STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455785	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Hills Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 residents (Resident #1) reviewed for supervision:The facility failed to put effective measures in place to prevent Resident #1 from eloping. Resident #1 was found outside the facility across the street in the parking lot of the convenience store on Saturday, 11/12/25 at 7:45 AM. The facility had a plan in place to monitor the front door, but the lock was not working to prevent Resident #1's elopement. The noncompliance was identified as PNC. The IJ began on 11-12-2025 and ended on 11-14-2025. The facility had corrected the noncompliance before the survey began.The findings included:Record review of Resident #1s chart reflected he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis of acute respiratory failure with hypercapnia, unspecified dementia, unspecified severity, with other behavioral disturbance. Record review of the MDS dated [DATE] reflected Resident #1 had a BIMS score of 10, indicating cognitive impairment, ambulating in a wheelchair and risk of elopement. Record review of the Care plan for Resident #1, dated 9/13/2025, reflected that Resident #1 was an elopement risk/wanderer and has a lack of understanding of the need for inpatient services. The resident has impaired cognitive function/dementia or impaired. thought processes related to orientation. status of to self and the location only, short and long-term memory issues. This was care planned before the elopement. In an interview on 11/19/2025 at 10:59 AM with the DM, the DM stated that doors are checked weekly. The DM said there were mag locks on the front and back doors. Resident #1 has a code alert bracelet, so when he gets close to the door, the alarm goes off and the door locks. The DM said on 11-12-2025, around 7:45 AM, Resident #1 made it to the front door. The alarm went off, but the door did not lock . The DM said the door when the door was inspected on 11-10-25, the door was working. DM said after Resident #1 left the facility, the door was checked, and the magnets on the lock were not lining up because the screw had come loose, causing the door not to lock. After the incident, the door was repaired the same day. In an interview on 11/19/2025 at 11:12 AM with the SW, SW said she heard the alarm going off at 7:45 AM, and she immediately went to the closest nurses' station to find out which door the alarm was going off at. The SW was told it was the front door where the alarm was going off, and Resident #1 was not in their room. The SW went out the front door to look for Resident #1 and saw he was across the street at the convenience store. The street was not busy at the time and the speed limit was unknown. Resident #1 was away from the facility for approximately 15 minutes. The SW stated she brought Resident #1 back to the facility. In an interview on 11/19/2025 at 12:12 PM with the AD, she said on 11-12-2025 at 7:50 AM, she stopped by the convenience store before work and saw Resident #1 in the parking lot. The AD stated there was some gravel in the parking lot, and Resident #1 was stuck in his wheelchair. The AD said she helped Resident #1 get the wheelchair unstuck and left. The AD did not know Resident #1 was an elopement risk. AD said there are some residents who were allowed to go to the convenience store. When she was leaving, the SW was coming out of the facility and came to get Resident #1 and took him back to the facility. In an interview on 11/19/2025 at 12:30 PM with the ADM, the ADM stated there was no specific policy/procedure for what to do when the alarm goes off. They had a policy if a resident leaves the building, the ADM stated a resident with a code system alert bracelet who went outside without supervision could get injured.In an interview on 11/20/2025 at 9:50 AM with the CMA. The CMA stated if she hears the door alarm go off, she will go to the nurses' station to look at the control box and find out which door was opened. Then she will check the room of the resident with a code alert bracelet on. The CMA knows which residents have a code alert bracelet on because there were only two in the facility. The CMA will then go find the resident. The CMA stated when she sees a resident with a code alert bracelet going to the door, she will redirect them. The CMA said if a resident with a code alert bracelet makes it outside, they could be hit by a car, fall and get injured, or tip out of the wheelchair. The CMA stated she was in-serviced on elopements last week.In an interview on 11/20/2025 at 10:30 AM with the LVN, the LVN said when the alarm goes off, she will try to find the resident. The LVN said that when a resident with a code-alert bracelet gets close to the door, the door alarm goes off and should lock. When they cross the barrier, the alarm goes off. The LVN said they check the control box at the nurses' station to see what door was open, then she will go find the resident. LVN said that she works with Residnet #1 and if she sees him going to to the door she will redirect him. The resident was then assessed for injuries. The ADM was made aware of the incident. She said that she has been