STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free from accident hazards and the residents received adequate supervision and assistance to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents. The facility failed to provide Resident #1 with adequate supervision and fall interventions on [DATE] when Resident #1 fell and received a laceration to the back of his head and a trace subarachnoid hemorrhage of the anterior interhemispheric fissure (a specific pattern of bleeding, often indicating a ruptured aneurysm of the anterior communicating artery). This failure could place all residents at risk for serious injury and accidents.Findings include: Record review of Resident #1's admission record, dated [DATE], indicated he was a [AGE] year-old male who had diagnoses including metabolic encephalopathy (a broad term for brain dysfunction caused by non-traumatic, systemic issues like chemical imbalances, organ failure, or infections, rather than direct brain injury), peripheral vascular disease, also known as peripheral artery disease, (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the body. Peripheral vascular disease can affect any blood vessel outside of the heart, but it most commonly affects the legs and feet), acute kidney injury (AKI), (the sudden, often reversible loss of kidney function, developing within hours or days. It causes rapid accumulation of urea, creatinine, and fluid, leading to symptoms like decreased urine, swelling, and fatigue), and diabetes (a group of diseases that result in too much sugar in the blood). Review of Resident #1's Quarterly MDS dated [DATE] reflected Resident #1 had a BIMS score of 14 which reflected Resident #1 was cognitively intact and had no functional limitation impairment on both of his lower extremities in range of motion. The MDS also reflected Resident #1 required set-up or clean-up assist for Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) and for Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. (-Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) Record review of Resident #1's comprehensive care plan, dated [DATE] and revised [DATE], indicated he had an ADL self-care performance deficit r/t Mild Cognitive Impairment, Metabolic Encephalopathy. Goal: Resident #1 would express satisfaction with type of activities and level of activity involvement when asked through the review date. Interventions included: TRANSFER: The resident requires set up to touching assistance with transfers X 1 staff. Record review of Resident #1's comprehensive care plan, dated [DATE] and revised on [DATE], indicated he had had an actual fall with no injury r/t Unsteady gait. [DATE] - fell attempting to self-transfer, no injury noted. [DATE] - Fell attempting to self-transfer to toilet, no injuries noted. [DATE] - slid out of bed, no injuries noted. [DATE] -fall at beside with abrasion to left pinky knuckle: ST protocol. [DATE] Witnessed fall with no injury. [DATE] fall in room no injuries noted. [DATE] Fall in restroom, bruising to left elbow, skin intact. [DATE] Fall in room, laceration to back of head. (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	911 called resident sent to (local hospital) for treatment. Goal: resume usual activities without further incident through the review date. Interventions included: Encourage resident to wear nonskid socks, Ensure adequate lighting, Fall mat at bedside if resident allows. Record review of Resident #1's physician orders dated [DATE] reflected resident had an order dated [DATE] for Floor mats at bed side if resident allows. Record review of Resident #1's electronic record of assessments reflected Resident#1 was at moderate risk for falling per Morse Fall Scale dated [DATE]. Record review of Resident #1's hospital records provided by the DON reflected Resident #1 had a Final Diagnoses of Subarachnoid Hemorrhage (a life-threatening type of stroke caused by bleeding into the space surrounding the brain, most commonly from a ruptured cerebral aneurysm). In an observation and interview on [DATE] at 10:10 AM, Resident #1 was observed in bed initially. Resident transferred into wheelchair with assist x 1 staff member and staff member told resident she would be back after interview with surveyor for his shower. Resident stated he was ok, but he would rather be at home. He stated he was not feeling too great because he fell. Resident pointed to the staples in his head. Observed staples in back of residents head. Area was clean and dry with no drainage noted. Resident had a fall mat to the side of his bed. Resident stated he did not know anything about how he fell. He stated he did not remember what he was doing before the fall, but he thought he was asleep and fell out of the bed. He stated he had hit his head on something he guessed because there was some blood. He stated he did not know why surveyor was asking all of those questions when he already told surveyor he did not know what happened. He stated he did not like the fall mat by his bed because it was harder for him to get around in his wheelchair with it there. Resident's room was clean and clutter free with his call light in reach. Resident was moving surveyors table out of the way and gathering his belongings for his shower. When surveyor left the room, resident went by himself into the bathroom. The CNA came to the resident's room as he closed the door. In an interview on [DATE] at 8:35 AM, the ADM and DON stated Resident #1 fell in his room and the CNA that was working told them she had just made her rounds and left out of his room. They stated resident was sent to the closest hospital where they did a CT and found a subarachnoid hemorrhage and resident was then transferred to another hospital. They stated Resident #1 had another CT done at the other hospital and the subarachnoid hemorrhage had no changes and had not gotten bigger. They stated resident received 12 staples for the laceration to the back of his head. They stated the hospital sent resident back in stable condition. They stated he had a history of a subarachnoid hemorrhage before in 2019 and they are waiting for the hospital records from the 2nd hospital at this time. They stated they were not sure of the exact spot of the admission subarachnoid hemorrhage, but they would try to find out. In an interview on [DATE] at 9:10 AM, CNA B stated she had worked in the facility for about 1 year. She stated she was in-serviced regularly on abuse and neglect, rounding, falls/fall prevention, and resident rights. She stated if a resident fell she would get the nurse. She stated some of the fall precautions used in the facility were fall mats, call lights, and rounding on residents more often. She stated she made rounds on her residents every hour and half and sometimes every 30 minutes if needed. She stated they had to round on residents every 2 hours at least but she did the rounds more often. She stated staffing was good. She stated she felt as though she could meet the needs of her assigned residents. She stated in the incident which involved Resident #1, she had gone to make her rounds and when she made her rounds, she went from room to room. She stated she was working from the back to the front and was in the 5th room on the left, which was next door to Resident #1's room, and she came out of the room to get that resident some ice water. She stated she walked out of the room and she got down the hall some, and she saw some socks on the floor. She stated she realized it was feet and not just socks and she put (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the water pitcher down and ran to Resident #1's room and was trying to ask him what happened. She stated Resident #1 was alert and responded correctly to her questions. She stated she turned and immediately called for the nurse and got the nurse to come check on the resident. She stated the nurse ran to the resident's room. She stated as the nurse was checking the resident out, she noticed there was a lot of blood by the bed and Resident #1 was over by the doorway. She stated she stayed in the room with resident while the nurse went and called 911 and resident went to the hospital. She stated resident stayed on the floor until the ambulance came and he stayed alert and responsive through the whole thing. She stated resident told her he fell over by the bed and slid himself over by the door. She stated resident told her he could not recall what he was doing or how he fell. She stated she did not understand how he got over by the door but when the ambulance got there, resident stood up and got on the stretcher. She stated she never heard any loud noise or heard anything at all that would have made her think someone had fallen. In an interview on [DATE] at 9:17 AM, the DON stated she found the paperwork of the area where Resident #1 had his admission subarachnoid hemorrhage and it was in the medial left frontal subarachnoid space. Observed Resident #1's hospital paperwork from his admission in 2019 with this information which reflected tiny subarachnoid hemorrhage and it was in the medial left frontal subarachnoid space. She stated the resident's diagnosis at the hospital yesterday was a trace subarachnoid hemorrhage of the anterior interhemispheric fissure (a hypodense structure broader than the falx with a zigzag configuration due to medial frontal sulci). In an interview on [DATE] at 11:38 AM, LVN A stated she had worked in the facility thru an agency and she had been in and out with them for a while. She stated she had been in-serviced on abuse and neglect, and she had done the electronic training for falls/fall prevention, rounding, and resident rights. She stated if a resident fell she would check on the resident and assess them to decide on what she had to do. She stated she wanted to make sure the resident was safe first. She stated then she would do the full assessment and send them to the hospital or treat any injuries if needed, and then she would get them up if able. She stated some of the fall precautions used in the facility were really good lighting, reiterating to residents to call for help, increased monitoring for those that are fall risks, and assisting residents as needed. She stated she made rounds on her residents a lot, she would say every 30 minutes to an hour. She stated staffing was good. She stated she felt as though she could meet the needs of her residents. She stated in the incident which involved Resident #1, she had not been down the hall for about 30 minutes, but she knew CNA B was on the hall rounding. She stated about 15-20 minutes after that, CNA B got her and she ran down to the resident's room and Resident #1 was on the floor. She stated she assessed the resident and found that he had bleeding from his head, but he could not tell her what happened. She stated she had some gloves and gauze on her and she placed the gauze on the resident's head where he had a cut. She stated she asked the CNA to stay with resident while she called 911 and after calling them, she went back to resident's room. She stated she then saw resident's remote was hanging off the bed with blood on it and there was blood on the ground by the head of the bed. She stated resident could not tell her how he fell or how he got on the floor by the door. She stated EMT arrived and resident was able to stand up and get on the gurney but said he felt a little dizzy. In an interview on [DATE] at 12:07 PM, CNA C stated she had worked in the facility for about 3 years. She stated she was in-serviced regularly on abuse and neglect, rounding, falls/fall prevention, and resident rights. She stated if a resident fell, she would stay with them and get the nurse. She stated some of the fall precautions used in the facility were stand-aids, gait belts, mechanical lifts, make sure resident was stable before transfers, and no clutter in rooms. She stated she made rounds on her residents every 2 hours, but she walked the halls all (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	day. She stated staffing was good. She stated she felt as though she could meet the needs of her residents. She stated in the incident which involved Resident #1, she was not here but was made aware he had fallen when she got to work. She stated the resident tried to do things on his own all the time and she constantly reminded him to call for help but he did not listen. In an interview on [DATE] at 12:29 PM, FM stated she had no concerns with the facility at all. She stated she was aware of the fall Resident #1 had yesterday morning. She stated she felt the facility was doing all they could to prevent falls and they were assisting him with everything, he is just a hard headed man and won't listen to anybody. She stated he had a history of getting up by himself and he was very impatient and did not want to wait on anyone to come help him so he just did not push the call light. She stated she was at the hospital the whole time with Resident #1 and he could not remember how he fell. She stated he thought he was in another town with a deceased friend so she was not sure if he was walking in his sleep or what. She stated he worked in this other town for a long time. She stated he had no history of walking in his sleep and she had no concerns for his care at the facility. She stated the facility had put the fall mat by resident's bed several times and resident threw a fit about it so they removed it. She stated resident said he could not get his wheelchair close to the bed with the mat there. She stated the staff constantly reminded him and warned him all the time about falling and she had heard them do that many times when she was visiting. In an interview on [DATE] at 1:08 PM, the DON stated she was in-servicing staff regularly on abuse and neglect, rounding, falls/fall prevention, and resident rights. She stated if a resident fell, the CNA should get the nurse and the nurse should assess the resident immediately and depending on if there were injuries or not that would determine what they did next. She stated the staff may need to use the lift or multiple staff to get them up, may need to send to the hospital, notify the doctor and get orders, neuros for unwitnessed fall, and inform the family. She stated some of the fall precautions used in the facility were low beds, fall mats, decreased clutter, night lights built into rooms, and grippy socks if the resident will wear them. She stated staff should be rounding on their residents every 2 hours at minimum. She stated staffing was good and they used agency as needed. She stated she felt as though the staff could meet the needs of their residents. She stated Resident #1 was alert and oriented and was able to make his own decisions. She stated resident could move his bed up and down. She stated resident had refused fall mats because it impeded his wheelchair mobility in his room. She stated they have offered Resident #1 fall mats several times and she could not remember how many times off the top of her head. She stated they would continue to try to keep encouraging him to keep the fall mat. She stated the staff made sure every residents' bed was in a low position on nightly rounds. She stated resident had grippy socks in his room and he refused to wear those also. She stated resident has had interventions in place and some of the interventions had recently been resolved from the care plan but were replaced yesterday. She stated her expectations for residents that were a fall risk were to make sure they were safe, frequent checks, at least required 2 hour checks, and for staff to follow the interventions put in place such as fall mats. She stated for fall risk residents she would have expected to decrease their falls and increase their safety. She stated she was aware that falls were going to happen but to decrease the severity of the outcomes of the falls would have been her expectation. She stated stricter interventions may have assisted with decreasing the outcomes of falls. In an interview on [DATE] at 2:26 PM, the MD stated he had no concerns for the facility for what they have done to try and prevent falls for the residents. He stated Resident #1 was a stubborn man and he kept transferring without calling for help. He stated the facility had a fall mat in place, resident's bed by the wall and constantly gave reminders to resident to call for help when needed. He (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated the facility only had 1 fall with a major injury in the past year that had already been investigated. He stated any head injury with a bleed could have been serious and Resident #1's was pretty tiny he believed. He stated resident had a subarachnoid hemorrhage when he first admitted but he believed that would have been healed up by now. He stated it seemed like resident had fallen out of bed and hit his head. He stated he did not feel like the facility could have done anything differently to prevent the fall and the resident seemed to manage himself well. In an interview on [DATE] at 5:06 PM, the ADM stated she was in-servicing staff regularly on abuse and neglect, rounding, falls/fall prevention, and resident rights. She stated if a resident fell, the CNA should get the nurse, and the nurse should go right away and assess the resident for any injuries from head to toe. She stated if there was an injury the nurse should call 911, inform the doctor and family, and check neuros if needed. She stated if they were able to get the resident up, they would do that also and notify her and the DON. She stated some of the fall precautions used in the facility were fall mats, low beds, call light, and antilock brakes for the wheelchairs. She stated staff should be rounding on their residents every 2 hours at least. She stated staffing was good and they used agency as needed. She stated she felt as though the staff could meet the needs of their residents. She stated for fall risk residents she would expect for the resident to feel safe, have decreased falls, and have a decreased severity of injuries for falls that may occur, and she feels it is their responsibility to make sure that happens. Record review of undated facility form titled Preventing Falls Policy reflected: RESPONSIBILITY: Licensed Nurse and Nurse Aide. PURPOSE: To create a safe environment for the resident. PROCEDURE: 1. Evaluate each resident to determine their level of fall risk. 2. Place call light within easy reach of the resident. 3. Place bed in low position when appropriate. 4. Make routine visits to check on the resident's condition and comfort. 5. Avoid leaving in the resident's room any clutter, equipment, trash, or personal belongings that may contribute to a fall. 6. Clean up all spills in a timely manner. 7. Ensure you are transferring resident with the proper level of assistance or with the proper equipment to reduce the risk for falls. 8. Lock brakes on wheelchairs before transferring residents. Ask maintenance to modify wheelchair with anti-lock brakes and anti-tipper mechanism if needed. 9. Check resident's posture in wheelchair before propelling to prevent falls. 10. Utilize bed side floor mats when appropriate. 11. Supply each resident with a pair of non-skid socks and encourage them to wear them. 12. Reorient and redirect confused residents as needed. 13. Ensure night light is working in resident room. 14. Encourage resident to call for assistance when needed. DOCUMENTATION: Document all interventions initiated for each resident in nurses note. Notify MDS to ensure care plan is updated accordingly.