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	04/28/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for two1 (Resident #1 and Resident #2) of 6 residents reviewed for quality of care. * CNA A failed to provide care to Resident #1 on 4/28/2026 when she turned the call light off and left the resident's room without meeting the resident's needs. *Nurse B failed to provide care to Resident #2 on 4/28/2026 when she turned the call light off and left the resident's room without meeting the resident's needs.* CNA A failed to provide care to Resident #2 on 4/28/2026 when she turned the call light off and left the resident's room without meeting the resident's needs.These failures placed the Resident at risk of not receiving adequate care and services, increased risk of injury, decreased self-worth and quality of life.Findings include:Resident #1Review of Resident #1's face sheet dated 4/28/2026, reflected an [AGE] year-old female admitted on [DATE] with diagnoses that included: after care following joint replacement surgery, B-cell Lymphoma (type of blood cancer), osteoarthritis, high cholesterol, low backpain, surgical repair of a right arm fracture, kidney disease, falls and high blood pressure.Review of Resident #1's un-typed MDS assessment dated [DATE] reflected resident had a BIMs of 9 suggesting moderate cognitive impairment.Review of Resident #1's care plan dated 4/28/2026 reflected the focus: [Resident] has an ADL self-care performance deficit r/t presence of right artificial shoulder joint, dementia, history of falling; with interventions for toilet use: The resident is able to: dependent upon staff for toileting needs.Resident #2Review of Resident #2's face sheet dated 4/28/2026, reflected an [AGE] year-old-female admitted on [DATE] with diagnoses that included: type 2 diabetes (blood sugar regulation disorder), cataract (age related eye condition that causes clouding of the lens of the eye), repeated falls, Dementia (decline in mental ability), muscle weakness, lack of coordination, and high blood pressure.Review of Resident #2's quarterly MDS assessment reflected a BIMs of 11 suggesting moderate cognitive impairment.Review of Resident #2's care plan dated 4/28/2026 reflected the focus: [Resident] has an ADL self-care performance deficit r/t Dementia, Stroke (serious disruption of brain function) with intervention: transfer: The resident requires assistance by X1 staff to move between surfaces and as necessary. (Meaning she needed assistance with one staff member helping.)During an observation on 4/28/2026 at 9:15 am, revealed Resident #1's call light was lit up. Observed CNA A go into the room and then come back out a minute later and the call light was turned off.During an interview on 4/28/2026, at 9:17 am, Resident #1 stated she put her call light on because she needed to use the restroom. She stated the aide came in and turned the call light off and said she would be right back.During an observation on 4/28/2026 at 9:24 am, revealed Resident #2's call light was lit up. Nurse B went into the room at 9:30 am, the call light went off and Nurse B came back out of the room.During an interview on 4/28/2024 at 9:31 am Resident #2 stated she had put her call light on because she wanted to be moved from her wheelchair to her recliner. She stated Nurse B came in and asked her what she needed and when she told her, Nurse B stated they needed to go collect the lunch trays and then she would come back. Resident #2 put her call light back on to request staff help. During an observation on 4/28/2026 at 9:32 am, revealed Resident #2's call light was lit up. CNA A went into the room at 9:32 am, the light went off and CNA A came back out.During an interview on (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/28/20206 at 9:34 am, Resident #2 stated she was still waiting for staff to transfer her to her recliner and be covered up with a blanket. She stated CNA A stated she would go get the sit to stand lift and come back and help her but turned the light off and left.During an interview on 4/28/2026 at 11:17 am, CNA A stated she worked for a staffing agency and had been trained on call lights. She stated she had turned off Resident #1 and Resident #2's call lights off before taking care of what the residents needed. She stated she had not known it was a big deal to turn the light without taking care of the residents' needs. She stated as an aide she knew she was supposed to answer the call lights promptly but did not know she could not turn the light off unless the residents' needs were met. She stated by turning the call light off and not taking care of what the resident needed staff could get distracted and forget the resident, something could go on with the resident, it would put them at risk of doing it themselves and they could fall.During an interview on 4/28/2026 at 12:44 pm, Nurse B stated she answered Resident #2's call light and when she went in the room the resident wanted her to re-position her in the wheelchair. She stated she sometimes leaned and she just wanted to put her straight in the chair. She stated Resident #2 did not mention wanting to be transferred to her recliner. She stated she recently attended training on call lights, and the call light was not to be turned off until the care had been provided. She staed if the light was turned off and care had not been provided there could be distractions; you might think you could go right back but anything can happen. She stated neglect could happen or falls could happen.During an interview on 4/28/2026 at 12:25 pm, the DON stated her expectation for call lights was that the light would be answered, staff would provide the assistance needed, if they could not provide assistance, or they needed to go get help or supplies then they should leave the call light on until care has been provided. She stated what could happen if call lights were turned off are the residents' needs being met, is there neglect going on, residents could be fall risk; they might get tired of waiting and get up and try to toilet themselves and fall.During an interview on 4/28/2026 at 2:40 pm, the ADM stated her expectation was that staff would answer the light and not turn it off until the residents' needs were met. She stated she had told residents that if that happened, they could turn the light back on to call staff again. She stated that it had been discussed at resident council with residents, and she told them to turn it back on. She stated if call lights were turned off without residents' needs being met it could be a quality-of-care issue if they had to go to the bathroom, they could sit in soil or could fall trying to get up by themselves.Review of undated facility policy, Call Light reflected: PURPOSE: 1. To respond promptly to resident's call for assistance2. To ensure call light system is functioning properlyPROCEDURE:1. All nursing personnel must be aware of call lights at all times.2. All nursing personnel are responsible to answer call lights promptly whether or not they are assigned to the resident.3. Call lights will be turned off at the point of origin. Bedside call lights sound will differ from emergency call light sound.4. Answer the call lights in a prompt, calm, courteous manner; turn off the call light once the resident's needs are met.