

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 05/12/2025
NAME OF PROVIDER OR SUPPLIER Weston Inn Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</p> <p>Based on observation, interview and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for one (Resident #1) of four residents reviewed for pharmaceutical services.</p> <p>1. The facility failed to ensure Resident #1 was administered his prescribed and scheduled medications CarBAMazepine (for seizures) , Kepra (anticonvulsant), RisperDAL Oral Risperidone (Antipsychotic) , Venlafaxine (For depression, anxiety, and panic disorder)</p> <p>HYDROcodone-Acetaminophen (for pain), before going for an appointment on 04/15/25 for a painful procedure on his right arm , causing him to be in increased pain on his arm, anxiety, and risked him of seizures and convulsions.</p> <p>This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications or could result in worsening or exacerbation of chronic medical conditions.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 05/09/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including epilepsy, major depressive disorder, conversion disorder with seizures or convulsions, quadriplegia, (paralysis of all the limbs) and hypertension.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 02/05/25, reflected a BIMS score of 0, indicating he had severely impaired cognition. Resident #1 had no difficulty in hearing however the clarity of his speech was poor with absence of spoken words.</p> <p>Review of Resident #1's quarterly care plan dated 01/14/25 reflected:</p> <p>1. Resident #1 had a communication problem r/t fragile X syndrome (X chromosome that is abnormally susceptible to damage,) and the relevant intervention was anticipating the needs and meet them in a timely manner.</p> <p>2. Resident #1 was diagnosed with major depressive disorder, impulse disorder, Epilepsy (seizure) The relevant intervention was administering relevant medications as ordered by physician.</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 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3. Resident #1 had potential for pain r/t Chronic Physical Disability and the interventions were :</p> <p>a) Administering analgesia (pain medication) as per orders.</p> <p>b) Giving PRN pain medication 1/2 hour before any treatment or care.</p> <p>c) Notify physician if interventions were unsuccessful or if there was a significant change in the pain from Resident#1's past experience of pain.</p> <p>Review of Resident #1's physician's order reflected:</p> <p>2. CarBAMazepine Tablet Chewable 100 MG Give 3 tablet via PEG-Tube(A tube inserted into the stomach through the abdominal wall) two times a day for Seizures -Start Date- 12/12/2024.</p> <p>3. Keppra Oral Solution 100 MG/ML (Levetiracetam) : Give 15 ml by mouth two times a day related to epilepsy, unspecified, not intractable, without status epilepticus -Start Date-12/15/2024.</p> <p>4. RisperDAL Oral Tablet 1 MG (Risperidone): Give 1 tablet via PEG-Tube two times a day for impulsivity -Start Date- 11/26/2024 1800.</p> <p>5. Venlafaxine HCl Oral Tablet 25 MG (Venlafaxine HCl) : Give 50 mg via PEG-Tube two times a day related to unspecified intellectual disabilities -Start Date- 11/14/2024 .</p> <p>6. HYDROcodone-Acetaminophen Oral Solution 7.5-325 MG/15ML (Hydrocodone-Acetaminophen) : Give 15 ml via PEG-Tube three times a day for pain.-Start Date- 04/14/2025 1500 .</p> <p>7. Acetaminophen Oral Tablet 500 MG (Acetaminophen) : Give 1 tablet via PEG-Tube four times a day for mild pain -Start Date-04/03/2025.</p> <p>Review of Resident #1's MAR of April 25, reflected none of his medications scheduled on 04/15/25 at 9:00am were administered and it was marked as 'OA' (Out on Appointment) . This includes the medications for Seizure, Epilepsy, Behavior, Depression and anxiety and Severe to mild pains.</p> <p>Observation on 05/08/25 at 10:45am revealed Resident #1 was relaxing on a wheelchair with other residents in front of a TV installed at the living room area, in front of the nursing station. He was responding to the investigator's effort to communicate with him, with facial expressions however could not verbalize. He was presented as calm, pleasant and relaxed .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/08/25 at 12:20pm LVN A stated she knew Resident #1 well though she worked only occasionally in the hall where he resides. She stated Resident #1 was nonverbal and his enteral feed and medications were administered via PEG tube. She stated on 4/15/25 she was working with Resident #1 and responsible for medication administration. LVN A said on 04/15/25 at about 7:45am Resident #1 left the facility accompanied by CNA B for a post-surgery procedure at a hospital. She stated Resident #1 had many medications scheduled at 9:00am and since he had to leave the facility at 7:45am, she did not give those medications as it was 15 minutes out of the medication administration time window. She said the pain medication also was included in that. LVN A stated since she had not worked with Resident #1 frequently, she did not know what the appointment was for. LVN A stated since the resident was nonverbal and she used the faces scale to rate his pain and also observed any restlessness, or similar cues. LVN A said , when the resident left the facility, he was in a calm and relaxed mood and was not showing any sign of pain or distress however on his return he was presented as distressed, agitated, and was showing sign of pain. She stated she had given him the PRN pain medication immediately on arrival. All other medications could not be provided as he arrived around noon and was past his morning medication administration time window. She stated she should have asked the NP and administer his medications prior to leaving the facility. She stated medicating him with the prescribed analgesic(pain medication) might have reduced his pain during and after the procedure. She stated all his other medications also was important for him as they were for agitation, seizures, and convulsions. She stated she received an in-service on the importance of premedicating residents with relevant medications prior to they leave the facility for procedures, especially the pain medications. She said it was a learning experience so that she would be cautious to avoid such mistake in the future.</p> <p>During a phone interview on 05/08/25 at 12:35pm the FM of Resident #1 stated on 4/3/2025, Resident #1 received contracted arm surgery on his right arm at a medical center and on 4/15/2025 he was transported, accompanied by CNA B, for a post-surgery follow up appointment. FM stated he also followed the resident to the medical center. He stated during the appointment, the doctor removed the bandages and cleaned up the surgical wound and during the process, the resident appeared to be agitated and difficult to handle. He said Resident #1 acted like he had not received his mood medication or his pain medication before leaving the facility. He stated on the way back to the facility, Resident #1 had hollered and cried the entire drive. FM stated , later in the evening he was informed by the facility that the resident did not have received any of his morning medications in the morning before leaving the facility for the appointment. He stated the facility staff knew that Resident #1 had an appointment on 4/15/2025 and should have administered his medications prior to leaving the facility.</p> <p>During an interview on 05/08/25 at 12:7pm CNA B stated she was the person who accompanied Resident #1 on 04/15/25 in the morning to the medical center for the appointment . She stated Resident #1's FM also had followed them on his vehicle to the medical center. She stated when resident was leaving the facility he was calm and relaxed and was in his usual demeanor indicating he was not in any pain however on return after the procedure on his operated arm, he was presented as agitated and restless as if he was in pain. She stated she tried to calm him down with therapeutic conversation and distraction technique, without any success. CNA B stated they had to wait at the hospital for a while for the procedure to be completed and not sure if they medicated him during the procedure. CNA B stated they returned to the facility on ly by noon on that day due to the delay at the medical center.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 05/08/25 at 1:35pm NP stated she was aware of the incident where Resident #1 went out for a procedure on 04/15/25 without having his morning medications including pain medication as it was a topic of discussion in the clinical meeting on 04/16/25 in the morning. She stated the clinical team in the meeting agreed that any resident who go out on a procedure should be premedicated for pain and also with relevant scheduled medications if any. She stated all the nurses at the facility were educated on the issue immediately after the incident. She stated she visited Resident #1 generally on alternate days and assessed his pain through observing his body language or physical cues like increased heart rate and restlessness. She stated sometimes he was able to smile if he was not in any discomfort. NP stated Resident #1 was on PRN pain medication however scheduled it as regular recently to reduce his discomfort from pain. NP added, this was because, since the resident was nonverbal the accuracy of the pain assessment based on other cues like facial expressions might not be always accurate and there were chances of underestimating his pain. She stated the pain management should be addressed properly to achieve pain reduction among residents. NP stated the nurse should have consulted the MD/NP prior to sending Resident #1 for appointment on 04/15/25, to make available his morning medications earlier than scheduled.</p> <p>During interview on 05/12/25 at 11:45am ADON stated she started working at the facility since March 2025. She stated Resident #1 should have been administered with his morning medication before he left the facility on [DATE]. She stated the DON at the facility had resigned from her position about a week ago however before she left the DON had discussed the issue of Resident#1's missing medication with the QA team and all the relevant staff were in serviced by her on 04/16/25, the next day after the incident occurred.</p> <p>Record Review of the facility in services revealed on 04/16/25 and 04/18/25 there were in-services conducted on When residents leave for appointments ask if they are in pain. 1) offer to premedicate the resident. 2) Offer to send meds with the resident in the event of painful procedure. 3) Upon return always ask and treat any complaints or signs of pain. Residents have the right to live pain free.</p> <p>Review of the sign in sheet revealed LVN A had attended the in-service with other staff members.</p> <p>Record review of the facility's undated Medication Administration Policy, reflected :</p> <p>Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.</p> <p>Record review of the facility's policy Pain-Clinical Protocol revised in October 2022 reflected:</p> <p>1. The physician and staff will identify individual who have pain or who are at risk of having pain. This includes reviewing known diagnoses and conditions that commonly cause pain</p> <p>.4. The nursing staff will identify any situations or interventions where an increase in resident's pain may be anticipated</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</p> <p>Based on observations, interviews, and record review the facility failed to ensure the facility established and maintained an infection prevention program designed to provide a safe environment and to help prevent the transmission of communicable diseases for 2 of 5 residents (Resident #2 and Resident #3) observed for infection control.</p> <p>LVN C failed to disinfect the blood pressure cuff while using it on Residents #2 and Residents #3.</p> <p>This failure could place residents at increased risk of healthcare associated infections.</p> <p>Findings included:</p> <p>Review of resident #2's face sheet dated 05/12/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke) , atrial fibrillation(Rapid irregular heartbeat of upper chamber of the heart) , insomnia, major depressive disorder, type 2 diabetes, heart failure and hypertension.</p> <p>Review of resident #2's quarterly MDSs assessment, dated 02/02/25, reflected a BIMS score of 15, indicating he was cognitively intact.</p> <p>Review of resident #2's quarterly care plan, dated 05/08/25, reflected he was at risk for cardiac complications as it relates to his diagnosis of hypertension and relevant intervention was administering anti-hypertensive medications as ordered and obtain blood pressure readings per MD ordered.</p> <p>Review of resident #3's face sheet dated 05/12/25 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including muscle weakness, cognitive communication deficit, unsteadiness on feet, generalized anxiety disorder, dementia, pain in right knee, and hypertension.</p> <p>Review of resident #3's quarterly MDS assessment, dated 04/08/25, reflected a BIMS score of 15, indicating she was cognitively intact.</p> <p>Review of resident #3's quarterly care plan, dated 03/17/25, reflected she had hypertension and was at risk for complications. The relevant intervention was administering anti-hypertensive medications as ordered and obtain blood pressure readings per MD orders.</p> <p>Observation on 05/12/25 at 10:25 am revealed LVN C was administering medications to the residents in Hall 700. While taking blood pressure of Resident #2 and Resident #3, LVN C had not sanitized the blood pressure cuff before Resident #2 , in between Resident #2 and Resident #3 and after checking blood pressure of Resident #3.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/12/25 at 10:55 am LVN C stated she was an agency nurse and came in as a replacement for a MA who had not turned up to work. She stated she did not sanitize the blood pressure cuff in between residents though she knew it was necessary . She stated since she was not a regular nurse at the facility, she was not sure where the wipes and other sanitizers were kept on the med cart. She stated she did not get any time to ask for the wipes before starting to administer medications to the residents in Hall 700 . She stated sanitizing the blood pressure cuff in between each resident was necessary to ensure infection control by reducing the risk of transferring the germs from one resident to another. LVN C stated she received on going in-services pertaining to infection, abuse and neglect and falls however could not recall any trainings provided specifically for sanitizing medical equipment, including blood pressure cuffs.</p> <p>During an interview on 05/12/25 at 11:30am the ADON stated she started working at the facility as ADON since March 2025. She stated the director of nursing resigned and left the facility on e week ago. ADON stated she was now in charge of making sure all staff were following hand hygiene, anytime she went through the facility she reminded staff. ADON stated if LVN C had not sanitized the blood pressure cuff in between the residents , it could be an infection control issue as this deficient practice might passed on pathogens to residents through contamination. ADON stated the facility had sufficient stock of wet wipes and sanitizers at any point of time and LVN C could have asked her or the nurse in charge for the wipes if she could not find one .</p> <p>During an interview on 05/12/25 at 2:30pm ADM stated he heard about the deficient infection control practice by LVN C in the morning. He stated it was unfortunate that she did not sanitize the blood pressure cuff in between the residents as it was an infection control concern. He stated the facility policy specifically instructed about the importance of sanitizing that medical equipment are in use on multiple residents on regular basis. He stated he would make sure the staff would be in serviced appropriately.</p> <p>Review of facility Policy Cleaning and disinfection of resident-care items and equipment revised in September 2022 reflected:</p> <p>Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.</p> <p>. 5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment)</p>		