

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 04/30/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269</p> <p>Based on Observations, interviews, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for one of three residents (Resident #1) reviewed for misappropriation.</p> <p>The facility failed to prevent a diversion (misappropriation) of Resident #1's oxycodone HCl Oral Tablet 5 MG, 16 tablets (an oxycodone pain reliever) received through hospice and reported missing on 04/18/2025.</p> <p>The noncompliance was identified as PNC. The non-compliance began on 04/10/2025 and ended on 04/28/2025. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet printed 04/30/2025 reflected a [AGE] year-old female admitted to the facility 12/04/2023. Her diagnoses included pain unspecified, chronic kidney disease stage 5, and other osteoporosis with current pathological fracture of the femur (thigh bone).</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 08 indicating moderately impaired cognition. Section GG (Functional Abilities) reflected she required maximal assistance with hygiene and bathing and only supervision with most other ADLs. Section J (Health Conditions) the resident did not complain pain during the assessment period and was on a scheduled pain medication regimen.</p> <p>Review of Resident #1's comprehensive care plan, revised 06/13/24, the resident had an ADL self-care performance deficit due to right femur fracture, weakness, comorbidities, osteoporosis, and was receiving hospice services due to terminal illness.</p> <p>Review of Resident #1's physician order reflected an order dated 08/28/2024 for oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth two times a day for Pain.</p> <p>Review of Resident #1's physician order reflected an order dated 12/07/2023 for oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 5 mg by mouth every 8 hours as needed for moderate to severe pain.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's medication administration record for April 2025, reflected no PRN dose of Oxycodone was administered during the month.</p> <p>Review of the Provider Investigation Report dated 12/28/23 reflected, on 4/10/25, a nurse with Hospice came to the facility and counted all medications for [Resident #1] and identified that resident had 16 PRN 5mg Oxycodone left in blister pack. On 4/18/25 around 11:30am, the same nurse with Hospice returned to the facility and identified that the PRN 5mg oxycodone blister pack and respective narcotic count sheet was not in the narcotic box or the narcotic book. At this time, nursing management attempted to find the oxycodone blister pack and card count sheet but could not find the medication.</p> <p>Observation on 04/30/2025 of the 300-hall nurse's narcotics book and cart, 200-hall medication aide and nurse's narcotics book and cart were completed, all medications and blister packets were correct.</p> <p>Review of facility's narcotics count sheet for the 200-hall reflected on 04/11/2025, there were 33 narcotic blisters at the beginning of the 6am to 6 pm shift. The nurses removed a total of 7 medications blister packet from the medication cart and the math was not done correctly, it reflected 25 packets instead of 26 .</p> <p>During an interview on 04/30/2025 at 1:26 pm Resident #1 stated she was on routine pain medication. Resident #1 stated she always got her pain medication when she needed it. Resident #1 stated she did not have concerns with her pain medication.</p> <p>During an interview on 04/30/2025 at 1:56 pm, the DON stated after the medication was noticed to be missing, she counted all narcotics in the facility to verify counts. The DON stated Resident #1 was assessed for pain and there was no adverse reaction for Resident #1. She stated Resident #1 never went without pain medication because Resident #1's routine pain medication was on the medication aide cart. The DON stated Resident #1 did not ask for PRN pain medication. The DON stated she initiated in-services on the process on narcotics count and when the narcotics cart keys change hands. The DON stated she initiated daily narcotic count monitoring of all carts in the facility. The DON stated she contacted the pharmacy and narcotics reconciliation was done. The DON stated she was the only one who could remove empty medication blister packets or discontinued medications from the medication cart. The DON stated 2 nurses were required to sign whenever the pharmacy delivered narcotics. The DON stated she suspected Resident #1's oxycodone went missing on 4/11/2025 when there was mistake on the blister count.</p> <p>During an interview on 04/30/2025 at 4:00 PM the Administrator stated he was made aware of the drug diversion on 4/18/2025. The Administrator stated he called all staff who had access to the 200-hall medication cart from 04/10/2025 to 4/18/2025 and they were interviewed and drug tested on [DATE] and all were negative. The Administrator stated he notified the local police, but they did not show up. The Administrator stated Resident #1's family and the Medical Director were notified. The Administrator stated staff were in-serviced on 04/18/2025. He stated they were not able to identify a perpetrator but there was a suspect. The Administrator stated the facility reordered Resident #1's oxycodone 16 tablets and paid for it on 4/18/2025 .</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 - Few</p>	<p>During interviews on 04/30/2025 starting at 11:25am through 3:41 pm with 3 LVNs, 2 RNs, and 1 MA, they all stated they were made aware there was drug diversion in the facility. They stated they were in-serviced on the process of narcotics count and when the narcotics cart keys changed hands, the carts and medications should be counted. They stated only the DON could remove empty medication blister packets or discontinued medications from the medication cart. They stated 2 nurses were required to sign whenever the pharmacy delivered narcotics .</p> <p>Review of the facility's investigation reflected the Quality Assurance Performance Improvement team met on 04/18/2025 at 4:18 pm.</p> <p>Review of facility's investigation folder reflected Police REPORT NUMBER: CL25040088 DATE: 04/18/2025 at 4:45 pm.</p> <p>Review of facility's in-services date 04/18/2025 reflected:</p> <p>In-Service for Narcotic Count and Medication Reconciliation</p> <p>For all Licensed Charge Nurses and Certified Medication Aides</p> <p>Beginning 4/18/25 and ongoing, all nurses and medication aides will continue the existing card count sheet and narcotic count sheet already in play. In addition, the following parameters will be put into action.</p> <p>Effective Immediately, medication cards need to remain in the medication cart, even if completely depleted, until the DON reviews the Narcotic Count and Narcotic Card Counts for these medications. If a Nurse or Medication Aide dispenses the final dose of a medication in the blister pack, the employee must put the card back into the medication cart and it will be counted in the card count completed at the end/beginning of the shift. Only the Director of Nursing may remove any card from the medication cart. All blister cards, full and empty, must remain on the cart and only the Director of Nursing may remove empty blister packs from the medication cart.</p> <p>Effective Immediately, all narcotics will require 2 nurse's signatures when accepting them from the pharmacy. When pharmacy brings narcotics to the nurse's station, two nurses must sign off on the Narcotic acceptance form (attached to this in-service). This is to ensure verification by two licensed nurses that the medication has been delivered and the quantity is accurately reported in the narcotic count sheet. All information must be filled in - Resident Name, medication name, dose, acceptance date, and quantity .</p> <p>Review of the facility's investigation folder reflected daily monitoring of narcotics count done by the DON for all carts in the facility initiated 04/18/2025 and was ongoing.</p> <p>Review of facility's investigation folder reflected: All 6 employees who were assigned to the 200-hall medication cart between 04/10/2025 and 04/18/2025 where the drug diversion occurred were suspended pending consensual drug screen. It was reflected all 6 staff were drug screened on 4/18/2025 and all came up negative. All 6 nurses were interviewed by the Administrator.</p> <p>Review of the facility's investigation folder reflected:</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 - Few</p>	<p>Controlled Substance Audit-- A controlled substance audit was performed at the request of the facility. The audit included 8 medication/nurse carts, 4 from each wing. Medication orders were reconciled against all active orders dated 4/22/2025 from the nursing home EHR . Controlled substances were audited for expired medications, medication orders with discrepancies, residents with medication orders without medications on-hand, and medications found without an active order. Facility was notified of issues and concerns upon exiting with nurse supervisors, with specific details provided by the end of day completed with this report.</p> <p>Review of the facility's in-services reflected an in-service dated 4/28/2025 Card/Narcotic count when keys change hands which was on going.</p> <p>Review of the facility policy Identifying Exploitation, Theft, and Misappropriation of Resident Property dated April 2021 reflected in part, 1. Exploitation, theft, and misappropriation of resident property are strictly prohibited. 4. Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 5. Examples of misappropriation of resident property include: f. drug diversion (taking the resident's medication).</p> <p>Review of the facility's policy titled Drug Discrepancies, Loss, or Diversion dated reflected:</p> <p>The facility will comply with all federal, state, and local laws as it pertains to dangerous drugs and controlled substances. The facility must have a system that records receipt, usage, and disposition of all controlled substances in sufficient detail that permits an accurate reconciliation. See sections 8.3 Schedule Medication Inventory Sheets and 8.4 Destruction of Scheduled Medication of the Policies and Procedures for Pharmacy Services for additional information regarding those processes. Drug diversion (as defined in The State Operating [NAME]): is the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use, as adapted from the Uniform Controlled Substances Act.</p> <p>Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 reflected:</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p>		