STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676386	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Rest Haven	503 Meadow Drive West, TX 76691

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided by the facility met professional standards of quality for 1 of 5 residents (Resident #1) reviewed for professional standards.The facility failed to ensure RN A provided services that met professional standards of care when she practiced outside her scope of practice and ordered/administered an antibiotic for Resident #1 without obtaining a physician's order on 08/14/25This failure could place residents at risk of inadequate care, possible adverse drug reaction or hospitalization. Findings included:Record Review of admission Record reflected Resident #1 was admitted to the facility on [DATE] with diagnosis of anxiety, unspecified psychosis, urinary tract infection, and nausea.Record review of Lab Results Report reflected Resident #1 had a urinalysis completed on 08/13/25. The urinalysis results were received on 08/13/25 and showed positive leukocytes (white blood cells indicating the fight of an infection) and blood within the urine indicating further testing was required to determine an antibiotic to correctly treat the Urinary tract infection. Record review of Physicians Order Recap Report for date 08/14/25 reflected an order for Resident #1 to be administered Ceftriaxone Sodium Injection Solution Reconstituted (Ceftriaxone Sodium) Inject 1 gram intramuscularly one time only for UTI (urinary tract infection) for 1 Day Signed by RN A Record review of the medication administration record dated 08/14/25 reflected resident received the medication Ceftriaxone Sodium Injection 1 gram intramuscularly one time for UTI. Signed by RN ARecord review of Nursing Progress Note reflected on 8/14/25 @ 3:11am Fax was received yesterday and forwarded to Dr by LVN B regarding patient UA with 3+ blood & 3+ leukocyte. Ceftriaxone 1gram intramuscularly given from emergency kit to prevent patient from becoming septic/and/or worsening of condition. Signed by RN ARecord review of facility incident investigation reflected that RN A was reported to the Texas state board of nursing for practicing medicine without a license on 8/14/25, by the Director of Nurses. Record review of Inservice documentation reflected All staff were educated on 8/14/25 on Texas scope of practice, and falsifying orders.Record review of Resident #s Quarterly MDS dated [DATE] reflected a BIMS score of 4 indicating Resident #1 had moderate cognitive impairment. The MDS reflected Resident #1 required partial moderate assistance with activities of daily living such as shower/bathing, toileting, upper and lower body dressing. In an interview on 09/16/25 at 11:58 with the DON stated the order that was written by RN A was reading different It did not state RN A had talked to the DR. and she was aware the urinalysis culture from 08/13/25 was still pending from the lab. This led her to further investigate the order. The DON stated she called the medical director who is also the primary Dr for Resident #1, and he confirmed he had not been contacted by RN A and he did not give an order for an injectable antibiotic to be administered. The DON stated she then called RN A, and the nurse confirmed she did not speak to the Dr to receive an order for the medication. The DON stated that RN A stated she felt like the resident could benefit from the medication. Resident #1 was immediately assessed by the DON for any abnormal reactions to the medication. Her RP was notified of the incident as well as her DR who was also the medical director of the facility. The DR gave an order to monitor Resident #1 for 24 hours and report any negative findings to him. The DON stated RN A was immediately suspended and then was terminated the facility on 08/14/25. The DON then educated all nursing staff on scope of practice and falsifying order on 08/14/25. She then reported RN A to the State Board of Nursing on 08/14/25. The DON stated Resident #1 did not have any negative outcomes related to the incident. In an interview on 9/16/25 12:30 RN A stated she had given Resident #1 the Antibiotic injections without calling the DR. She stated she would normally call the dr and obtain an order for any medication, but she was trying to be respectful since the Urinalysis came in the middle of the night. RN A stated the resident was not feeling well, Resident #1 had been treated with Ceftriaxone in the past and she had assumed it would have been ok. RN A stated negative effects for treating residents with unnecessary medications could include reactions to the medication or creation of a superbug in the urine by using the wrong type of antibiotics. In an interview on 9/16/25 at 12:45pm The facility Medical Director stated he expects all nurses to call him for an order prior to administration. He stated he was shocked that a nurse took it upon herself to administer medications without an order. The Medical Director stated there were no ill effects related to the administration of the antibiotic to Resident #1. He stated Resident #1 has had frequent urinary tract infections. He stated the nurse was terminated almost immediately and the staff were educated on calling him or any DR for orders prior to administering any medications. Record review of undated facility policy titled PHARMACY POLICY AND PROCEDURE'S reflected The purpose of this Pharmacy Policy and

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any medication errors for 1 of 5 (Resident #1) residents reviewed for medication errors.The RN ordered and administered an antibiotic Ceftriaxone (an antibiotic used to treat infection) 1gram intramuscularly without a physician's order to Resident #1 on 08/14/25.These failures could place residents at risk of being administered medications that have not been prescribed.Findings included:Record Review of admission Record reflected Resident #1 was admitted to the facility on [DATE] with diagnosis of anxiety, unspecified psychosis, urinary tract infection, and nausea.Record review of Lab Results Report reflected Resident #1 had a urinalysis completed on 08/13/25. The urinalysis results were received on 08/13/25 and showed positive leukocytes (white blood cells indicating the fight of an infection) and blood within the urine indicating further testing was required to determine an antibiotic to correctly treat the Urinary tract infection. Record review of Physicians Order Recap Report for date 08/14/25 reflected an order for Resident #1 to be administered Ceftriaxone Sodium Injection Solution Reconstituted (Ceftriaxone Sodium) Inject 1 gram intramuscularly one time only for UTI (urinary tract infection) for 1 Day Signed by RN A Record review of the medication administration record dated 08/14/25 reflected resident received the medication Ceftriaxone Sodium Injection 1 gram intramuscularly one time for UTI. Signed by RN ARecord review of Nursing Progress Note reflected on 8/14/25 @ 3:11am Fax was received yesterday and forwarded to Dr by LVN B regarding patient UA with 3+ blood & 3+ leukocyte. Ceftriaxone 1gram intramuscularly given from emergency kit to prevent patient from becoming septic/and/or worsening of condition. Signed by RN ARecord review of facility incident investigation reflected that RN A was reported to the Texas state board of nursing for practicing medicine without a license on 8/14/25, by the Director of Nurses. Record review of Inservice documentation reflected All staff were educated on 8/14/25 on Texas scope of practice, and falsifying orders.Record review of Resident #s Quarterly MDS dated [DATE] reflected a BIMS score of 4 indicating Resident #1 had moderate cognitive impairment. The MDS reflected Resident #1 required partial moderate assistance with activities of daily living such as shower/bathing, toileting, upper and lower body dressing. In an interview on 09/16/25 at 11:58 with the DON stated the order that was written by RN A was reading different It did not state RN A had talked to the DR. and she was aware the urinalysis culture from 08/13/25 was still pending from the lab. This led her to further investigate the order. The DON stated she called the medical director who is also the primary Dr for Resident #1, and he confirmed he had not been contacted by RN A and he did not give an order for an injectable antibiotic to be administered. The DON stated she then called RN A, and the nurse confirmed she did not speak to the Dr to receive an order for the medication. The DON stated that RN A stated she felt like the resident could benefit from the medication. Resident #1 was immediately assessed by the DON for any abnormal reactions to the medication. Her RP was notified of the incident as well as her DR who was also the medical director of the facility. The DR gave an order to monitor Resident #1 for 24 hours and report any negative findings to him. The DON stated RN A was immediately suspended and then was terminated the facility on 08/14/25. The DON then educated all nursing staff on scope of practice and falsifying order on 08/14/25. She then reported RN A to the State Board of Nursing on 08/14/25. The DON stated Resident #1 did not have any negative outcomes related to the incident. In an interview on 9/16/25 12:30 RN A stated she had given Resident #1 the Antibiotic injections without calling the DR. She stated she would normally call the dr and obtain an order for any medication, but she was trying to be respectful since the Urinalysis came in the middle of the night. RN A stated the resident was not feeling well, Resident #1 had been treated with Ceftriaxone in the past and she had assumed it would have been ok. RN A stated negative effects for treating residents with unnecessary medications could include reactions to the medication or creation of a superbug in the urine by using the wrong type of antibiotics. In an interview on 9/16/25 at 12:45pm The facility Medical Director stated he expects all nurses to call him for an order prior to administration. He stated he was shocked that a nurse took it upon herself to administer medications without an order. The Medical Director stated there were no ill effects related to the administration of the antibiotic to Resident #1. He stated Resident #1 has had frequent urinary tract infections. He stated the nurse was terminated almost immediately and the staff were educated on calling him or any DR for orders prior to administering any medications. Record review of undated facility policy titled PHARMACY POLICY AND PROCEDURE'S reflected The purpose of this Pharmacy Policy and Procedure Manual is to: Ensure that drugs are prescribed, administered, and handled in this facility in a