STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weston Inn Nusring and Rehabilitation	2505 S 37th St 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47243 Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of three residents (Resident # 1) reviewed for misappropriation. The facility failed to prevent a diversion (misappropriation) of Resident #1's Oxycodone 0.5 mg, 30 tablets (opiate narcotic medication); Tramadol 50 mg 30 tablets (a pain medication) received from the pharmacy on 2/7/24 at 4:11 AM and reported missing 2/11/2025 during the day shift. This failure could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity. Findings include: Record review of Resident # 1's face sheet, printed 2/14/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Sciatica, Right -side (pain that originates along your sciatic nerve), Chronic Pain syndrome (Pain that persists beyond the expected healing time for an injury or illness, often causing significant disruption to daily functioning), Tubulointerstitial nephritis (a kidney disorder that causes inflammation of the kidney tubules and surrounding tissues). Record review of Resident's #1's admission MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #1's physician orders, dated 2/6/2025, revealed order written on 2/6/2025 Oxycodone 0.5 mg 8 hours as needed for moderate or greater pain. Tramadol 50 mg one time daily for pain. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the provider investigation report, dated 2/12/2025, reflected on 2/7/2025 at 4:11 AM the pharmacy delivered 30 (thirty) tablets of Oxycodone 0.5 mg 30 (thirty) and Tramadol 50 mg 30 (thirty) for Resident #1, the packing slip from the pharmacy was signed by RN A as received. The Medication was noticed as missing, four days later. A search of the facility's medication rooms, and medication carts and the medications were not located. The report reflected no injury or harm to the resident as the medication was available in the emergency medication kit and the facility replaced the missing medication after the investigation was completed, the facility notified Hospice, the responsible party, the medical director, and the police. Statements were obtained from staff. The investigation findings confirmed the drug diversion. Record review of the pharmacy packing slip, dated 2/7/2025, reflected Oxycodone 0.5 mg 30 (thirty) and Tramadol 50 mg 30 (thirty) tablets were delivered to the facility and signed as received by RN A Record review of the Business card left by the responding police officer reflected, Case No: P25012257 dated 2/12/2025 . Record review of RN A's statement reflected On Friday 2/7/2025, she received medications including narcotics from pharmacy. The narcotics were for [Resident #1]. When she wanted to put the medication away, she noticed she was not a resident on the northside, and she did not find her at all. She received the medication at approximately 4:00 AM. RN A placed the medication in the narcotics box on her side until day shift arrived including the bag of medications she received. When the day shift nurse arrived, she counted with the day shift LVN A and CMA A. She showed them both narcotics bag and name and asked if the resident was in the facility? CMA A stated she did not know, and she did not think she was still here. LVN A stated she did not know but she will take care of it. She handed off the bag to LVN A and CMA A was there when she handed off the bag to nurse LVN A. She asked if the resident is no longer there, where do they put the medication for returns. She was told to put it in the medication room for returns. She asked if she was sure, and she said yes because she works there regularly. She walked into the medication room with nurse LVN A, showed her where she dropped off the narcotics and looked for a supply for another resident with her. She asked her again was it ok to set the medication down there in the medication room for returns or if there was another place to put it in and she said there is no problem. She stated they exited the medication room, and she exited the facility. She stated the medication was intact in the bag because the bag was unopened but the plastic piece for the name was torn by her earlier to see the piece of paper that had the name of the resident. She stated she exited the facility at 7:53 AM , During a phone interview on 2/14/2025 at 12:55 PM with the local police department desk sergeant, revealed the investigator on the case was not available, a message was left for a return phone call. No return phone call received prior to exit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Weston Inn Nusring and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 S 37th St Temple, TX 76504	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CMA A on 02/13/25 at 1:15 PM revealed she was passing morning med's, and one of the agency nurses stated she had med's for Resident #1. She advised her she no longer had her, but she did not know they moved her on the other side. She told her they were narcotics. She was unsure what to do with them once the resident was no longer there. She stated if the resident passed away, the DON was supposed to count them, but she was unsure what she did with them. If she had someone's med's on the cart and the resident passed away the DON would count them. When Resident #1 was discharged , she went to the hospital and then when she came back, she went to the other side. Resident #1's family member made the decision to have her go to the hospital. The med's were not taken from her cart that day, but she was off and when she came back to work, her med's were gone off her cart. Her son realized she needed long term care, so she came back, and she returned, and she was placed on the other side. She did not know what went on the other side. She was surprised they were getting medication. She was wondering why they were still getting medication for her. All the rest of her medication went over to the south side where she was once, she came back. She stated seems like the pharmacy would have sent them to that side since the rest of her med's were going over there. The agency nurse received the med's and placed them in the med room and locked the room. She stated she was not going to open the envelope (purple bag). The DON asked her if she threw them away. She stated she checked the bag. She stated sometimes they had papers in the bag but that day they were busy. She stated 2/7/2025 was the date of the incident. She worked the night shift. Someone from the pharmacy delivered the medication. They were supposed to check the med's when they first came in, and it was because the pharmacy made mistakes. When the med aids came in in the morning, they put the med's on the cart. She stated a lot of the time the night nurses did not know where the med's went, and she had the wrong medication on her cart. The morning med aides would check them in. When the med's came in at night, they would lock them in the med room until the med aides came in. The nurse would advise them they had med's in the med room, and they got them and placed them where they were supposed to be. During an interview with LVN A on 02/13/25 at 2:18 PM, she stated she was asked about it, but she was not aware of the medication missing. She stated she could not admit she saw the resident's medication. She stated when she came into work, the medication was in the medication room on the counter and the morning med aid put the medication away. She stated when the medication was delivered, they took it to the nurse's station. They took it and placed the medication in the med room. The night nurse or whatever nurse was on duty would sign for it. Only charge nurses, LVN and RNs, could sign for the medications. During an interview with LVN B on 02/13/25 at 3:06 PM, she stated she did not see the medication to give it to her. LVN B knew she could not give it to her because it was not here. It was a PRN medication for her. The oxycodone was not scheduled for her to give to her. She stated the resident did not ask for the medication and that was why she did not know it was not there . During an interview with LVN C on 02/13/25 at 3:20 PM, she stated when the medication was received, she took the sheet, opened the bag, compared it, and gave it to them. She stated she would put it on her cart or give it to the med aid and if it must be refrigerated, she would place it in there. The med aid would put the medication in its proper place . (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADM on 02/13/25 at 3:40 PM, she stated she thought the missing medication was in the bag that had been thrown away. She stated all nurses had access to the medication room from 2/7/25 to 2/11/25 . She stated no one saw the medication, and no one admitted having thrown it away. She stated they received in-services on what to do when the med's were received and what to do with them. She stated she placed a sin up in the medication room advising the staff to throw away the purple bags and not to leave them on the counter. She stated when the med's came in, they were supposed to verify and sign what was in the bag. Once the med's were in their possession, they were to secure the med's in their proper places. She stated the medication usually came in about 4:00 AM and about 4:00 PM. She stated there was always 2 nurses in the building. She stated she would be doing an in-service on what to do when there was another nurse on duty and the medication came in. She stated the resident did not have any pain from the med's missing. She stated they contacted the pharmacy and got med's from the e-kit. The pharmacy sent another round of med's for the resident . Record review of Inservice, dated 2/12/2025, reflected all LVN and RNs were in-service on Controlled Substance which included the process for accepting scheduled medications from the pharmacy. Record review of RN A employee file reflected she did not have a file within the facility. RN A was working at the facility through agency. Per the ADM, RN A was not allowed to return to the facility. Record review of the facility's, undated, policy Controlled Substances reflected 3. Controlled substances are counted upon delivery . The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record. Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of three residents (Resident # 1) reviewed for misappropriation. misappropriation of resident property, and exploitation for one of three residents (Resident # 1) reviewed for misappropriation. The facility failed to prevent a diversion (misappropriation) of Resident #1's Oxycodone 0.5 mg, 30 tablets (opiate narcotic medication); Tramadol 50 mg 30 tablets (a pain medication) received from the pharmacy on 2/7/24 at 4:11 AM and reported missing 2/11/2025 during the day shift. This failure could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity. Findings include: Record review of Resident # 1's face sheet, printed 2/14/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Sciatica, Right -side (pain that originates along your sciatic nerve), Chronic Pain syndrome (Pain that persists beyond the expected healing time for an injury or illness, often causing significant disruption to daily functioning), Tubulointerstitial nephritis (a kidney disorder that causes inflammation of the kidney tubules and surrounding tissues). Record review of Resident's #1's admission MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician orders, dated 2/6/2025, revealed order written on 2/6/2025 Oxycodone 0.5 mg 8 hours as needed for moderate or greater pain. Tramadol 50 mg one time daily for pain. Record review of the provider investigation report, dated 2/12/2025, reflected on 2/7/2025 at 4:11 AM the pharmacy delivered 30 (thirty) tablets of Oxycodone 0.5 mg 30 (thirty) and Tramadol 50 mg 30 (thirty) for Resident #1, the packing slip from the pharmacy was signed by RN A as received. The Medication was noticed as missing, four days later. A search of the facility's medication rooms, and medication carts and the medications were not located. The report reflected no injury or harm to the resident as the medication was available in the emergency medication kit and the facility replaced the missing medication after the investigation was completed, the facility notified Hospice, the responsible party, the medical director, and the police. Statements were obtained from staff. The investigation findings confirmed the drug diversion. Record review of the pharmacy packing slip, dated 2/7/2025, reflected Oxycodone 0.5 mg 30 (thirty) and Tramadol 50 mg 30 (thirty) tablets were delivered to the facility and signed as received by RN A Record review of the Business card left by the responding police officer reflected, Case No: P25012257 dated 2/12/2025 . Record review of RN A's statement reflected On Friday 2/7/2025, she received medications including narcotics from pharmacy. The narcotics were for [Resident #1]. When she wanted to put the medication away, she noticed she was not a resident on the northside, and she did not find her at all. She received the medication at approximately 4:00 AM. RN A placed the medication in the narcotics box on her side until day shift arrived including the bag of medications she received. When the day shift nurse arrived, she counted with the day shift LVN A and CMA A. She showed them both narcotics bag and name and asked if the resident was in the facility? CMA A stated she did not know, and she did not think she was still here. LVN A stated she did not know but she will take care of it. She handed off the bag to LVN A and CMA A was there when she handed off the bag to nurse LVN A. She asked if the resident is no longer there, where do they put the medication for returns. She was told to put it in the medication room for returns. She asked if she was sure, and she said yes because she works there regularly. She walked into the medication room with nurse LVN A, showed her where she dropped off the narcotics and looked for a supply for another resident with her. She asked her again was it ok to set the medication down there in the medication room for returns or if there was another place to put it in and she said there is no problem. She stated they exited the medication room, and she exited the facility. She stated the medication was intact in the bag because the bag was unopened but the plastic piece for the name was torn by her earlier to see the piece of paper that had the name of the resident. She stated she exited the facility at 7:53 AM , During a phone interview on 2/14/2025 at 12:55 PM with the local police department desk sergeant, revealed the investigator on the case was not available, a message was left for a return phone call. No return phone call received prior to exit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Weston Inn Nusring and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 S 37th St Temple, TX 76504	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CMA A on 02/13/25 at 1:15 PM revealed she was passing morning med's, and one of the agency nurses stated she had med's for Resident #1. She advised her she no longer had her, but she did not know they moved her on the other side. She told her they were narcotics. She was unsure what to do with them once the resident was no longer there. She stated if the resident passed away, the DON was supposed to count them, but she was unsure what she did with them. If she had someone's med's on the cart and the resident passed away the DON would count them. When Resident #1 was discharged , she went to the hospital and then when she came back, she went to the other side. Resident #1's family member made the decision to have her go to the hospital. The med's were not taken from her cart that day, but she was off and when she came back to work, her med's were gone off her cart. Her son realized she needed long term care, so she came back, and she returned, and she was placed on the other side. She did not know what went on the other side. She was surprised they were getting medication. She was wondering why they were still getting medication for her. All the rest of her medication went over to the south side where she was once, she came back. She stated seems like the pharmacy would have sent them to that side since the rest of her med's were going over there. The agency nurse received the med's and placed them in the med room and locked the room. She stated she was not going to open the envelope (purple bag). The DON asked her if she threw them away. She stated she checked the bag. She stated sometimes they had papers in the bag but that day they were busy. She stated 2/7/2025 was the date of the incident. She worked the night shift. Someone from the pharmacy delivered the medication. They were supposed to check the med's when they first came in, and it was because the pharmacy made mistakes. When the med aids came in in the morning, they put the med's on the cart. She stated a lot of the time the night nurses did not know where the med's went, and she had the wrong medication on her cart. The morning med aides would check them in. When the med's came in at night, they would lock them in the med room until the med aides came in. The nurse would advise them they had med's in the med room, and they got them and placed them where they were supposed to be. During an interview with LVN A on 02/13/25 at 2:18 PM, she stated she was asked about it, but she was not aware of the medication missing. She stated she could not admit she saw the resident's medication. She stated when she came into work, the medication was in the medication room on the counter and the morning med aid put the medication away. She stated when the medication was delivered, they took it to the nurse's station. They took it and placed the medication in the med room. The night nurse or whatever nurse was on duty would sign for it. Only charge nurses, LVN and RNs, could sign for the medications. During an interview with LVN B on 02/13/25 at 3:06 PM, she stated she did not see the medication to give it to her. LVN B knew she could not give it to her because it was not here. It was a PRN medication for her. The oxycodone was not scheduled for her to give to her. She stated the resident did not ask for the medication and that was why she did not know it was not there . During an interview with LVN C on 02/13/25 at 3:20 PM, she stated when the medication was received, she took the sheet, opened the bag, compared it, and gave it to them. She stated she would put it on her cart or give it to the med aid and if it must be refrigerated, she would place it in there. The med aid would put the medication in its proper place . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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