STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675797	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weston Inn Nursing 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 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 observation, record review and interviews, the facility failed to ensure resident received adequate supervision to prevent accidents for 3 (Residents 1, 2, and 3) of 6 residents reviewed for supervision. The facility failed to ensure Resident #1 did not elope from the facility on March 26, 2022, February 1, 2025, and again on June 21, 2025. On June 21, 2025, resident #1 was seen on the corner of the facility near a stop sign of an unbusy street. The facility was unsure how the resident eloped. A root cause analysis was not completed to determine how the resident eloped. There were two other residents at the facility (Resident #2 and #3) who were at a high risk for elopement with no interventions to prevent the elopement. Intervention's not put in place include but are not limited to: Redirecting, placing on a one on one once staff has seen a behavior change until assist, and or talking to. This failure resulted in an identification of an (IJ) Immediate Jeopardy on July 22, 2025, at 08:25pm. The IJ Immediate Jeopardy template was provided to the ADM on July 22, 202 at 08:25pm. While the (IJ) Immediate Jeopardy was removed on July 23, 2025, at 3:45pm, the facility remained out of compliance at a scope of isolate and severity level scope of isolate and severity level of no actual harm because all staff had not been trained on elopement.This deficient practice could place residents at risk of elopements that could result in serious injury and death.Findings included: Resident #1A record review of Resident #1's face-sheet updated, reflected that he was a [AGE] year-old man admitted to the facility on [DATE], with a readmission on [DATE]. Resident 1 was admitted with diagnosis of Unspecified Dementia, Nontraumatic Intracerebral Hemorrhage, Unsteadiness on feet, Bradycardia, Heart Failure, Allergic Rhinitis, Cerebral Infraction, Vitamin D Deficiency, Benign Neoplasm of colon and Anima. A record review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 6 which indicated severe cognitive impairment. Review of section GG- functional abilities indicated Resident #1 required moderate assistance for personal hygiene and was dependent for lower and upper body dressing, showering and toileting. Resident #1 required supervision or touching assistance to roll left and right, sit to lying, and lying to sit. Resident 1 required moderate assistance to sit to stand, chair to bed transfer, toilet transfer and tub/shower transfer. A record review of Resident #1's care plan from March,21,2025 reflected Resident #1 was an elopement risk. The goal was the resident's safety would be maintained through the review date. The Interventions were for staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. All CAN's will document wandering behavior and attempted diversional interventions in behavior log. All CNA's will Monitor resident for elopement attempts and for verbalizations of wanting to go home. A record review of Residents #1's Progress Notes reflected Resident #1 was an elopement risk and had over 21 wandering risk scale assessments completed throughout his stay at the facility. Resident 1 had eloped on March 2, 2022, February 2,2025 and June 21, 2025, while at the facility. A record review, of Residents #1's progress notes dated March 2, 2022, at 02:21pm entered by CNA B stated Appears that pt was let out of the building by someone entering as the door was locked but it was reported to this nurse that resident was outside in the parking lot. Initially he was not seen but he was near the end of the parking lot, looking out over the street. Asked if he was simply enjoying the sunshine he responded, No I'm trying to go home! Brought inside. Vitals assessed. ADON aware. Administrator aware. Phoned and spoke with [Residents #1's] [family member] who will come up to visit although I did make clear there were no injuries. Monitoring will be completed with resident location. A record review conducted on July 22, 2025, of residents #1'a progress notes dated June 21, 2025, entered by LVN A, resident #1 will discharged from the current facility and placed at a sister facility with a secure unit. A record review of Resident #1 progress notes dated June 22, 2025 at 02:21pm CNA B, reflected that Resident #1 was outside down the street at a stop sign by passerby who called facility to notify staff and also a residents family member from the North side notified staff of resident being outside. Resident brought back into facility by staff and assessed with no injuries.noted and vitals are 124/64,67,18,98.1. When asked where he was going, he stated to my brother's house. Resident taken to his room and placed into bed. 15-minute checks implemented at this time. DON, Administrator, and RP notified of incident. Plans in place to move resident to secure unit once consent from his daughter. Record review of the Wander Risk Scale assessment dated [DATE], at 06:31am reflected that Resident #1 score was a 9 indicating that Resident #1 is at a high risk to Wander. A telephone interview conducted on July 22,2025 at 3pm with LVN A reflected during shift change she received a call from a community member who had been passing by. A community