a skin tear to her right forearm and bump to the left side of her forehead.</p> <p>This deficient practice could place residents at risk of injuries.</p> <p>Findings include:</p> <p>Review of Resident #8's admission record, dated 01/22/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8 had diagnoses including unspecified Parkinsonism (a general term for a group of neurological disorders that affect movement), unspecified fall, unspecified pain, age-related physical debility (a symptom of frailty, which is a syndrome of physiological decline that occurs with aging), unspecified obesity, generalized anxiety disorder, major depressive disorder, pain in unspecified joint, carpal tunnel syndrome (a common condition that occurs when the median nerve in the wrist is compressed) in bilateral upper limbs, acute (a sudden, sharp pain caused by a tumor (neoplasm) that comes on quickly and lasts for a short period of time) and chronic (a persistent, ongoing pain associated with a tumor that can last for months or even years, often with varying levels of intensity and may be present even when not actively treated) neoplasm related pain, and encounter for palliative care.</p> <p>Review of Resident #8's quarterly MDS assessment, dated 08/08/24, reflected she had a BIMS score of 12 out of 15, which indicated she had moderate cognitive impairment. Resident #8 had no falls since admission. Resident #1 was dependent on toileting and required substantial/maximal assistance with bed mobility.</p> <p>Review of Resident #8's care plan, dated 09/17/24, reflected she was at risk for falls. Resident #8 also had an ADL self-care performance deficit and had right-handed resting hand splints, but she chose digit aluminum splints during the day. Staff were required to provide Resident #8 with total assistance to turn and reposition in bed and for toileting. Resident #8's speech was unclear at times and staff were required to allow adequate time for her to respond, repeat as necessary, to not rush her, and request clarification to ensure understanding.</p> <p>Review of Resident #8's admission fall risk evaluation, dated 10/13/24, reflected she was at high risk for falls, had no falls in the past three months, was independent and continent, was confined to chair in mobility status, not able to attempt testing without physical help for mobility, had 1-2 present risk factors/health conditions, and took 1-2 high risk medications at the time and/or within last seven days.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #8's progress notes, dated 01/22/25, reflected the following:</p> <p>-A nurse's note on 11/04/24 at 6:43 a.m. by RN H: Resident fell out of bed while being changed by CNA G at approximately 3:45 a.m. Resident alert and oriented x4 and able to make needs known. Vitals within normal limits. Resident has bump to left forehead and a small skin tear to left forearm which I cleaned and covered with a bandage. Resident rated pain 10/10. 911 called and resident transported to hospital per EMT at 4:20 a.m. DON informed, on call informed, daughter informed, and on call provider informed.</p> <p>-A nurse's note on 11/04/24 at 2:52 p.m. LVN K: Resident returned from ER. CT and X-rays of bilateral forearms and left femur performed at ER. No new orders noted.</p> <p>Review of Resident #8's pain level summary, dated 01/22/25, reflected the following pain levels on 11/04/24:</p> <p>-10/10 pain level at 4:00 a.m.</p> <p>-8/10 pain level at 10:50 a.m.</p> <p>-8/10 pain level at 12:02 p.m.</p> <p>-8/10 pain level at 3:45 p.m.</p> <p>-10/10 pain level at 5:05 p.m.</p> <p>-3/10 pain level at 7:25 p.m.</p> <p>-3/10 pain level at 7:47 p.m.</p> <p>-5/10 pain level at 10:29 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Provider Investigation Report, dated 11/04/24, reflected on Resident #8's family reported on 11/04/24 that on 11/04/24 at 3:45 a.m. in Resident #8's room, CNA G was assisting Resident #8 with incontinent care in bed, CNA G asked Resident #8 to hold on to bed, Resident #8 lost grip and fell to floor from 2.5 feet. Resident #8's family alleges that CNA G was neglectful and resulted in fall. CNA G denied the allegations. RN H assessed Resident #8. Resident #8 was alert and oriented x4, able to make needs known, and vitals were within normal limits. RN H noted Resident #8 had a bump to the left forehead, a small skin tear to the left forearm, and cleaned and covered the left forearm with a bandage. Resident #8 rated her pain to her head 10/10. Resident #8 was transferred to the hospital for further evaluation. At the hospital ED, x-rays were obtained as followed: Pelvis: No acute displaced pelvic fracture; Left femur: No acute fracture or discoloration; Right femur: No acute right femur fracture of discoloration; CT cervical spine without contrast: Bones: No acute fracture. Mild degenerative anterolisthesis of C3 on C4; 2 views left forearm: Findings: No acute fracture or dislocation' CT head without contrast: No acute intracranial abnormality, left frontal scalp contusion; XR forearm 2 views right: No evidence of acute fracture or subluxation. Acetaminophen 1000mg was administered and subsequently, Fentanyl 50 mcg/ml injection 25 mcg dose intravenously. Pain medication administration frequency increased per physician order due to increased pain upon readmission. CNA G was immediately suspended pending investigation, staff were re-educated on 1 vs 2 person staff assistance with bed mobility and incontinent care and where/how to determine level of assistance per specified resident, abuse, neglect, and exploitation that were ongoing. Ombudsman, RP, and MD were notified. Resident safety surveys were initiated on Resident #8's hall. Staff ensured Resident #8 felt safe and comfortable in the environment, provided her with an electric bed with halos to assist with bed mobility, interviewed her to determine comfortability with 1 person vs 2-person bed mobility/incontinent care, updated care plan accordingly, and audited care plans to ensure Kardex accurately reflected appropriate care level for bed mobility/incontinent care. The facility did not find evidence to support the neglect allegation. Resident #8 was care-planned as a 1-person incontinent care service. Resident #8 felt comfortable with CNA G up until the incident occurred including several other brief changes throughout the same shift. Resident #8 experienced a fall while CNA G was providing incontinent care.</p> <p>Review of Resident #8's statement from the Provider Investigation Report, dated 11/04/24, reflected CNA G was changing her brief and was on the left side of her bed, CNA G turned her over with the drawsheet, her legs hung off the bed and she told CNA G such, CNA G told her to hold onto the bed, she told CNA G that she could not, CNA G told her that she did it before and could do it again, CNA G went to her right side and told her again to hold onto the bed, the mattress at some point gave way, she fell to the floor, staff came into her room, CNA G said, I'm out of here, and left her room, her legs and head hurt, she hit her head on her oxygen concentrator and her legs on the trash can.</p> <p>Review of CNA G's statement from the Provider Investigation Report, dated 11/05/24, reflected she changed Resident #8 several times during the night shift, she pulled Resident #8 toward her using the draw sheet, told Resident #8 to hold onto the bed like she usually did and asked her repeatedly if she had grip of the bed and assured her that she would get assistance if she did not have grip, Resident #8 told her that she had grip of the bed, she moved to the right side of Resident #8, she reached for a brief sitting on the top of Resident #8's headboard, Resident #8 slipped off the bed, Resident #8 did not cue her that she was ready to fall or felt like she was falling, Resident #8 did not hit anything, she notified RN H, LVN I, and CNA J to help her, they used a Hoyer to help put Resident #8 back in bed, Resident #8 started complaining of pain when she was back in the bed, EMS was notified and arrived, they tried to notify Resident #8's RP and there was no answer, and Resident #8's RP called in the morning of 11/05/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #8's ED arrival information, dated 11/04/24 at 9:48 a.m., reflected she arrived at the ER on [DATE] at 4:49 a.m. on a chief complaint of a fall. Resident #8's CT head without contrast final result was no acute intracranial abnormality and a left frontal scalp contusion (bruise). Resident #8's CT cervical spine without contrast findings were no acute fracture and mild degenerative anterolisthesis of C3 on C4 (the third cervical vertebra (C3) has slightly slipped forward onto the fourth cervical vertebra (C4) due to age-related wear and tear on the spine).</p> <p>Review of Resident #8's ED provider notes, dated 11/04/24 at 9:49 a.m., reflected on Resident #8 presented to the ED from the facility after a fall from her bed. Resident #8 reported CNA G rolled her, she was left unattended, rolled out of bed impacting her left-sided forehead, her bilateral forearms, and her left femur. Resident #8 was alert and oriented x4, had Parkinson's disease at normal baseline, had a left-sided hematoma on her left femur, bruising to her left forehead, and a small skin tear on her right forearm.</p> <p>An attempt to interview Resident #8 was made on 01/17/25 at 11:10 a.m. Resident #8 was difficult to understand when asking open ended questions about the incident, despite the surveyor asking her several different ways. Resident #8 was able to answer close ended questions. Resident #8 replied, No. She was let go, when asked if CNA G still worked with her. Resident #8 replied, No, when asked if she had any other falls after the incident on 11/04/24. Resident #8 replied, No, when asked if the staff continued to perform incontinent care in the manner CNA G did after the incident. Resident #8 replied, Yes, when asked if she felt safe .</p> <p>An attempt to interview CNA G was made on 01/22/25 at 10:07 a.m. A voicemail and call back number were left. CNA G did not return the surveyor's call before exit.</p> <p>During an interview on 01/22/25 at 10:21 a.m., Resident #8's RP stated she was not there when Resident #8's incident happened. Resident #8's RP stated she received a voicemail from Resident #8, who told her that she was going to the hospital on 11/04/24. Resident #8's RP stated she called the facility and spoke with an unknown staff member, who told her that Resident #8 fell out of bed and was going to the hospital. Resident #8's RP stated Resident #8 also told her that CNA G told her to hold onto the left side of the bed with her right hand. Resident #8's RP stated Resident #8's right arm was weak. Resident #8's RP proceeded to state that Resident #8 told her that she told CNA G that she could not hold on, CNA G told Resident #8 that she could, CNA G left Resident #8's weak side unattended, CNA G flipped Resident #8, Resident #8 fell out of the bed and hit her right thigh on a metal trash can and her knee on the AC unit. Resident #8's RP stated Resident #8 did not break any bones, but she struggled with experiencing pain for a while. Resident #8's RP stated she believed it was a blatant case of negligence on CNA G's part and that the DON agreed with her and told her that they would follow-up. Resident #8's RP stated Resident #8 required 1-person assistance with repositioning in bed.</p> <p>During an interview on 01/22/25 at 10:29 a.m., RN H stated she assessed Resident #8 on 11/04/24. RN H stated Resident #8 expressed that she was in pain, observed Resident #8 had a bump on her forehead and a skin tear on one of her forearms. RN H stated she cleaned and bandaged Resident #8's skin tear and contacted EMS and the DON because she believed Resident #8 had a change in condition. RN H was unable to provide more information due to being at the hospital and about to undergo surgery and ended the call.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An attempt to interview LVN I was made on 01/22/25 at 10:44 a.m. A voicemail and call back number were left. LVN I did not return the surveyor's call before exit.</p> <p>An attempt to interview CNA J was made on 01/22/25 at 10:46 a.m. A voicemail and call back number were left. CNA J did not return the surveyor's call before exit.</p> <p>During an interview on 01/22/25 at 12:08 p.m., the DON stated CNAs had access to residents' Kardex (care summary), which showed how much level of assistance and how many staff were required to assist residents with their ADLs. The DON stated she taught staff how to access residents' Kardex during in-service on 11/04/24 after Resident #8's incident. The DON stated CNAs always had access to residents' care plans. The DON stated CNA G was terminated due to performance related issues.</p> <p>During an interview on 01/22/25 at 12:36 p.m., the DON stated CNA G was suspended after Resident #8's incident on 11/04/24. The DON stated she did not know how long CNA G was suspended for. The DON stated CNA G was reinstated and did not work with Resident #8 after she returned to work. The DON stated the ADON did 1:1 training with CNA G. The DON stated she did not know what kind of 1:1 training the ADON did with CNA G.</p> <p>During an interview on 01/22/25 at 1:40 p.m., LVN D stated Resident #8 was a 2-person assist with her ADLs. LVN D stated CNAs and LVNs performed incontinent care on residents. LVN D stated CNAs could not ask residents to hold onto their beds during incontinent care. LVN D stated CNAs were required to ask a charge nurse if they did not know how much assistance and how many staff were required to assist a resident with incontinent care. LVN D stated CNAs had access to residents' electronic health records. LVN D stated she did not know if CNAs had access to residents' care plans. LVN D stated nurses had access to residents' electronic health records, care plans, and assessments. LVN D stated she did not receive any grievances and complaints about CNA G from residents and visitors. LVN D stated she knew it was important to know the type of assistance a resident needed during incontinent care and bed mobility and proper techniques to be utilized and said, 100% safety. That is why care plan in place. For safety issue. To feel emotionally and physically safe with 2 staff.</p> <p>During an interview on 01/22/25 at 2:18 p.m., the RNC stated CNA G was suspended from 11/04/24 through 11/06/24 and was terminated on 12/09/24. The RNC stated CNA G was written up related to Resident #8's incident, received a second write up due to other resident concerns related to professionalism and failing to provide adequate incontinent care. The RNC explained CNA G would perform incontinent care, but she would leave BM. The RNC stated CNA G was terminated due to customer service issues and not being a team player.</p> <p>During an interview on 01/22/25 at 3:27 p.m., CNA F stated she could not recall if she received in-services related to Resident #8's incident. CNA F stated CNAs, RNs, and LVNs performed incontinent care. CNA F stated residents willingly held onto their beds out of fear of falling back and forward. CNA F stated CNAs could not ask residents to grab onto the bed during incontinent care. CNA F stated CNAs had access to residents' Kardex and care plans to determine their ADL status. CNA F stated she knew it was important to know the type of assistance a resident needs during incontinent care and bed mobility and proper techniques to be utilized and said, Because you can turn them wrong and to not hurt them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/22/25 at 4:00 p.m., RN E stated she was in-serviced on resident safety, reporting, and notifying families. RN E stated CNAs changed briefs most of the time. RN E stated LVNs, and RNs also changed briefs. RN E stated RNs and LVNs had access to residents' care plans to verify ADL status. RN E stated CNAs could determine residents' ADL status on their plan of care. RN E stated CNAs could ask LVNs and RNs for assistance. RN E stated staff could not ask the resident to hold onto the bed if they were incapable. RN E stated she knew it was important to know the type of assistance a resident needs during incontinent care and bed mobility and proper techniques to be utilized and said, Resident safety. Want residents to be comfortable and progress. And for their well-being.</p> <p>During an interview on 01/22/25 at 5:32 p.m., the ADON stated she received concerns and complaints about CNA G's timeliness. The ADON stated CNA G was terminated for quality of care and working while intoxicated. The ADON stated she recalled in-servicing staff on 2 person ADL assistance and never walking to the opposite side of a resident's bed when a resident was rolled over to their side. The ADON stated nurses and CNAs performed incontinent care. The ADON stated CNAs mainly performed incontinent care. The ADON stated CNAs had access to residents' Kardex, which would tell them residents' ADL status. The ADON stated CNAs could ask residents to grab onto the bed during incontinent care. The ADON stated staff could not ask a resident to grab onto the bed if a resident had poor grip strength and one-sided weakness. The ADON stated she knew it was important to know the type of assistance a resident needs during incontinent care and bed mobility and proper techniques to be utilized and said, Safety first and foremost. Falls and injury could occur.</p> <p>During an interview on 01/22/25 at 6:43 p.m., the DON stated during Resident #8's investigation, she found that CNA G told her that Resident #8 was always able to hold onto the bed and that it was her normal behavior. The DON stated she interviewed Resident #8, who told her that she did not want CNA G to take care of her anymore after the incident on 11/04/24. The DON stated she asked Resident #8 whether she wanted more than be educated regarding determining residents' ADL status. The DON stated she did not see CNA G noted on the in-services. The DON stated CNA G was suspended from 11/04/24 through 11/06/24. The DON stated the ADM told her that CNA G could return on 11/06/24. The DON stated CNA G also refused to sign the 1:1 education. The DON stated CNA G was terminated in December 2024. The DON stated CNA G could not be terminated sooner because human resources told her that it was difficult to terminate staff despite CNA G refusing to sign the re-education and 1:1 training. The DON stated CNA G received a write up after the 11/04/24 incident on paper. The DON stated CNA G was terminated due to calling out of work at the last minute on two occasions. The DON stated she did not refer CNA G's license due to not being able to terminate CNA G at the time of the incident. The DON stated the nurses and CNAs performed incontinent care. The DON stated she personally would not rely on residents holding onto the bed when asked if staff could ask residents to hold onto the bed. The DON stated nurses accessed residents' care plans and CNAs accessed residents' Kardex for residents' ADL status. The DON stated she knew it was important to know the type of assistance a resident needs during incontinent care and bed mobility and proper techniques to be utilized and said, Safety. Safety for resident and safety for staff because do not want to drop or hurt a resident. Also, resident preference. The DON stated Resident #8 was x-rayed and had no fractures. The DON stated Resident #8 complained of pain later, staff sent her out to the hospital, they notified the physician, and the physician increased her pain medication. The DON stated when CNA G was reinstated, she no longer worked with Resident #8 and was re-educated on locating Kardex and performing bed mobility and incontinent care. The DON stated she did not believe there were any other grievances and concerns before and after Resident #8's incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/22/25 at 7:39 p.m., the ADM stated he did not find any substantiation for neglect due to CNA G being the only witness of the incident with Resident #8. The ADM stated CNA G told him that Resident #8 slid during incontinent care. The ADM stated CNA G told him that she asked Resident #8 to hold onto the bed. The ADM stated Resident #8 was care-planned for one-person assistance and still felt comfortable with 1-person during care after the incident on 11/04/24. The ADM stated Resident #8 did not feel CNA G was competent enough to perform ADL care. The ADM stated CNA G was suspended for 2-3 days. The ADM stated CNA G was instructed not to provide care to Resident #8 when she returned to work. The ADM stated other CNAs provided care to Resident #8 after the incident. The ADM stated CNA G was given re-education on staff assistance with bed mobility and incontinent care and abuse and neglect. The ADM stated CNA G had no allegations before and after the incident. The ADM stated CNA G was terminated due to poor customer service. The ADM stated he was unsure if nursing staff could ask residents to hold onto their beds during incontinent care. The ADM stated CNAs referred to residents' Kardex for ADL status information. The ADM stated he knew it was important to know the type of assistance a resident needs during incontinent care and bed mobility and proper techniques to be utilized and said, Care plan was created by licensed nursing staff and IDT team and was coordinated with family. It captures residents' daily needs. Adhering to the care plan ensures staff provide care according to resident, families, and providers preferences and recommendations. The ADM stated Resident #8 had no allegations against staff before and after the incident. The ADM stated Resident #8 had no fractures after the incident. The ADM stated he in-serviced staff on abuse and neglect, reporting, abuse and neglect definitions, examples of abuse and neglect, and had staff demonstrate examples.</p> <p>Review of the facility's in-services reflected staff were taught that some residents required one or two staff for bed mobility and incontinent care, the importance of providing residents with the appropriate level of care and assistance based on their individual needs, two staff members must participate to ensure the residents' safety if a resident required two staff assistance to perform bed mobility and incontinent care, checking the residents' Kardex and electronic health record when staff were unsure of a residents' abilities to perform bed mobility and incontinent care and how many staff were required to perform bed mobility and incontinent care, and how to locate the Kardex by the DON on 11/04/24. CNA G and RN E were not listed.</p> <p>Review of the facility's Perineal Care policy, revised in February 2018, reflected the following:</p> <p>Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.</p> <p>Preparation: 1. Review the resident's care plan to assess for any special needs of the resident.</p> <p>There was nothing in the policy about whether a staff member could ask the resident to hold onto the bed during perineal care.</p> <p>Review of the facility's Falls and Fall Risk Managing policy, revised April 2022, reflected the following:</p> <p>Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Definition: According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.</p> <p>Fall Risk Factors:</p> <p>2. Resident conditions that may contribute to the risk of falls include:</p> <ul style="list-style-type: none"> <li>c. delirium and other cognitive impairment;</li> <li>d. pain;</li> <li>e. lower extremity weakness;</li> <li>f. poor grip strength;</li> <li>i. functional impairments;</li> <li>k. incontinence</li> </ul> <p>3. Medical factors that contribute to the risk of falls include:</p> <ul style="list-style-type: none"> <li>e. balance and gait disorders; etc.</li> </ul>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47065</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 7 of 9 (Resident #10, #11, #12, #13, #14, #15, and #16) residents reviewed.</p> <p>A. The facility failed to ensure Resident #16 received Rifaximin (an antibiotic used to prevent hepatic encephalopathy). Ten doses of the medication were missed during the 34 days stay at the facility.</p> <p>B. The facility failed to prevent the misappropriation of Resident #10's Oxycodone (a schedule II controlled opioid medication used to treat moderate to severe pain) taken during the days of 10/17/24 through 10/21/24, and Residents #11, #12, #13, #14 and #15's hydrocodone/APAP tablets (a schedule II controlled opioid medication used to treat pain) taken on unknown dates.</p> <p>This deficient practice could place residents at risk for adverse effects by not receiving the therapeutic effects of the medication.</p> <p>Findings included:</p> <p>A. Review of Resident #16's admission record, undated, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Diagnoses included encephalopathy (loss of brain function when a damaged liver does not remove toxins from the blood.), hepatorenal syndrome (complication liver causing rapid kidney deterioration), altered mental status.</p> <p>Review of Resident #16's Admission MDS assessment, dated 12/18/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 13 which indicated cognition was intact.</p> <p>Review of Resident #16's care plan reflected a focused area, initiated on 12/15/2024, of Resident #16 received Rifaximin for cirrhosis on the liver. The goal was that the resident would be free of adverse effects of the antibiotic. The interventions included administer medication as ordered.</p> <p>Review of Resident #16's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered on 12/13/2024 to receive Rifaximin 550 mg twice a day for alcoholic cirrhosis.</p> <p>Review of Resident #16's MAR for December 2024 reflected Rifaximin was not administered on 12/30/2024 the MAR notes OT on both doses due which according to the Chart Codes means Other/See Nurses Notes.</p> <p>Review of Resident #16's Nurses Progress Note revealed on 12/30/2024 the nurse documented Rifaximin was on order.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #16's MAR for January 2025 reflected Rifaximin was not administered on 1/04/2025 and 1/08/2025 the MAR notes OT on all four doses. On 01/13/2025 the evening dose is initialed OT which according to the Chart Codes means Other/See Nurses Notes. On 01/14/2025 the morning dose initial area is blank with no code; the evening dose contains a H meaning on hold.</p> <p>Review of Resident #16's Nurses Progress Note revealed on 1/04/2025 and 01/08/2025 there was no documentation indicating a reason the Rifaximin was not given. On 1/13/2025 the Rifaximin was not given due to being on order. On 01/15/2025 Resident #16 was noted to have been discharged home.</p> <p>During an interview on 01/18/2025 at 1:54 pm MA Q explained that writing OT on the MAR indicated that the medication was not given and the reason would be documented in the progress notes. MA Q stated she had intended to write the cause in the progress notes but had missed doing so on some days. MA Q stated there had been a problem with the pharmacy only sending 3 or 4 doses each time causing them to run out of the Rifaximin.</p> <p>During an interview on 01/18/2025 at 3:42pm with the facility DON revealed she was not aware of all the missed doses of Resident #16's Rifaximin. The DON stated MA Q should have notified her that the pharmacy was not sending enough to prevent running out of Rifaximin. The DON stated the notes written in progress notes each day were automatically transferred over to the 24-hour report which was reviewed by her or an ADON at the beginning of each day. If an issue needed to be addressed they would follow up. If the MA does not tell her personally or failed to write the issue in the progress notes she had no way of knowing. The DON stated the outcome of a resident not getting their Rifaximin could be and increase in ammonia levels which for a person with liver disease can be toxic.</p> <p>During an interview on 01/22/2025 at 12:21pm with the facility MD revealed he was uncertain if he had been notified of Resident #16's missed doses of Rifaximin but thinks he probably had been. He stated there was no substitution he could prescribe for Rifaximin. The MD explained the purpose of the antibiotic was to treat bacteria that builds up in the gut. The MD stated it was frequently common that Rifaximin can be scarce and difficult to obtain from pharmacies. An occasional missed dose would probably not affect the resident but too many missed doses can cause hepatic encephalopathy.</p> <p>B.1. Review of Resident #10's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, stage 5 (kidney failure), congestive heart failure (heart cannot pump an adequate amount of blood for circulation), femur fracture (broken thighbone) and pain unspecified (uncertain cause)</p> <p>Review of Resident #10's Annual MDS assessment, dated 11/20/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 12 which indicated moderate cognitive impairment.</p> <p>Review of Resident #10's care plan reflected a focused area, revised on 1/16/2024, of generalized pain related to a femur fracture. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #10's Order Summary Report, viewed on 1/17/2025, reflected the resident was ordered 1 oxycodone tablet, 5mg by mouth every 8 hours PRN for pain; Ordered 12/7/2023.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #10's MAR for October reflected a PRN oxycodone tablet was not requested during the month.</p> <p>2. Review of Resident #11's admission record, undated, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Diagnoses included DM II, pain in unspecified knee, HTN (high blood pressure) and heart failure.</p> <p>Review of Resident #11's Quarterly MDS assessment, dated 10/17/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 15 which indicated cognition was intact.</p> <p>Review of Resident #11's care plan reflected a focused area, revised on 1/15/2025, of generalized pain related to a femur fracture. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #11's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 10-325mg by mouth every 6 hours PRN for pain; Ordered 3/13/2024.</p> <p>Review of Resident #11's MAR for October reflected prn hydrocodone-acetaminophen tablets had been given 12 times from 10/1/2024 until 10/21/2024.</p> <p>3. Review of Resident #12's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, stage 5 (kidney failure), disorder of bone (medical conditions affecting the bones), HTN and chronic pain.</p> <p>Review of Resident #12's quarterly MDS assessment, dated 12/2/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 15 which indicated cognition was intact.</p> <p>Review of Resident #12's care plan reflected a focused area, revised on 3/3/2024, of generalized pain related to a femur fracture. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included anticipate the resident's need for pain relief and respond immediately.</p> <p>Review of Resident #12's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 5-325mg by mouth every 8 hours PRN for pain; Ordered 2/16/2024.</p> <p>Review of Resident #12's MAR for October reflected PRN hydrocodone-acetaminophen tablets had been given 5 times from 10/1/2024 through 10/21/2024.</p> <p>4. Review of Resident #13's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE], with an original admission of 10/21/2022. Diagnoses included heart failure, DM II, and unspecified pain.</p> <p>Review of Resident #13's care plan reflected a focused area, revised on 8/13/2024, of pain. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #13's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 5-325mg by mouth every 6 hours PRN for pain; Ordered 5/6/2024.</p> <p>Review of Resident #13's MAR for October 2024 reflected prn hydrocodone-acetaminophen tablets had been given 26 times from 10/1/2024 through 10/21/2024.</p> <p>5. Review of Resident #14's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE], with an original admitted [DATE]. Diagnoses included unspecified fractured neck (fracture of any of the seven cervical vertebrae in the neck), dementia (gradual decline of brain functions) and chronic pain syndrome.</p> <p>Review of Resident #14's quarterly MDS assessment, dated 10/18/2024, reflected based on Section C: Cognitive Patterns, the resident had a BIMs score of 12 which indicated moderate cognitive impairment.</p> <p>Review of Resident #14's care plan reflected a focused area, revised on 9/9/2024, of chronic pain. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #14's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 10-325mg by mouth every 8 hours PRN for pain; Ordered 8/16/2024, updated 10/16/2024 to include PRN for moderate or greater pain.</p> <p>Review of Resident #14's MAR for October reflected PRN hydrocodone-acetaminophen tablets had been given 13 times from 10/1/2024 through 10/21/2024.</p> <p>6. Review of Resident #15's admission record, undated, reflected a [AGE] year-old female, who was admitted to the facility on [DATE], with an original admitted [DATE]. Diagnoses included idiopathic aseptic necrosis of right and left femur (unknown cause of a bone disease causing bone death due to lack of adequate blood supply, in the thigh bone), dementia (gradual decline of brain functions) and pain cause unspecified.</p> <p>Review of Resident #15's care plan reflected a focused area, revised on 12/12/2024, of right leg pain. The goal was that the resident would not have an interruption in normal activities due to pain through the review date. The interventions included administer medications as ordered.</p> <p>Review of Resident #14's Order Summary Report, viewed on 1/18/2025, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 10-325mg by mouth every 12 hours PRN for pain; Ordered 8/16/2024, updated 10/16/2024 to include PRN for moderate or greater pain.</p> <p>Review of Resident #14's MAR for October reflected PRN hydrocodone-acetaminophen tablets had been given 4 times from 10/1/2024 through 10/21/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility provided investigation report, dated 10/29/2024, reflected on 10/21/2024, visiting hospice nurse, RN L, notified facility staff Resident #10's Oxycodone blister pack and the narcotic count sheet for the medication were missing. RN L reported the blister pack and the count sheet had been in the cart the week prior when she visited the facility. The facility DON began an investigation. The report notes Resident #10's Oxycodone were not located; the facility began drug testing the nursing staff who had access to the cart in which the drug had been located. Overnight nurse, RN M, was the final nurse needing to be drug tested. The other three nurses who had access to the cart had tested negative for the presence of oxycodone. RN M was scheduled to be tested prior to her shift; the DON arranged for LVN O to be available to work if the drug test results were positive for RN M. LVN O mentioned to the DON that a similar situation had occurred at a sister facility. LVN O stated RN M had worked at the sister facility and was suspected of being the one to take the narcotics missing. LVN O described that the blister packs containing narcotics had been slit in the back and replaced with a similar looking non-narcotic pill and put back in the cart. The report noted RN M was suspended pending the investigation. All medication cart blister packs were inspected for alterations. The facility discovered the Residents #11, #12, #13, #14 and #15 had hydrocodone blister packs containing methocarbamol (a non-narcotic muscle relaxant) in place of hydrocodone pills.</p> <p>Review of the facility RN M's personnel revealed she was hired on 08/12/2024 and her employment was terminated on 10/25/2024. RN M had received training on Abuse, Neglect and Exploitation on 9/13/2024. RN M's file contained a current RN nursing license with an expiration date of 9/30/2026.</p> <p>During an interview on 01/17/2025 at 12:21pm and 1/18/2025 at 3:42pm with the facility DON revealed she had been notified by LVN N that Hospice nurse, RN L, was at the facility and had reported she was unable to find Resident #10's PRN Oxycodone or the count sheet. The DON stated it was initially believed that the Oxycodone had been placed in a different cart than the PRN cart. She stated Resident #10 also had a blister pack of scheduled Oxycodone which she received as scheduled daily twice a day, in the schedule medications cart and was not missing. On 10/22/2024 all carts were checked, and the medication was not found. The DON stated she then started the drug testing of all nurses that had access to the PRN cart and discovered from LVN O that RN M had a history of working at a sister facility where narcotic medications had also been stolen. LVN O had described that narcotic blister packs had been tampered with and replace with a medication that looked similar. The DON stated that after the drug test, which was negative for narcotics, RN M was suspended. A search of all narcotics in all medication carts with a focus on whether the foil backing on the blister packs had been tampered with and if the pills were as labeled on the packs. The DON stated the additional missing narcotic were then found, the count sheets corresponding to the medication remained. The DON stated it had not been easy to detect the tampering as the foil was cut along the edge of the bubble and the medication was substituted with methocarbamol which looks the same other than the pill imprint. The DON stated since the RN M's urine tested negative, and the tampering was so hard to detect she wonders if it was being done to resale the narcotics on the street, but she does not have evidence of this theory. The DON stated since the misappropriation occurred, she had implemented a process in which she or an ADON were notified daily by the pharmacy of the facility narcotic reconciliation report and one of them has checked all carts daily and will continue to do so.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/18/2025 at 12:58pm with hospice RN L revealed each hospice nurse when they visit a facility is required to do a narcotic count. She had been visiting Resident #10, so she was counting the residents' narcotics. RN L stated she had been unable to locate Resident #10's PRN Oxycodone blister pack and the corresponding count sheet. She stated the previous hospice nurse that visited on 10/17/2024 had documented there was 29 tablets left in a blister pack and the count sheet had the correct count. RN L stated she notified the facility nurse who was working at the time, and she had also looked for the blister pack. When it was not found the facility DON was notified by the facility nurse and she had called her hospice supervisor to notify of the missing drug. RN L stated she had never experienced missing medications at the facility prior to this so she assumed the blister pack had been misplaced.</p> <p>During an interview on 01/18/2025 at 3:25pm with LVN O revealed she had worked at another facility owned by the same company. She stated she knew RN M had also worked at the facility as an agency nurse. She had not known her well but when she was called in to work and RN M came in she had recognized her. LVN O stated the sister facility had not known for certain that missing drugs were caused by RN M but they had requested she not be sent back to the facility from the Agency.</p> <p>During an interview on 01/22/2025 at 12:21pm with the facility MD revealed he had been notified of the missing medication for Resident #10 then again notified of the other residents possibly having received a muscle relaxant in place of the narcotic ordered. The MD stated assessments were completed on all residents involved that as with any medication there can be adverse reactions and or side effects, none were found.</p> <p>Review of the facility's policy Identifying Exploitation, Theft and Misappropriation of Resident Property, dated 4/2021, revealed misappropriation of resident property meant the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. According to the document, an example of misappropriation of property included, drug diversion (taking the resident's medication).</p> <p>Review of the facility Medication and Preparation Administration Policy, undated, reflected the following: Medication Administration- Facility staff should take all measures required by Facility Policy, Applicable Law, and the State Operations manual when administering medications. Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.</p>		

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NAME OF PROVIDER OR SUPPLIER  Western Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  512 Draper Dr Temple, TX 76504	
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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to provide each resident at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care for five (Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) of 15 reviewed for timely meals.</p> <p>The facility failed to provide lunch according to the lunch meal service schedule on 01/17/25 to Residents #3, #4, #5, #6, and #7.</p> <p>This deficient practice could place residents at risk of low blood sugar levels, increased stress levels, slowed metabolism rates, weakened immune systems, malnutrition, weakened hearts, and organ failures.</p> <p>Findings include:</p> <p>Review of Resident #3's admission record, dated 01/17/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses including a wedge compression fracture, unspecified Parkinsonism, Hypokalemia (a condition where there are low levels of potassium in the blood), unspecified and recurrent major depressive disorder, generalized muscle weakness, age-related osteoporosis (a disease that weakens bones, making them more likely to break), unsteadiness on feet, other abnormalities of gait and mobility, other lack of coordination, and repeated falls.</p> <p>Review of Resident #3's comprehensive MDS assessment, dated 12/31/24, reflected she had a BIMS score of 8, which indicated she had moderate cognitive impairment.</p> <p>Review of Resident #3's care plan, dated 01/13/25, reflected she had no altered meal time preference listed.</p> <p>Review of Resident #4's admission record, dated 01/17/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses including hypertensive chronic kidney disease.</p> <p>Review of Resident #4's comprehensive MDS assessment, dated 01/17/25, reflected she had no BIMS score listed .</p> <p>Review of Resident #4's baseline care plan, dated 01/09/25, reflected she was alert, oriented, and had no altered meal time preference listed.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #5's admission record, dated 01/17/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses including unspecified asthma (a chronic lung disease), chronic pulmonary edema (a long-term condition that causes fluid to build up in the lungs), type 2 diabetes, chronic systolic (congestive) heart failure, essential (primary) hypertension (a chronic condition where the force of blood pushing against artery walls is consistently too high), muscle wasting and atrophy, chronic kidney disease stage 2, unsteadiness on feet, other abnormalities of gait and mobility, other lack of coordination, cognitive communication deficit, and weakness.</p> <p>Review of Resident #5's quarterly MDS assessment, dated 12/19/24, reflected she had a BIMS score of 10, which indicated she had moderate cognitive impairment. Resident #5 required a therapeutic diet.</p> <p>Review of Resident #5's care plan, dated 01/07/25, reflected she had diabetes mellitus and staff were required to monitor, document and report as needed any signs and symptoms of hyperglycemia, hypoglycemia, and infection. Resident #5 also did not have an altered meal time preference listed.</p> <p>Review of Resident #6's admission record, dated 01/17/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus), moderate protein-calorie malnutrition (a state where a person is experiencing a moderate level of deficiency in both protein and calories), hyperlipidemia (a condition where there are high levels of fats, like cholesterol and triglycerides, in the blood), hypokalemia, unspecified anemia (a blood disorder that occurs when the body doesn't produce enough healthy red blood cells), essential hypertension, chronic diastolic congestive heart failure, generalized muscle weakness, chronic kidney disease stage 3A, unsteadiness on feet, other abnormalities of gait and mobility, and other lack of coordination.</p> <p>Review of Resident #6's comprehensive MDS assessment, dated 12/06/24, reflected she had a BIMS score of 10, which indicated she had moderate cognitive impairment. Resident #6 required a therapeutic diet.</p> <p>Review of Resident #6's care plan, dated 01/07/25, reflected she required a no salt on tray diet. Resident #6 also did not have an altered mealtime preference listed.</p> <p>Review of Resident #7's admission record, dated 01/17/25, reflected she was an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #7 had diagnoses including acute cystitis with hematuria (a condition where someone experiences a sudden onset of bladder inflammation (acute cystitis) accompanied by blood in the urine (hematuria)), unspecified sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), other iron deficiency anemias, hyperlipidemia, vascular dementia, unspecified depression, other chronic pain, essential hypertension, generalized muscle weakness, chronic kidney disease stage 3B, and abnormal weight loss.</p> <p>Review of Resident #7's comprehensive MDS assessment, dated 12/23/24, reflected she had a BIMS score of 9, which indicated she had moderate cognitive impairment. Resident #7 required a therapeutic diet.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #7's care plan., dated 01/10/25, reflected she had chronic pain and staff were required to monitor, record and report to the nurse loss of appetite, refusal to eat, and weight loss. Resident #7 also required a no salt on tray diet. Resident #7 did not have an altered mealtime preference listed.</p> <p>Review of the facility's Meal Times posting, undated, reflected the following:</p> <p>6:45 a.m. -- Breakfast</p> <p>11:45 a.m. -- Lunch</p> <p>4:45 p.m. -- Dinner</p> <p>An observation of the dining room on 01/17/25 at 12:00 p.m. found there were sixteen residents sitting in the dining room and 3 staff members monitoring the residents and serving beverages. No meals had been served to residents.</p> <p>During an interview on 01/17/25 at 12:02 p.m., the DM stated she did not receive any complaints and grievances about meal service times. The DM stated if a resident complained about dietary, a grievance was filed, and she resolved the grievances.</p> <p>During an interview on 01/17/25 at 1:01 p.m., CNA C stated she often received complaints about meal service times. CNA C stated she notified dietary staff whenever she received dietary concerns and complaints. CNA C stated she knew it was important to serve residents' meals according to the meal service schedule.</p> <p>During an interview on 01/17/25 at 1:02 p.m., RN E stated lunch meal service was at 12:15 p.m. RN E stated she did not know why lunch meal service was late. RN E stated CNAs served residents' meal trays. RN E stated nurses sometimes served residents' meal trays. RN E stated she passed out snacks to residents at about 10:30 a.m.</p> <p>During an interview on 01/17/25 at 1:05 p.m., Resident #3 stated she had not been served her meal tray. Resident #3 stated she was usually served lunch around 1:00 p.m. and it was not her preferred mealtime. Resident #3 stated she was hungry. Resident #3 stated she was not served snacks around 10:30 a.m. Resident #3 stated she usually had to wait an hour after the scheduled lunch meal service start time to receive her lunch meal. Resident #3 stated she felt concerned and bothered that she did not receive her lunch meal tray.</p> <p>During a group interview on 01/17/25 at 1:09 p.m., Residents #4 and #5 stated they had not been served their meal trays. Residents #4 and #5 stated they were usually served lunch around 1:00 p.m. and it was not their preferred mealtime. Residents #4 and #5 stated they were both hungry. Residents #4 and #5 stated they were not served snacks around 10:30 a.m. Resident #5 stated she felt bothered that she did not receive her lunch meal tray because she was a diabetic and felt like her sugar levels were dropping. Resident #4 stated she did not feel bothered that she did not receive her lunch meal tray today (01/17/25), but she felt bothered at times.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a group interview on 01/17/25 at 1:13 p.m., Residents #6 and #7 stated they had not been served their meal trays. Residents #6 and #7 stated they were usually served lunch around 1:00 p.m. and it was not their preferred mealtime. Residents #6 and #7 stated they were both hungry. Residents #6 and #7 stated they were not served snacks around 10:30 a.m. Resident #7 stated she felt bad because she was hungry and did not have lunch yet. Resident #6 stated she did not know how she felt, but she was bothered that she did not get lunch yet.</p> <p>An observation on 01/17/25 at 1:23 p.m., the last meal tray was served .</p> <p>During an interview on 01/22/25 at 1:48 p.m., LVN D stated residents were supposed to be served lunch at 12:00 p.m. LVN D said, Residents could be served lunch between 12:00 p.m. and 12:30 p.m. at the latest. Sometimes lunch was served at 1:00 p.m. LVN D stated she received questions from residents about where their lunch was. LVN D stated CNAs and LVNs provided residents with snacks after lunch trays were returned to the kitchen. LVN D stated she knew it was important to serve residents' meals according to the meal service schedule and said, Because we have patients who have a specific nutrition plan. To help patients return home by attaining their required protein intakes. For dementia residents, it could throw their day off due to the inconsistency. Following scheduled meal services helped dementia residents feel staff are there for them and care about them. Having an off-schedule meal service was negligent to me .</p> <p>During an interview on 01/22/25 at 3:17 p.m., CNA F stated CNAs, LVNs, and RNs served residents' meal trays. CNA F stated she did not receive any concerns or complaints about meal service timeliness by residents or visitors. CNA F stated some residents complained to her about where their meal trays were. CNA F said, Lunch meal service trays were brought to residents' hallways and served to residents as soon as the meal tray carts get to the hallways around 12:30 p.m. and 12:45pm. It was not normal for lunch to be served after 1:00 p.m. CNA F stated meal service took place for one hour. CNA F stated residents were served snacks when the meal trays were returned to the kitchen after each meal service. CNA F stated she knew it was important to serve residents' meals according to the meal service schedule and said, Because nurses conduct blood pressure checks and residents got to eat. Residents could have their sugar levels drop and be hungry. Sometimes the kitchen ran late with getting meal trays out.</p> <p>During an interview on 01/22/25 at 3:55 p.m., RN E stated the kitchen prepared residents' meal trays. RN E stated CNAs served meal trays to residents. RN E stated residents who sat in the dining room were served their meals first. RN E stated lunch meal service was scheduled to start in the dining room at 11:30 a.m . and for residents' rooms at 12:30 p.m. RN E stated lunch meal service was late sometimes. RN E stated she received concerns about meal service timeliness a couple of times from residents. RN E explained residents would tell her that they were hungry and asked where their meals were. RN E stated she provided snacks to residents and informed residents that their meals were on their way if a resident told her that they were hungry and asked where their meal tray was. RN E stated dietary staff brought out snacks around 10:00 a.m. , 3:00 p.m., on request, and as needed. RN E stated she knew it was important to serve residents' meals according to the meal service schedule and said, We have some residents who were medication dependent, who must follow provider orders for their digestive purposes, and who follow a routine. We also cannot let residents be hungry and uncomfortable.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/22/25 at 5:29 p.m., the ADON stated lunch meal service was served at 12:00 p.m. The ADON stated CNAs and nurses served meal trays to residents. The ADON stated she received concerns about the lack of meal service timeliness. The ADON stated she most recently received concerns about the lack of meal service timeliness sometime last week. The ADON stated dietary concerns were brought up and discussed during morning meetings and were addressed with dietary. The ADON stated she knew it was important to serve residents' meals according to the meal service schedule and said, Consistency is good for patients. Blood sugars could drop. Behaviors could occur. Patients could be over hungry. Main thing is it could affect medications.</p> <p>During an interview on 01/22/25 at 6:34 p.m., the DON stated she was told that residents were served lunch at 11:45 a.m. The DON did not indicate who told her that residents were served lunch at 11:45 a.m. The DON stated the dietary prepared residents' meals, and the CNAs and nurses served the meal trays to the residents. The DON stated she did not receive any concerns or grievances about the lack of meal service timeliness within the last 2 months. The DON said, However, if lunch was due at 12:00 p.m. and it's 12:05 p. m., then I consider meal service to be late. The DON stated she knew it was important to serve residents' meals according to the meal service schedule and said, Because of patient satisfaction. Disease processes. People are diabetic. If you go later than schedule, residents could have a hypoglycemic episode. It is a resident right to know what and when they are eating. It is also policy. Meal times are posted in the building. If a resident knows what time meals are to be served as with anything else, then we are supposed to accommodate them.</p> <p>During an interview on 01/22/25 at 7:31 p.m., the ADM stated he did not receive any concerns or grievances about the lack of meal service timeliness. The ADM said, Lunch was to be served at 11:45 a.m. in the dining room. Meal tray carts go to the hallways after the dining room was served. Dietary prepared the meals, CNAs, and nurses passed out the meals. The ADM stated he knew it was important to serve residents' meals according to the meal service schedule and said, They (Residents) should be expecting a regular day to day basis with their meals. There are nursing concerns. For example, if residents need to take medications with their food. Diabetics. There are also issues that could arise with that .</p> <p>Review of the facility's Meal Times policy, dated 2018, reflected the following:</p> <p>Policy: The facility provides three meals daily at regular times which are comparable to meal times in the community setting. Meals are served at the specified times except in emergency situations.</p> <p>Procedures:</p> <ol style="list-style-type: none"> <li>1. Meals will be served according to the state and federal regulations, with no more than fourteen hours between the evening meal and breakfast the following day.</li> <li>2. There will be at least a four-hour interval between breakfast and lunch and between lunch and dinner.</li> </ol> <p>.5 Standard meals must be offered as required by the regulations above, but altered meal times should be offered as requested by the resident(s). A plan of care must be developed to document the resident's altered meal times.</p> <p>Review of the facility's Resident Rights policy, revised December 2016, reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Policy Statement: Team members shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <ul style="list-style-type: none"> <li>a. a dignified existence.</li> <li>b. be treated with respect, kindness, and dignity;</li> </ul>