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	06/27/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** B) Review of Resident #10's face sheet, printed on 06/27/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included acute respiratory failure with hypoxia (not enough oxygen in the blood), post-traumatic stress disorder (PTSD - a mental health condition caused by a traumatic event), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), and low back pain. Review of Resident #10's quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 which indicated moderately impaired cognition. The MDS reflected Resident #10 received antipsychotic, antidepressant, antianxiety, and anticonvulsant medications. Review of Resident #10's comprehensive care plan, revised on 12/11/24, reflected in part, Focus - [Resident #10] uses antidepressant medication related to depression. Goal - [Resident #10] will be free from discomfort or adverse reactions related to antidepressant therapy . Interventions - Administer antidepressant medications . Focus - The resident uses psychotropic medications related to major depression. Goal - The resident will be/remain free of psychotropic drug related complications . Interventions - Administer psychotropic medications . Focus - [Resident #10] uses anti-anxiety medications. Goal - The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy . Interventions - Administer anti-anxiety medications . Focus - [Resident #10] has a mood problem related to disease process. Goal - Resident #10 will have improved mood state . Interventions - Administer medications as ordered .: Review of Resident #10's Order Summary Report for active orders as of 06/27/25 reflected the following: Depakote Sprinkles (an anti-seizure medication used to stabilize mood) oral capsule delayed release sprinkle 125 mg. Give 2 capsules by mouth two times a day related to psychotic disorder with delusions due to known physiological condition. Do not crush. Order date 02/17/25. Review of Resident #10's Medication Administration Record (MAR) for June 2025, reflected the Depakote Sprinkles were administered twice daily as ordered. Review of Resident #10's electronic medical record and the paper medical record, reflected no signed consent for the Depakote Sprinkles. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C) Review of Resident #71's face sheet, printed on 06/27/25, reflected an [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included unspecified dementia, depression, anxiety disorder, and altered mental status, and unspecified psychosis not due to a substance or known physiological condition. Review of Resident #71's admission MDS assessment, dated 05/24/25, reflected a BIMS score of 7 which indicated severely impaired cognition. The MDS reflected Resident #71 had inattention and disorganized thinking. Resident #71 rejected care and wandered. The MDS reflected she received antipsychotic, antianxiety, and antidepressant medications. Review of Resident #71's comprehensive care plan, revised on 05/29/25, reflected in part, Focus - [Resident #71] has impaired cognitive function or impaired thought process . Goal - The resident will be able to communicate basic needs . Interventions - Administer medications as ordered. Monitor for side effects and effectiveness . Focus - [Resident #71] uses anti-anxiety medications . Goal - The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy . Interventions - Administer anti-anxiety medications as ordered . Review of Resident #71's Order Summary Report for active orders as of 06/27/25 reflected the following: Seroquel (an antipsychotic medication) oral tablet 50 mg give 2 tablets by mouth at bedtime for psychosis related to unspecified psychosis not due to a substance or known physiological condition. Order date 05/28/25. Review of Resident #71's MAR for June 2025, reflected the Seroquel was administered at bedtime as ordered except on four occasions when the resident refused. Review of Resident #71's electronic medical record and the paper medical record, reflected no signed consent for the Seroquel. D) Review of Resident #78's face sheet, printed on 06/26/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included anxiety disorder, unspecified dementia - unspecified severity - with other behavioral disturbance, and mood disorder due to known physiological condition with depressive features. Review of Resident #78's quarterly MDS assessment, dated 03/28/25, reflected a BIMS score of 3 which indicated severely impaired cognition. The assessment reflected inattention and disorganized thinking. The MDS reflected Resident #78 rarely felt lonely or isolated. No signs or symptoms of depression or behavioral symptoms were identified. The assessment reflected Resident #78 took antipsychotic, antianxiety, and antidepressant medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #78's comprehensive care plan, revised on 02/21/25, reflected in part, Focus - The resident uses psychotropic medications . Goal - The resident will be/remain free of psychotropic drug related complications . Interventions - Administer psychotropic medications as ordered . Focus - The resident uses antidepressant medication . Goal - The resident will be free from discomfort or adverse reactions . Interventions - Administer antidepressant medications as ordered . Monitor/document side effects and effectiveness . Review of Resident #78's Order Summary Report for active orders as of 06/27/25 reflected the following: Sertraline HCl (an antidepressant medication) oral tablet 25 mg give 1 tablet by mouth one time a day related to unspecified dementia. Order Date 02/21/24. Seroquel (an antipsychotic medication) oral tablet 50 mg give 1 tablet by mouth two times a day related to mood disorder. Order date 11/07/23. Review of Resident #78's MAR for June 2025 reflected the Sertraline was administered as ordered. The MAR reflected the Seroquel was administered as ordered except for five doses that were refused. Review of Resident #78's electronic medical record and the paper medical record, reflected no signed consent for Sertraline or Seroquel. In an interview on 06/26/25 at 10:05 AM, Nurse Supervisor A stated consents for psychotropic medications were obtained on admission or when a new psychotropic medication was ordered. She stated usually the nurse would notify the responsible party to get consent. If the consent was obtained over the phone, the nurse would document that on the form. She stated during the phone call, the nurse would let the family know the consent for was at the nurse's station and needed to be signed on the next visit to the facility. Nurse Supervisor A searched for the signed consents for Residents #10, #71, and #78. In an interview on 06/26/25 at 10:10 AM, LVN F stated she did not have any psychotropic consent forms at the nurse's station or on the clip board waiting for signatures. In an interview on 06/27 /25 at 10:49 AM, the DON stated the nurse who received the order was responsible for obtaining the consent for psychotropic medications. She expected the nurse told the responsible party the consent needed a signature on the next visit. She stated some responsible parties lived out of town so consents were mailed or emailed for signature. She stated some consents had not been signed and returned. The DON stated the nursing supervisors were responsible to monitor the psychotropic consents. She stated without a consent in place, a resident may have received a medication the family or responsible party did not want given for a variety of reasons. She stated the facility was unable to find any other consents for Residents #10, #71, and #78. Review of the undated Informed Consent for Antipsychotic Medication Therapy Policy reflected in part, It is the policy of this facility to obtain informed consent for psychoactive medication prior to administration, except in the event of a psychiatric emergency. 1. Upon receiving a physician's order for a psychoactive medication, the resident's responsible party will be notified to obtain informed consent for the medication before initiation of therapy, except in the event of a psychiatric emergency 2. Informed consent may be obtained in person or by telephone . 8. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If the resident's responsible party is at the facility when informed consent is obtained, have them sign the consent form. If the consent is obtained by telephone, the responsible party may sign the form on their next visit to the facility. If the consent is mailed to the responsible party for signature, a copy will be kept on the chart until the original is returned. 9. The signed consent is to be filed in the resident's chart. Based on record review and interview, the facility failed to ensure that the resident has the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 4 of 5 residents (Resident #15, Resident #10, Resident #71, and Resident #78,) reviewed for resident rights. A) The facility failed to obtain informed consent for the use of Risperdal (an antipsychotic medication) Divalproex Sodium (a mood stabilizer) duloxetine HCL (an antidepressant medication) and Xanax (an antianxiety medication) for Resident #15. B) The facility failed to obtain signed consent for Resident #10's psychotropic medication Depakote Sprinkles (an anti-seizure medication used for mood stabilization). C) The facility failed to obtain signed consent for Resident #71's psychotropic medication Seroquel (an antipsychotic medication). D) The facility failed to obtain signed consent for Resident #78's psychotropic medications Sertraline (an antidepressant medication) and Seroquel (an antipsychotic medication). These failures could place residents who receive psychotropic medications at risk of receiving medications without consent, knowledge of possible side effects of the medications, or other treatment options. Findings included: A) Review of Resident #15's face sheet dated 06/26/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses psychotic disorder with delusions (characterized by unshakable belief in something that is not true or based on reality), hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain. It is caused by disrupted blood supply (ischemia) and restricted oxygen supply (hypoxia).) Review of Resident #15's annual MDS assessment dated [DATE] reflected she was assessed to have a BIMS score 14 indicating she was cognitively intact. Resident #15 was assessed to have verbal and other behavioral symptoms 1 to 3 days week. Resident #15 was assessed to have Psychiatric/ mood disorder: anxiety disorder, depression, and psychotic disorder (other than schizophrenia). Resident #15 was further assessed to be on an antipsychotic, antianxiety and antidepressant medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's comprehensive care plan reflected a focus area initiated on 08/07/2023 Resident uses antidepressant medication related to depression. The medication was not listed. Interventions included educate the resident/family/ caregivers about risks, benefits and the side effects and/or toxic symptoms. Further review reflected a focus area initiated on 06/04/2025 uses anti-anxiety mediations Diazepam related to anxiety disorder Interventions included educate the resident/family/ caregivers about risks, benefits and the side effects and/or toxic symptoms. Resident #15's comprehensive care plan further reflected a focus area initiated 06/04/2025 Resident uses antipsychotic medication related to bipolar disorder: Risperdal Interventions included discuss with MD, family regarding ongoing need for use of medication Review of Resident #15's consolidated physician's orders dated 06/26/2025 reflected an order for Divalproex Sodium 125 mg give 5 capsules to =625 mg twice daily for bipolar disorder dated 11/02/2024; an order for Duloxetine HCL 60 mg one capsule by mouth one time day related to major depression; and an order for Risperdal 0.25mg one tablet by mouth two times a day related to psychotic disorder with delusions dated 03/28/2025. Further review reflected an order for Xanax 0.25 mg give one table by mouth every 8 hours as needed for anxiety/ agitation/mood for 14 days with an order date of 06/19/2025 and end date of 07/03/2025. Review of Resident #15's Psychiatric Subsequent assessment dated [DATE] reflected a list of her current psychotropic medications that included Duloxetine, Depakote, Xanax and Risperdal. Review of Resident #15's MAR dated June 2025 reflected Resident #15's psychotropic medications Duloxetine, Depakote, Xanax and Risperdal were administered daily as ordered. Review of Resident #15's electronic medical record and the paper medical record, reflected no signed consent for the Duloxetine, Depakote, Xanax or Risperdal. In an interview on 06/26/2025 at 2:26 PM the DON stated the unit nurse supervisors were in charge of getting consents for psychotropic medications. In an interview on 06/26/2025 at 2:52 PM Nursing Supervisor B stated after reviewing Resident #15's EMR and paper chart she did not see any consents for her psychotropic medications and the consents should have been signed on admission. NS B stated the consents should have been done on admission and/or when the medications were started. NS B stated Resident #15 should have had a consent for each medication she was on. She stated by not having the consents it could lead to the resident getting medications that the family or resident did not want. In an interview on 06/26/2025 at 4:56 PM the Pharmacist Consultant stated when he did his medication review for psychotropic drugs he did not check to see if consent forms were in place. He stated he could if it was something he needed to do. In an interview on 06/27/2025 at 12:34 PM the Administrator stated she expected that consents be signed prior to administration of psychotropic medication to ensure the family's and residents have been informed of the SE and to ensure a resident was not getting a medication they did not want. She stated the pharmacist should be reviewing that on his visit as it was part of unnecessary medication.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure the residents had the right to voice grievances to the facility, make prompt efforts by the facility to resolve grievances the resident may have, and make information on how to file a grievance or complaint available to the resident for 1 of 12 residents (Resident #11) reviewed for grievances. 1. On an unknown date and time, the SW heard a grievance on Resident #11's behalf and failed to initiate the grievance process. 2. On an 06/26/2025 at unknown time, LVN I heard a grievance on Resident # 11's behalf and failed to initiate the grievance process. These failures could place residents at risk of not having their grievances heard and a diminished quality of life. Findings included : Record review of Resident #11's face sheet dated 06/26/2025 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus with Diabetic Chronic kidney disease (body do not produce enough insulin kidney disease that develops as a complication of diabetes), malignant neoplasm of the uterus refers (cancerous tumors that develop within the uterus),major depressive disorder (mental health condition), hypertension (high blood pressure), heart failure . Record review of Resident #11's quarterly MDS dated [DATE] indicated she made herself understood and was able to understand others. The MDS also indicated she had a BIMS score of 12 which meant she was cognitively intact. Section B- Hearing, Speech and vision reflected, Minimal difficulty - difficulty in some environments (e.g., when person speaks softly, or setting is noisy. Record review of Resident #11's care plan dated 01/04/2025 indicated she had an ADL self-care performance deficit r/t Impaired balance, Limited Mobility and had a communication problem r/t a Hearing deficit. Record review of the facility grievances dated 01/01/2025 - 06/28/2025 indicated there was not a grievance filed for Resident #11 in the last 6 months. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/25 at 11:57 AM Resident #11 said about 6 months ago an aide (name unknown), helped her with a shower, and told her she would give her hearing aids to the nurse. She stated every night the nurses would come to her room and pick up her hearing aids for charging . She stated the next morning she went to the nursing station to get her hearing aids and she was told by a nurse (name unknown) her hearing aids was not there. She stated she told the SW, and she told her she could not have replaced them because her insurance would not pay for them. During an interview on 06/26/25 at 09:44 AM the SW said Resident #11 did report her hearing aids were missing but she did not remember when . She stated once Resident # 11 told her about the hearing aids she looked for a provider to help with replacement, but no one would accept her Medicaid or Medicare. She stated if a resident had a complaint, she or a staff member should make sure a grievance was filed. She said although Resident #11 did say her hearing aids were lost, she did not complete a grievance form and she was not sure if another staff did. She stated grievances should be completed by the resident , staff or family and addressed by the Administrator. She stated a potential risk for a resident not having their hearing aids could be a decrease in activities, not hearing properly which would lead to communication problems , and the resident's needs and grievances would not be given to the correct person to address the issues. During an interview on 06/26/25 at 1:12 PM LVN I stated the nurses are responsible for getting the hearing aids from the resident and charge them at night . She stated, If the hearing aids are lost, I think we would tell the case manager , but I am not sure. She stated once personal property is reported to the nurse they would try to find the lost items, such as hearing aids , and if they cannot find something they would report it to the nurse supervisor , family and provider. She stated she was not aware of Resident #11 hearing aids being lost until today. She was asked by the Surveyor if she reported it to her Supervisor and she stated , I have not but I will do so before I leave today. During an interview on 06/26/25 at 02:42 PM with the LVN Supervisor, she stated she was not informed Resident #11's hearing aids were missing until Resident #11's family member informed her on 06/25/2025, and she told her she would see what she could do. The LVN Supervisor was asked to explain see what she can do we meant and she stated , If a Resident is missing their hearing aids , they will contact dietary and laundry services to see if the hearing aids was found, and if not found she or any nurse would contact the Administrator or Assistant Administrator . She stated the resident could write a grievance or have a staff help them. She stated an adverse effect of not having their hearing aids would be not being able to hear or understand what other people are saying and if a grievance was not completed a resident's concern would not be addressed appropriately . An interview 06/26/25 at 02:32 PM with the Assistant Administrator, she stated if hearing aids were lost for any resident , the go to the SW to discuss the concerns in their morning meeting. She stated in order to find hearing aids a staff would go to the rooms to look for the items , and if found they would give their personal item back to resident; or if not found they would start the grievance form. She stated the resident can start the grievance form or a staff member can do so. She sated a potential risk for Resident #11 not having her hearing aids can lead to her being unable to hear clearly and being unhappy. She stated if grievances are not completed the resident can become upset and lose trust in the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy Grievance policy, undated, revealed, Any resident or the resident representative has the right to voice grievances orally or in writing without fear of discrimination or reprisal. Any resident or resident representative may file a grievance anonymously. They have the right to expect review of the grievance and a written decision regarding the grievance within 7 working days. 1. Any employee, while on duty, may receive a grievance from a resident, resident representative, family member, or visitor on behalf of a resident employee will report the grievance to their department head or charge nurse. A written report will be initiated, and the Grievance Official will be notified. 3.The Grievance Official is responsible for overseeing the grievance process, receiving and tracking grievances through their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, and issuing written grievance decisions to the resident. Coordinating, as necessary, with state and federal agencies in light of specific allegations, as appropriate in accordance with state law. 4. If a potential violation of a resident right is identified, the Grievance Official, will take immediate action to prevent further potential violations while the investigation is in progress. The Grievance Official will ensure any corrective action needed, is taken. 5. The Grievance Official will maintain grievance forms and tracking records for a minimum of three years of the issuance of the grievance decision residents will be notified through postings at each nurse's station of their right to file grievances. Blank Grievance forms are available at each nurse's station, the social service office, and receptionist desk.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all alleged violations involving mistreatment, neglect, abuse, or misappropriation of resident property were reported immediately, but not later than 2 hours if the alleged violation involved abuse or resulted in serious bodily injury, to other officials (including to the State Agency) for one resident (Resident #43) of eight reviewed for abuse and neglect. The facility failed on 4/14/2025 to immediately report to the State Agency (within 2 hours) Resident #43's witnessed fall which resulted in 9th, 10th and 11th right rib fractures, C4 spinous process fracture, T10 compression fracture, and a frontal scalp hematoma/laceration. This failure placed residents at risk of further potential neglect. Findings include: Review of Resident #43's admission MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included heart failure, osteoporosis (bone disease which causes weakened bones and increased fractures), depression (sadness), and mild cognitive impairment. In Section GG-Functional Abilities, for the tasks of sit to stand and chair/bed-to-chair transfer, she was coded as needing substantial/maximal assistance. Her BIMS score was a 10, indicating she had mildly impaired cognition. Review of Resident #43's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included heart failure, renal failure (where the kidney's lose their ability to filter waste), other fracture, unspecified fracture of fourth cervical vertebra, repeated falls, osteoporosis, depression, and mild cognitive impairment. In Section GG-Functional Abilities, for the tasks of sit to stand and chair/bed-to-chair transfer, she was coded as needing substantial/maximal assistance. Her BIMS was a 14, indicating she was cognitively intact. Review of Resident #43's comprehensive care plan dated last revised 4/3/2025 reflected the resident was care planned for falls and had been care planned for requiring extensive assistance by 1 staff to move between surfaces and as necessary but did not indicate if she needed a gait belt, stand aide machine, mechanical lift, or touch assistance. Review of an incident report dated 4/14/2025 documented by CNA Q revealed a statement, Was taking {Resident #43} to the restroom using the bedrails to stand up as I stood by the wheelchair to help guide her to her chair as she went to turn to sit her ankle twisted, I believe, and she fell over head first and hit the wall. I could not catch her and try to keep her from falling. Review of Resident #43's physical therapy evaluation dated 3/25/2025 revealed that she was a moderate assistance with transfers. Review of a Nurse Practitioner visit dated 5/21/2025 revealed that the primary issues included for that visit were: Concerns per nursing staff: Depression (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Concerns per patient: Patient reports depression due to her fall. She is scared and anxious due to her fall. Review of Resident #43's hospital record dated 4/14/2025 revealed: 9th, 10th and 11th right rib fractures, C4 spinous process fracture, T10 compression fracture, and a frontal scalp hematoma/laceration. Review of an incident report dated 4/14/2025 titled, 'Witnessed Fall' with a note added at the bottom dated 4/24/2025 revealed, Resident was initially transported to ER via EMS. Later noted by family with cervical FX and rib fx. She then gave up bed hold and went to [Hospital] in patient comp rehab documented by the DON. In an interview on 6/24/2025 at 2:50pm with Resident #43, she stated that she had a fall a couple of months ago that resulted in her having to have surgery at the hospital. She stated that she required assistance for almost everything from staff and that during her fall CNA Q was helping her get out of bed, and was holding onto the back of her wheelchair, and she was getting herself into it. She stated that her shoe must have gotten stuck, and she fell straight forward into the wall/baseboard and there was blood everywhere (due to a forehead laceration). She stated that CNA Q did not have her hands on her during the transfer, and that prior to that fall she was able to get out of bed by herself most of the time. She stated that was how they always did transfers, meaning the staff would hold onto the chair for her. She stated that after the fall she was taken by ambulance to the hospital, and during the wait time the nurses conducted neurological checks on her. In an interview on 6/24/2025 at 3:15pm with CNA Q, she stated that Resident #43 was transferring from her wheelchair into bed, and she (CNA Q) was holding onto the resident's wheelchair while the resident transferred herself into bed. She stated she was not using a gait belt. She stated that the resident was pivoting from the chair toward the bed when her foot got caught on the floor and she fell straight ahead into the wall and CNA Q called for help. She stated that they were doing their transfer the way they always did it, where CNA Q was standing by, and not touching the resident for assistance. She stated she got her nurse, and they began neurological checks until EMS arrived and the resident was transported to the hospital. In an interview on 6/24/25 at 3:45 PM with the DON she stated that Resident #43 needed moderate assistance (meaning staff were to have a hand on her during transfers) with transfers and that she didn't know about the fractures until the resident re-admitted on [DATE]. She stated that it was her practice during fall investigations to obtain the hospital records to find out the extent of someone's injuries, but in this case, she did not request them. (continued on next page)

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	06/27/2025

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/25/25 at 9:43 AM with Nurse Supervisor A she stated that she had provided CNA Q with a verbal reprimand on 4/15/2025. Nurse supervisor A revealed that she did not look at the fall that Resident #43 had from a neglect standpoint, she looked at it as CNA Q failing to transfer the resident appropriately. She stated CNA Q was never suspended due to the fall, or not permitted to work with residents. She stated that negative outcomes could have been physical injury, psychological harm, residents could feel as though their needs were not being met, and it could have caused an overall decline in their well-being. She stated that Resident #43 had experienced depression and anxiety from the fall and that the facility referred her to psych services after she was re-admitted . She also had the in-house physician start the resident on SSRI's. She stated that her expectations for resident transfers were communicated through a shift book and transfer statuses were in there but that things changed rapidly. She stated she encouraged dayshift to give report to the ongoing shift. She stated she did a lot of verbal in-servicing for her staff. In an interview on 06/27/25 at 12:36 PM with the DON, she stated that her expectation regarding witnessed falls was that the charge nurse would do an investigation to determine how the resident fell. She stated that Resident #43 was supposed to discharge home the day after the fall occurred and they didn't have any definitive documents stating the extent of the resident's injuries until the hospital records came in with the resident's re-admittance on 5/05/2025. She stated she did not realize she needed to report the fall/injuries to HHSC. She stated that at the time she thought that CNA Q made a mistake and needed more training, which they tried to educate her. She stated that after the fall they were focused on sending the Resident #43 out to the hospital. The DON stated that residents could be susceptible to continuous improper transfers, injuries, or death if falls were not properly investigated. Review of an Employee Disciplinary Record dated 4/15/2025 and addressed to CNA Q revealed under the heading, 'Describe the action that made it necessary to prepare this report. Include dates and events.' Nurse supervisor A typed, Multiple complaints from families, transfer safety. Resident safety. Grooming during showers. Under the heading, 'Describe the counseling received by the employee and the corrective action given and what will happen if not followed' Nurse supervisor A typed Appropriate transfers. Importance of gait belts for weakness. Pivot transfers. Answer lights in a timely manner. Review of an Employee Status Report dated 6/24/25 revealed that CNA Q was terminated from her employment on 6/24/25 due to Employee was counseled many times on failure to provide adequate care to residents. She continues to refuse care to residents. She was terminated for neglect. Review of the facility's Abuse, Neglect, and Misappropriation of Resident Property policy dated last revised 1/2022 revealed, Neglect-the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Recognizing potential signs of abuse: fear and anxiety. As members of the health team, nurse aides are legally and ethically responsible for reporting actual or suspected abuse, neglect, or misappropriation of resident property.

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS system for 1 of 3 discharged residents (Resident #16) reviewed for closed records. The facility failed to complete and transmit a discharge MDS assessment for Resident #16, who discharged on [DATE], within 14 days of the discharge date . This failure could place residents at risk of not having assessments completed and submitted in a timely manner as required. The findings included: Review of Resident #16's face sheet dated [DATE] reflected a [AGE] year-old female admitted on [DATE] with the following diagnoses dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) and Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.). Review of Resident #16's Discharge summary dated [DATE] reflected Resident #16 expired in the facility. Further review reflected .She did have a change in condition and family signed palliative care on [DATE]. Resident expired in facility on [DATE]. Review of Resident #16's MDS list in PCC on [DATE] reflected Resident #16's last transmitted MDS was her admission MDS dated [DATE]. Review of the warnings associated with Resident #16's MDS transmission reflected discharged -ARD complete by [DATE]- 141 days overdue. In an interview on [DATE] at 11:00 am the DON stated the facility has been without a MDS coordinator and they have just hired one and moving forward she would ensure MDSs were completed on time. She stated Resident #16's MDS should have been done on discharge. The DON stated she was responsible for the missed assessment and would complete and transmit the MDS as soon as possible. She stated it was important to do a discharge MDS assessment so that CMS and insurance would be notified of changes. In an interview on [DATE] at 12:34 PM the Administrator stated it was her expectation that MDS assessments be done timely and accurately to ensure the residents are being provided with care that is up to date with their conditions. Review of the facility's undated MDS policy reflected Prepare, implement, and evaluate Resident assessment and Comprehensive Care Plan and MDS according to facility guidelines . Correctly and timely record and document any forms on resident care, personnel, and training. Follow all guidelines for MDS set by state and federal. Refer to the RAI manual for interpretation of any and all MDS questions. Record review of the RAI (Resident Assessment Instrument) Manual OBRA Assessment Summary, dated [DATE], revealed OBRA Discharge assessments -Return Not Anticipated (A0310F = 10) (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).

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	676386	A. Building B. Wing	06/27/2025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 (Resident #39) of 8 residents reviewed for accuracy of assessments. The facility failed to ensure the MDS accurately reflected Resident #39's broken natural teeth. This deficient practice could place residents at risk of inadequate care due to inaccurate assessments. Findings include: Record review of Resident #39's comprehensive MDS assessment dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), high cholesterol, arthritis (swelling and tenderness of one or more joints), depression (sadness), cataracts (clouding of the lends in the eye), mild cognitive impairment, vitamin D deficiency, and legal blindness. Resident #39 had a BIMS score of 11 which indicated she had moderately impaired cognition. In Section L - Oral/Dental Status the box Z. None of the above were present was checked, indicating the resident had no dental issues. Review of Resident #39's care plan, updated on 6/26/2025 revealed that the resident refused dental care. Review of Resident #39's psychosocial note dated 6/10/2025 revealed, She [Resident #39] has broken teeth but they do not hurt her at this time, and she does not want them fixed. Observation/interview on 6/25/2025 at 10:45am of Resident #39 in her room revealed that she had black and broken teeth. When asked, she stated that they did not bother her, the CNAs helped her with oral care, and she stated that she should probably go to the dentist, but she didn't want to bother with it. In an interview on 6/26/2025 at 9:20am with CNA N, she stated that she worked with Resident #39 a lot and provided dental care to the resident which included brushing the resident's teeth and reporting any new or worsening dental concerns to the RN. In an interview on 6/26/2025 at 9:45am with the DON she stated that the person who completed Resident #39's comprehensive MDS assessment no longer worked at the facility, but that they [the facility] could go in and modify it up to 2 years after completion. She stated that she [the MDS coordinator] would have been the person to sign off on the MDS assessment as complete and accurate at that time. She stated that negative outcomes of inaccurate assessments could be overall inaccuracy of the person, possibly the care provided, any kind of payments, and that they want to try and code it as accurate as possible. Review of the facility's undated 'MDS Policy' revealed, Resident information will be as accurate and truthful as possible and may be collected and documented in multiple areas.

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	676386	A. Building B. Wing	06/27/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0645 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 the Pre-admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for one (Resident #74) of three residents reviewed for PASRR Level 1 screenings.The facility's failed to ensure the accuracy of the PASRR Level 1 Screening for Resident #74. The PASRR Level 1 Screening dated 01/22/25 did not indicate a diagnosis of mental illness, although the diagnoses of psychotic disorder with hallucinations, major depressive disorder, and anxiety disorder were present upon Resident #74's admission on [DATE].This failure could place residents with mental illness of not receiving a PASRR Evaluation, individualized care, or special services to meet their needs.Findings included:Review of Resident #74's face sheet, printed on 06/27/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included psychotic disorder with hallucinations (the perception of something not present) due to known physiological condition, major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs).Review of Resident #74's quarterly MDS assessment dated [DATE], reflected a BIMS score of 6 which indicated severely impaired cognition. Resident #74's active diagnoses included anxiety, depression, and psychotic disorder (mental health conditions that cause abnormal thinking and perceptions). No neurological diagnoses (disease that affects the brain or nerves), including dementia, were identified.Review of Resident #74's comprehensive care plan, revised 05/01/25, reflected in part, Focus - [Resident #74] has Major depression disorder. Goals - The resident will remain free of s/sx of distress, symptoms of depression, anxiety, or sad mood . Interventions - Administer medications as ordered. Monitor/document side effects and effectiveness .Review of Resident #74's PASRR Level 1 Screening completed on 01/22/25 by the referring nursing facility reflected Resident #74 did not have a primary diagnosis of dementia and no indicator of mental illness.In an interview on 06/26/25 at 12:40 PM, the DON stated Resident #74 had a mental illness diagnosis, thus the PASRR screening was positive, not negative as reflected on the screening form. She stated a corrected screening should have been completed and sent to the local authority for evaluation. The DON stated she was responsible for PASRRs as the new MDS nurse was still being trained.In an interview on 06/26/25 at 1:06 PM, the DON stated she had completed and transmitted a corrected PASRR Level 1 Screening. The facility's PASRR policy was requested from the DON. A policy was not received prior to exit from the survey.In an interview on 06/27/25 at 10:49 AM, the DON stated she expected the PASRRs to be accurate and timely. She stated if an error in a PASRR was later found, a corrected form was sent. She stated residents may not have received the benefits or treatments they needed or were entitled to if the PASRR screenings was inaccurate.In an interview on 06/27/25 at 12:40 PM, the Assistant Administrator stated she expected the PASRR Level 1 Screening was completed correctly upon admission. She stated if a resident had a positive screening, they may have been entitled to extra services. She stated if an error was found, she expected it to be corrected immediately. Review of the Texas Health and Human Services Detailed Item by Item Guide for Local Authorities and Nursing Facilities to Complete the PASRR Level 1 Screening Form, revised June 2023, and accessed at PASRR Forms and Instructions | Texas Health and Human Services reflected in part, The PASRR Level I (PL1) Screening Form is designed to identify individuals who are suspected of having mental illness (MI), intellectual disability (ID) or a developmental disability (DD). Developmental disabilities are also referred to as related conditions.If documentation entered on the PL1 Screening Form indicates a suspicion of MI, ID, or DD, a PASRR Evaluation (PE) must be completed to confirm PASRR eligibility. The PE is designed to confirm the suspicion of MI, ID or DD and ensure an individual is placed in the most integrated residential setting receiving the specialized services needed to improve and maintain an individual's level of functioning. Examples of MI diagnoses are:SchizophreniaMood Disorder (Bipolar Disorder, Major Depressive Disorder, or other mood disorder)Paranoid DisorderSevere Anxiety DisorderSchizoaffective DisorderPost-Traumatic Stress Syndrome What is not considered an MI:Neurocognitive Disorders, such as Alzheimer's disease, other types of dementia, Parkinson's disease, and Huntington's. (DSM-5*), Depression, unless diagnosed as Major Depression; and Anxiety, unless diagnosed as severe anxiety disorder.*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

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	676386	A. Building B. Wing	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 6 (Residents #36, #39, #43, #15, #10, and #8) of 25 residents reviewed for care plans. A) The facility failed to ensure Residents #36, #39, and #43's care plans addressed the specific individualized method of transfer needed (etc. use of a gait belt, mechanical lift, stand aid) for resident transfers. An Immediate Jeopardy (IJ) was identified on 6/25/2025. The IJ template was provided to the facility on 6/25/2025 at 12:24pm. While the IJ was removed on 6/27/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. B) The facility failed to ensure Resident #15's comprehensive care plan reflected a plan of care for her left-hand contracture (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM). C) The facility failed to ensure Resident #10's Comprehensive Care Plan reflected triggers and individualized interventions for her diagnosis of PTSD (condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashbacks, and avoidance of similar situations). D) The facility failed to ensure Resident #8 comprehensive care plan reflected a plan of care for Resident #8's recurrent UTI's and prophylactic antibiotic use. The failures placed resident at risk of harm, hospitalization, psychosocial distress, and care needs not being identified.Findings included: A) Review of Resident #43's admission MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included heart failure, osteoporosis (bone disease which causes weakened bones and increased fractures), depression (sadness), and mild cognitive impairment. In Section GG-Functional Abilities, for the tasks of sit to stand and chair/bed-to-chair transfer, she was coded as needing substantial/maximal assistance. Her BIMS score was a 10, indicating she had mildly impaired cognition. Review of Resident #43's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included heart failure, renal failure (where the kidney's lose their ability to filter waste), other fracture, unspecified fracture of fourth cervical vertebra, repeated falls, osteoporosis, depression, and mild cognitive impairment. In Section GG-Functional Abilities, for the tasks of sit to stand and chair/bed-to-chair transfer, she was coded as needing substantial/maximal assistance. Her BIMS was a 14, indicating she was cognitively intact. Review of Resident #43's comprehensive care plan dated last revised 4/3/2025 reflected the resident was care planned for falls and had been care planned for requiring extensive assistance by 1 staff to move between surfaces and as necessary but did not indicate if she needed a gait belt, stand aide machine, mechanical lift, or touch assistance. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an incident report dated 4/14/2025 documented by CNA Q revealed a statement, Was taking {Resident #43} to the restroom using the bedrails to stand up as I stood by the wheelchair to help guide her to her chair as she went to turn to sit her ankle twisted, I believe, and she fell over head first and hit the wall. I could not catch her and try to keep her from falling. Review of Resident #43's physical therapy evaluation dated 3/25/2025 revealed that she was a moderate assistance with transfers. In an interview on 6/24/2025 at 2:50pm with Resident #43, she stated that she had a fall a couple of months ago that resulted in her having to have surgery at the hospital. She stated that she required assistance for almost everything from staff and that during her fall CNA Q was helping her get out of bed, and was holding onto the back of her wheelchair, and she was getting herself into it. She stated that her shoe must have gotten stuck, and she fell straight forward into the wall/baseboard and there was blood everywhere (indicating a laceration). She stated that CNA Q did not have her hands on her during the transfer, and that prior to that fall she was able to get out of bed by herself most of the time. She stated that was how they always did transfers, meaning the staff would hold onto the chair for her. In an interview on 6/24/2025 at 3:15pm with CNA Q, she stated that Resident #43 was transferring from her wheelchair into bed, and she (CNA Q) was holding onto the resident's wheelchair while the resident transferred herself into bed. She stated she was not using a gait belt. She stated that the resident was pivoting from the chair toward the bed when her foot got caught on the floor and she fell straight ahead into the wall and CNA Q called for help. She stated that they were doing their transfer the way they always did it, where CNA Q was standing by, and not touching the resident for assistance. Review of Resident #36's comprehensive MDS assessment dated [DATE], reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including heart failure, high blood pressure, benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), arthritis (inflammation of the joints), hemiplegia (total or nearly complete paralysis on one side of the body), seizure disorder, neuropathy (nerves do not function normally), and amnesia (loss of memories). His BIMS score was a 14, indicating intact cognition. Review of Resident #36's care plan last revised 3/7/2025 indicated he was a high risk for falls related to balance problems and hemiplegia. He was care planned for using the stand aide assistive device to maximize independence with transferring, but it was not indicated if a gait belt was to be used or if staff were to provide touch assistance during transfers. During an interview and observation on 6/25/25 at 2:49 PM with Resident #36 and their family, the resident stated that CNA Q would not use a gait belt, and she would just grip under his arms when getting him off the shower chair, and when transferring him out of his recliner and into the stand-aid she would pull on his belt loop/belt on his pants. He stated that recently the CNAs would have a gait belt around their waists when they would enter his room, but would not always use it, and they would still pull on his belt loops to transfer him into the stand aide. During an observation on 6/25/25 at 3:17 PM with CNA V revealed she informed Resident #36 of what she was going to be doing. The aide washed her hands and put on gloves. She did not use a gait belt when transferring the resident out of his recliner and into the stand aid. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/25/25 at 3:20 PM with CNA V she stated they were to put a gait belt on the residents for transfers. She stated she should have gotten a gait belt for the transfer, but she did not. She pulled out a slip of paper which indicated what kind of assist the residents she was assigned to were to receive, but Resident #36 was not on her list. She stated a negative outcome could be that the resident could fall. CNA V stated she was handed a gait belt by her nursing supervisor but was provided no instruction on how to use it, nor was she asked if she knew how to use one. Record review of Resident #39's comprehensive MDS assessment dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), high cholesterol, arthritis (swelling and tenderness of one or more joints), depression (sadness), cataracts (clouding of the lends in the eye), mild cognitive impairment, vitamin D deficiency, and legal blindness. Resident #39 had a BIMS score of 11 which indicated she had moderately impaired cognition. Review of Resident #39's care plan dated last revised 5/14/2024 revealed that the resident required limited assistance by 1 staff using a stand aid to move between surfaces as necessary but did not indicate if a gait belt was to be used or if staff were to provide touch assistance during transfers. In an observation on 06/25/25 at 10:34 AM CNA O was observed assisting Resident #39 to transfer using the stand aid to get into bed. CNA O was not using a gait belt to assist the resident during the transfer, nor was the resident wearing slip resistant footwear, she was wearing fuzzy socks. A gait belt was observed lying on the shelf of the resident's bookcase. In an interview on 06/25/25 at 11:19 AM with CNA O, she stated that she knew what kind of assistance Resident #39 required based on the CNA assignment sheet at the nurse's station. She stated that when using the stand aid, the CNAs were also supposed to be supporting the residents by using a gait belt, but she had forgotten to use the gait belt because she was answering the call light for one of her coworkers who was tending to another resident at that time. She stated without the use of a gait belt and slip resistant footwear the resident could fall and injure themselves. In an interview on 6/25/25 at 3:20 PM with CNA V she stated that they were basically to always put a gait belt on the residents for transfers. She stated that she should have gotten a gait belt for the transfer, but she did not. She pulled out a slip of paper which indicated what kind of assist the residents she was assigned to were, but Resident #36 was not on her list. She stated that a negative outcome could be that the resident could fall. During a follow-up interview with CNA V, she stated that she was handed a gait belt by her nursing supervisor but was provided no instruction on how to use it, nor was she asked if she knew how to use one. In an interview on 6/24/2025 at 3:28pm with the DOR he stated that Resident #43 was a contact guard assist at the time of her fall, meaning that a staff member was to have had a hand on her for assistance. In an interview on 6/24/2025 at 3:45pm with the DON she stated that Resident #43 needed moderate assistance with transfers and that meant they needed hands on assistance. Her expectation was that for all transfers with Resident #43 staff had hands on her for assistance. (continued on next page)

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	06/27/2025

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #15's face sheet dated 06/26/2025 reflected a [AGE] year-old female admitted on [DATE] with the following diagnoses: psychotic disorder with delusions (characterized by unshakable belief in something that is not true or based on reality), hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain. It is caused by disrupted blood supply (ischemia) and restricted oxygen supply (hypoxia).) Review of Resident #15's annual MDS assessment dated [DATE] reflected she was assessed to have a BIMS score 14 indicating she was cognitively intact. Resident #15 was assessed to have functional limitations in range of motion on one side for her upper and lower extremities. Review of Resident #15's comprehensive care plan reflected a focus area for ADL self-care performance deficit related to hemiplegia to left side initiated on 08/07/2023. Interventions included Contractures: The resident has contractures of the left upper extremity. Provide skin care on shower days and PRN (as needed). Further review of her care plan reflected no other entries or plans for her left-hand contracture. Observation on 06/24/2025 at 10:00 AM revealed Resident #15 up in wheelchair in room. Resident #15 was observed to have a left-hand contracture with her fingers fixed into a closed position toward her palm. No palm guard or device was observed in her left hand. Review of definition of contracture in the [NAME] dictionary reflected a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility. Observation and interview on 06/26 2025 at 1:00 PM revealed Resident #15 in her room. Resident #15 was observed to have two therapy carrots, one on the floor and the other on a shelf. (The therapy carrot is an inflatable cone-shaped orthosis used for hand contractures. It gradually reduces sever contractures and provides painless positioning for severely contracted hands.) Resident #15 stated she could not open her left hand and using her right hand tried to open her left hand. Resident #15's left hand opened slightly to reveal long fingernails on her contracted fingers (middle finger to pinky finger). Resident #15 stated they did not really help her with her hand or trim her fingernails. Resident #15 further stated the hand these things (pointing to a therapy carrot) that they were supposed to put in her hand, but the staff rarely got around to it. In an interview on 06/26/2025 at 1:23 PM the DOR stated that Resident #15 was currently on therapy services for strengthening and stated Resident #15 was not on services for contracture management. The DOR stated Resident #15 was discharged from services on 01/29/2025. He stated a contracture management plan was not given to restorative in writing. He stated they just discussed it verbally in the morning meetings. The DOR further stated he did not provide the nursing staff with discharge notes. In an interview on 06/26/2025 at 1:45 PM the DON stated, after handing the surveyor a restorative plan for Resident #15 dated 07/28/2024, that Resident #15 was not currently getting restorative care for her left-hand contracture and should be. She further stated her contracture management was not on her care plan, and it should be. The DON stated Resident #15 should not have come off of restorative care but stayed on for contracture management to ensure her contracture did not worsen. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #15's Restorative: hand program dated 07/28/2024 reflected the plan was active and included Restorative: Hand Program for LUE 1) Hygiene to hand, dry well. File and Trim Nails; 2) PR0M/AR0M to each joint of finger, hand and wrist joint of hand; 3) Assist resident to place hand on flat surface and stretch fingers while lightly pressing down X 10 reps; 4) Assist resident to squeeze and release ball X 10 reps; 5) Apply soft splint to hand. In an interview on 06/26/2025 at 2:00 PM CNA R stated Resident #15's left hand was contracted, and she has a carrot to put in her hand and they use it when they think about it. She stated there was no plan in her medical record or anywhere to document the use of the carrot or when they are supposed to put it in her hand. She stated since Resident #15 was not diabetic that any staff can trim her fingernails and that fingernails are usually done on the weekends. In an interview on 06/27/2025 at 12:34 PM the Administrator stated it was her expectation that residents with contractures should be seen by therapy then sent to restorative for maintenance. She stated the resident should remain on restorative and if not being seen by restorative the resident should be getting treatment from floor staff and should have a plan of care for contracture management. She stated failure of staff not doing this could result in worsening of the contracture and other complications. Review of the undated facility policy Plan of care for contracture management reflected Goals: First you want to reduce the risk of development/progression of contractures of fingers, hands or wrist. Improve range of motion of fingers hands or wrist. Improve hand hygiene. Approaches: Hygiene to right/left hand. Dry hands well and file and trim nails as needed. PROM/AROM to each joint of finger hand and wrist joint of right/left hand. Assist resident to place hand on flat surface and stretch fingers while lightly pressing down. Assist resident to squeeze and release ball. Apply soft splint to right/left hand. Review of Resident #10's face sheet, printed on 06/27/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included acute respiratory failure with hypoxia (not enough oxygen in the blood), post-traumatic stress disorder (PTSD), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), and low back pain. Review of Resident #10's quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 which indicated moderately impaired cognition. The MDS reflected Resident #10 had a diagnosis of PTSD. Review of Resident #10's comprehensive care plan, revised on 12/11/24, reflected in part, [Resident #10] has lived a long life and has potentially suffered a traumatic event as some time in her life. Goal - [Resident #10] will remail calm/stress free during their stay in the facility. Interventions - Always approach resident calmly and speak clearly by announcing what is happening prior to performing task; Do not sneak up behind and try not to startle resident; Get to know resident and his/her preferences or triggers; Given resident choices when possible . There were no triggers identified. Review of Resident #10's Psychiatric Subsequent Assessment, dated 06/13/25, reflected a previous mental health diagnosis included PTSD. (continued on next page)

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	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and an attempted interview on 06/25/25 at 09:30 AM, Resident #10 was observed in her bed. She stated she was comfortable, but her feet hurt. When asked about trauma, she stated she just wanted to rest, and she closed her eyes. In an interview on 06/27/25 at 10:33 AM, the Social Worker stated she asked residents about trauma when she completed the resident's social history. She stated she completed the care plans for residents with trauma. She stated she did not remember if Resident #10 had a diagnosis of PTSD. After looking into the electronic medical record, she stated she did not have any information about PTSD or triggers on the social history from when the resident was admitted . She stated if triggers were not on the care plan, staff could do something to upset or scare the resident and put them back in the situation that caused their trauma. In an interview on 06/27/25 at 10:49 AM, the DON stated she expected care plans to be accurate, individualized, and completed timely. She stated the Social Worker was responsible for completing some care plans including trauma related care plans. She stated if triggers were identified, staff would be able to avoid retriggering the resident. The DON stated she tried to monitor the care plans, and the care plans were reviewed in the quarterly IDT meetings. The DON stated if the care plan was not accurate or individualized, the resident may not receive appropriate care or support. In an interview on 06/27/25 at 12:40 PM, the Assistant Administrator stated she expected the care plans to be individualized, accurate, and completed timely. She stated the residents may not have their needs met if care plans were inaccurate. D) Review of Resident #8 face sheet dated 06/27/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses acute pulmonary edema (fluid on the lungs), urinary tract infection (bladder infection) and congestive heart failure (heart failure). Review of Resident #8's quarterly MDS assessment dated [DATE] reflected Resident #8 was assessed to have a BIMS score of 11 indicating moderate cognitive impairment. Resident #8 was assessed to always be incontinent of urine. Resident #8 was assessed to not have any infections and was assessed to be on antibiotics. Review of Resident #8's consolidated physician's orders dated 06/26/2025 reflected an order dated 08/15/2024 Keflex 500mg give one capsule by mouth at bedtime for prevention. Review of Resident #8's UTI's from 08/15/2024 through 06/26/2025 reflected she was diagnosed with a UTI on three separate occasions: -01/10/2025 reflected an individual resident infection surveillance report dated 01/08/2025. Symptoms listed: AMS (altered mental status) Culture: Yes; Organism: Pseudomonas Aeruginosa >100,00 CFU/ml. Medication Cipro 500 mg BID x 7 days. Further review of the infection surveillance report reflected no other symptoms were documented. -04/25/2025 reflected an individual resident infection surveillance report dated 04/25/2025. Symptoms listed: increased confusion: Culture yes: organism Enterococcus faecium 50-100,00 CFU/ml. Medication: Amoxicillin 500 mg TID x 10 days. (continued on next page)

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	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-05/29/2025 reflected an individual resident infection surveillance report dated 05/28/2025. Symptoms listed: Resident not feeling well. antibiotics orders for ciprofloxacin HCL 250 mg one tablet two times daily for 7 days. Review of Resident #8's culture report reflected Pseudomonas Aeruginosa >100,00 CFU/ml. Review of Resident #8's comprehensive care plan initiated on 12/20/2023 and last revised on 04/23/2025 reflected no entries related to urinary tract infections or antibiotic use. In an interview on 06/27/2025 at 11:00 am the DON stated residents should have care plans for all UTIs and if a resident was on routine antibiotics a care plan should be done with a plan for monitoring for SE. She stated the facility has been without a MDS coordinator and they have just hired one moving forward she stated they will ensure the development of care plans to ensure the residents receive appropriate care to resolve UTI's. Review of the facility's undated policy Resident Care Plan reflected 1. To develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment . 2. A comprehensive care plan should be oriented towards . 5) Applying current standards of practice in the care planning process. 6) Evaluating treatment of measurable objectives, timetables, and outcomes of care.7) Respecting the resident's right to decline treatment. 8) Offering alternative treatments, as applicable. 9) Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. 10) Involving resident, resident's family, and other resident representatives as appropriate. 11) Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs. 12) Involving the direct care staff with the care planning process relating to the resident's expected outcomes. 13) Addressing additional care planning areas that are relevant to meeting the resident's need in the long-term care setting . The assistant ADM and DON were notified on 6/25/2025 at 12:15pm that an Immediate Jeopardy had been identified due to the above failure and an IJ template was provided. The following POR was accepted on 6/26/2025 at 12:35pm: On 06/25/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of the Immediate Threat states as follows: F656- The facility must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The facility failed to ensure Resident #43's care plan addressed the specific individualized method of transfer needed (etc. use of a gait belt, mechanical lift, stand aid) for resident transfers. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Action: All resident care plans will be updated and individualized with specific patient care needs. MDS Coordinator will review all care plans and individualize. Director of Nursing will monitor and assist as needed, and update with 72 hours. Care Plans will be individualized to the resident's specific needs. Start Date: 06-25-2025 Completion Date: 06-25-2025 Responsible: Director of Nursing Action: Assistant Administrator In-Serviced Director of Nursing and MDS Coordinator on the importance of updating and individualizing the care plans within 72 hours. Informed them this would be discussed during morning meeting and if there were any status changes or new orders, the care plan would need to be updated within 72 hours. Assistant Administrator or Administrator will do a visible audit to ensure care plans are being updated, once a week for four weeks, then monthly for 6 weeks, then quarterly thereafter. Care Plan policy will be updated to reflect all new practices adopted. Start Date: 06-25-2025 Completion Date: 06-25-2025 Responsible: Administrator Action: The MDS Coordinator will be responsible for reviewing the most recent comprehensive assessments to ensure they match the individualized resident care plan. The DON or ADON will monitor for accuracy. Start Date: 06-25-2025 Completion Date: 06-25-2025 Responsible: Director of Nursing The surveyor monitored the POR on 6/27/2025 as follows: Review of Resident #36's care plan last updated on 6/25/2025 revealed that his care plan was changed to The resident uses stand aide assistive device with gait belt to maximize independence with transferring. Review of Resident #39's care plan last updated on 6/25/25 revealed that her care plan was changed to The resident requires assistance by 1 staff using stand aid and gait belt to move between surfaces as necessary. Review of Resident #43's care plan last updated on 6/25/25 revealed that her care plan was changed to The resident requires extensive assistance by 1 staff with stand aide and gait belt to move between surfaces and as necessary. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a list of residents was provided to the state surveyors on 6/27/25, revealing that all residents had their care plans reviewed and updated if applicable. Review of the facility's updated policy titled; Resident Care Plan revealed the following updates: Addressing additional care planning areas that are relevant to meeting the resident's need in the long-term care setting. Any changes in condition that are reported by the nursing staff will be updated within 72 hours of notification. Review of an in-service titled Care Plan Updates In-Service conducted by the ADM on 6/25/25, revealed that the DON and MDS coordinator were counseled on the timely updates of care plans to be individualized, the importance of recognizing when a resident had a change in their specific care needs and method of transfer had changed. It reflected those things would be discussed during each morning meeting held and that care plans needed to be updated accordingly and timely, if needed. The signatures of the ADM, DON, and MDS were reflected. In an interview on 6/27/2025 at 12:29 PM with the DON she stated she had the nursing supervisors to pass out the gait belts to all staff and placed them at nurses' station to ensure a gait belt was available to each CNA. She stated the IDT would bring up any issues in morning meetings to ensure access to gait belts. She stated she had the nursing supervisors print out current transfer status and had each resident assessed and care plans were updated to reflect resident specific transfers. She stated that she would be responsible for monitoring the accuracy of resident assessments and care plans. In an interview on 6/27/2025 at 12:40 PM with the ADM she stated that she in-serviced the DON and MDS Coordinator on the importance of updating and individualizing resident care plans within 72 hours. She informed them it would be discussed during morning meetings and if there were any status changes or new orders, the care plan would need to be updated within 72 hours. She stated she would do a visible audit to ensure care plans were being updated once a week for four weeks, then monthly for 6 weeks, then quarterly thereafter. She further stated the care plan policy was updated to reflect the new procedures. In an interview on 6/27/2025 at 12:47 PM with the MDS Coordinator she stated that she was going to be responsible for reviewing all resident's most recent comprehensive MDS assessments and would ensure that the comprehensive care plan would reflect the same. She stated that she recently received in-service training from the ADM regarding this. Review of the facility's updated on 6/27/2025 Care Plan policy revealed, A comprehensive care plan should be oriented towards managing risk factors to the extent possible or indicating the limits of such interventions. Involving the direct care staff with the care planning process relating to the resident's need in the long-term care setting. The ADM and DON were notified the IJ was removed on 06/27/25 at 3:30PM. However, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to review and revise the person-centered, comprehensive care plan for 1 (Resident #89) of 6 residents reviewed for comprehensive care plan revisions. The facility failed to update Resident #89's care plan to reflect the current need for extensive assistance for transfers. This failure could put residents at risk of not receiving the appropriate care, services, or treatments they need. Findings included: Review of Resident #89's face sheet, printed 06/27/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included essential hypertension (high blood pressure), major depressive disorder, muscle weakness, difficulty walking, unsteadiness on feet, other abnormalities of gait and mobility, and unspecified pain. Review of Resident #89's quarterly MDS assessment, dated 05/28/25, reflected both short- and long-term memory impairment. A BIMS assessment was not attempted. Resident #89 was assessed to need partial/moderate assistance with sit to stand, chair/bed to chair transfers, and toilet transfers. Review of Resident #89's comprehensive care plan, initiated on 04/24/25, reflected in part, Focus - [Resident #89] has an ADL self-care performance deficit . Goal - The resident will maintain current level of function through review date. Interventions - Transfer: The resident requires limited assistance by 1 staff to move between surfaces, as necessary. Review of Resident #89's Order Summary Report, for active orders as of 06/24/24, reflected the following orders: May transfer with Stand Aid or Mechanical lift PRN. Date ordered 01/08/24. May use Stand Aid for transfers if weight bearing. Date ordered 01/08/24. Review of Resident #89's transfer task documentation from 05/27/25 through 06/25/25, revealed the resident required limited assistance two times, extensive assistance 31 times, and total dependence 25 times. An observation on 06/24/25 at 9:29 AM, revealed Resident #89 sitting up in a wheelchair in the activity room. A blue sling, used with a mechanical lift, was observed in place between the resident and the wheelchair. An observation on 06/25/25 at 12:13 PM revealed Resident #98 sitting up in a wheelchair in the dining room. A blue sling was observed between the resident and the wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/25/25 at 12:15 PM, CNA J stated she had worked at the facility for about two years as a CNA. She stated she frequently provided care to Resident #89. CNA J stated Resident #89 at one time used the Stand Aid for transfers but for the last several weeks, they used the mechanical lift to transfer the resident in and out of bed. She stated two staff were required for the mechanical lift. In an interview on 06/27/25 at 1049 AM, the DON stated she expected care plans to be accurate and individual. She stated she was responsible for most care plans, but the facility recently hired a new MDS coordinator who would be responsible. She stated other disciplines such as dietary and social services contributed to making the care plans. She stated they reviewed a report daily in the morning meeting and care plans were updated when there was a change. She stated the care plans were updated and revised in the IDT meetings. The DON stated if care plans were not accurate, residents may not receive the appropriate care. In an interview on 06/27/2025 at 12:34 PM, the Assistant Administrator stated she expected care plans were completed accurately and updated timely with care that is up to date with the resident's conditions. Review of the facility's undated Resident Care Plan policy reflected in part, 1. The comprehensive care plan must be: .2) prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's family or legal representative; 3) periodically reviewed and revised by a team of qualified persons after each assessment; . 10) Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs. To update the resident's care plan: For EMR care plans: (using the electronic records program) resolve, edit, or add any focus, goal, or intervention as needed based on the resident's needs.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1of 2 residents reviewed with limited range of motion (Resident #15), received appropriate treatment and services to prevent a decrease in range of motion. The facility failed to ensure Resident #15 had interventions in place for her left- hand contracture (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM) to prevent further decline of the range of motion in her left hand. This deficient practice could place residents with contractures at risk for decrease in mobility, range of motion, and could contribute to worsening of contractures. Findings Include: Review of Resident #15's face sheet dated 06/26/2025 reflected she was admitted on [DATE] with the diagnoses of hemiplegia and hemiparesis (one-sided paralysis) . Review of Resident #15's annual MDS assessment dated [DATE] reflected she was assessed to have a BIMS score 14 indicating she was cognitively intact. Resident #15 was assessed to have functional limitations in range of motion on one side for her upper and lower extremities. Review of Resident #15's comprehensive care plan reflected a focus area for ADL self-care performance deficit related to hemiplegia to left side initiated on 08/07/2023. Interventions included Contractures: The resident has contractures of the left upper extremity. Provide skin care on shower days and PRN (as needed). Further review of her care plan reflected no other entries or plans for her left-hand contracture. Review of Resident #15's consolidated physician orders dated 06/26/2025 reflected no orders or treatments for a left- hand contracture. Review of Resident #15's Occupational therapy evaluation and plan of treatment for the certification period of 4/15/2025 through 05/14/2025 reflected .She propels herself in wheelchair, has had frequent falls, has contracture to LUE . The OT evaluation did not give a specific treatment plan for her left-hand contracture. Observation on 06/24/2025 at 10:00 AM revealed Resident #15 up in wheelchair in room. Resident #15 was observed to have a left-hand contracture with her fingers fixed into a closed position toward her palm. No palm guard or device was observed in her left hand. (continued on next page)

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	06/27/2025

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 06/26 2025 at 1:00 PM revealed Resident #15 in her room. Resident #15 was observed to have two therapy carrots one on the floor and the other on a shelf. (The therapy carrot is an inflatable cone-shaped orthosis used for hand contractures. It gradually reduces sever contractures and provides painless positioning for severely contracted hands.) Resident #15 stated she could not open her left hand and using her right hand tried to open her hand. Resident #15's left hand opened slightly to reveal long fingernails on her contracted fingers (middle finger to pinky fingers). Resident #15 stated they do not really help her with her hand or trim her fingernails. Resident #15 stated she had these things (pointing to a therapy carrot) that they are supposed to put in her hand, but the staff rarely get around to it. In an interview on 06/26/2025 at 1:23 PM the DOR stated Resident #15 was currently on therapy services for strengthening and stated Resident #15 was not on services for contracture management. The DOR stated Resident #15 was discharged from services on 01/29/2025. He stated a contracture management plan was not given to restorative in writing, he stated they just discussed it verbally in the morning meetings. The DOR further stated he does not provide the nursing staff with discharge notes. In an interview on 06/26/2025 CNA O (Restorative Aide) stated they were not currently seeing Resident #15 for her left-hand contracture. She stated she was discharged a long time ago. She stated she was not sure if they had any documentation of the ROM or contracture management she would have to check. She stated to her knowledge when restorative stops seeing the residents they do not turn over care to the nursing staff. Observation and interview on 06/26/2025 at 1:30 PM the DON stated after observation of Resident #15's left hand that her hand was contracted, and her nails were long and needed to be trimmed. The DON stated she was not sure if Resident #15 hand a contracture management plan or if she was being seen by therapy, but she would look into it. Review of Resident #15's Restorative: hand program dated 07/28/2024 reflected the plan was active and included Restorative: Hand Program for LUE l) Hygiene to hand, dry well. File and Trim Nails; 2) PR0M/AR0M to each joint of finger, hand and wrist joint of hand; 3) Assist resident to place hand on flat surface and stretch fingers while lightly pressing down X 10 reps; 4) Assist resident to squeeze and release ball X 10 reps; 5) Apply soft splint to hand. In an interview on 06/26/2025 at 1:45 PM the DON stated, after handing surveyor a restorative plan for Resident #15 dated 07/28/2024, that Resident #15 was not currently getting restorative care for her left-hand contracture and should be. She further stated her contracture management was not on her care plan, and it should be. The DON stated Resident #15 should not have come off of restorative care but stayed on for contracture management to ensure her contracture did not worsen. In an interview on 06/26/2025 at 2:00 PM CNA R stated Resident #15's left hand was contracted, and she has a carrot to put in her hand and they use it when they think about it. She stated there was no plan in her medical record or anywhere to document the use of the carrot or when they are supposed to put it in her hand. She stated since Resident #15 was not diabetic that any staff can trim her fingernails and that fingernails are usually done on the weekends. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/27/2025 at 12:34 PM the Administrator stated it was her expectation that residents with contractures should be seen by therapy then sent to restorative for maintenance. She stated the resident should remain on restorative and if not being seen by restorative the resident should be getting treatment from floor staff and should have a plan of care for contracture management. She stated failure of staff not doing this could result in worsening of the contracture and other complications. Review of definition of contracture in the [NAME] dictionary reflected a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility. Review of the undated facility policy Plan of care for contracture management reflected Goals: First you want to reduce the risk of development/progression of contractures of fingers, hands or wrist. Improve range of motion of fingers hands or wrist. Improve hand hygiene. Approaches: Hygiene to right/left hand. Dry hands well and file and trim nails as needed. PROM/AROM to each joint of finger hand and wrist joint of right/left hand. Assist resident to place hand on flat surface and stretch fingers while lightly pressing down. Assist resident to squeeze and release ball. Apply soft splint to right/left hand.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 each resident received adequate supervision and assistance devices to prevent accidents for 4 (Residents #19, #36, #39, and #43) of 24 residents reviewed for accidents and hazards. A) The facility failed on [DATE] to ensure Resident #43 was provided contact guard assistance during sit to stand transfers which resulted in an actual fall which resulted in 9th, 10th and 11th right rib fractures, C4 spinous process fracture, T10 compression fracture, and a frontal scalp hematoma/laceration. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 6:00pm. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. B) The facility failed to on [DATE] and [DATE] ensure there was appropriate assistance provided to Residents #19, #36, and #39 while utilizing the stand aide (mechanical lift to assist the resident into a standing position). These failures could place residents at risk for falls, injuries, hospitalization, or death. Findings include: A) Resident #43 Review of Resident #43's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included other fracture, unspecified fracture of fourth cervical vertebra, repeated falls, osteoporosis, and mild cognitive impairment. In Section GG-Functional Abilities, for the tasks of sit to stand and chair/bed-to-chair transfer, she was coded as needing substantial/maximal assistance. Her BIMS was a 14, indicating she was cognitively intact. Review of Resident #43's comprehensive care plan dated last revised [DATE] reflected the resident was care planned for falls and had been care planned for requiring extensive assistance by 1 staff to move between surfaces and as necessary. Review of Resident #43's physical therapy evaluation dated [DATE] revealed that she was a moderate assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an incident report dated [DATE] documented by CNA Q revealed a statement, Was taking {Resident #43} to the restroom using the bedrails to stand up as I stood by the wheelchair to help guide her to her chair as she went to turn to sit her ankle twisted, I believe and she fell over head first and hit the wall. I could not catch her and try to keep her from falling. Review of Resident #43's hospital record dated [DATE] revealed: 9th, 10th and 11th right rib fractures, C4 spinous process fracture, T10 compression fracture, and a frontal scalp hematoma/laceration. In an interview on [DATE] at 2:50pm with Resident #43 she stated she had a fall a couple of months ago that resulted in her having to have surgery at the hospital. She stated that she required assistance for almost everything from staff and that during her fall CNA Q was helping her get out of bed, and was holding onto the back of her wheelchair, and she was getting herself into it. She stated that her shoe must have gotten stuck, and she fell straight forward into the wall/baseboard and there was blood everywhere. She stated that CNA Q did not have her hands on her during the transfer, and that prior to that fall she was able to get out of bed by herself most of the time. She stated that was how they always did transfers, meaning the staff would hold onto the chair for her. In an interview on [DATE] at 3:15pm with CNA Q she stated that Resident #43 was transferring from her wheelchair into bed, and she (CNA Q) was holding onto the resident's wheelchair while the resident transferred herself into bed. She stated she was not using a gait belt. She stated that the resident was pivoting from the chair toward the bed when her foot got caught on the floor and she fell straight ahead into the wall and CNA Q called for help, the nurse assessed the resident, began neurological checks, and called the EMS. She stated that they were doing their transfer the way they always did it, where CNA Q was standing by, and not touching the resident for assistance. In an interview on [DATE] at 3:28pm with the DOR he stated that Resident #43 was a contact guard assist at the time of her fall, meaning that a staff member was to have a hand on her for assistance. In an interview on [DATE] at 3:45pm with the DON she stated that Resident #43 needed moderate assistance with transfers and that meant they need hands on assistance. Her expectation was that for all transfers with Resident #43 staff have hands on her for assistance. Review of CNA Q's in-service record revealed she was last in-serviced on resident fall prevention on [DATE]. B) Resident #19 Record review of Resident #19's comprehensive MDS assessment dated [DATE] reflected an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including osteoporosis (bone disease which causes weakened bones and increased fractures), muscle weakness, lack of coordination, and a history of falling. In Section GG-Functional Abilities, for the tasks of sit to stand and chair/bed-to-chair transfer, she was coded as needing supervision or touching assistance. She had a BIMS score of 12, which indicated she had moderately impaired cognition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #19's care plan revealed she had limited physical mobility due to weakness. She was care planned for being on diuretic therapy and had an intervention for being monitored for an increased risk of falls. She was care planned for being a moderate risk for falls related to mobility abnormality, lack of coordination, muscle weakness, falls. Interventions included to make sure the resident's call light was within reach, follow facility fall protocol. Review of Resident #19's weekly skin assessment dated [DATE] revealed a note that stated, Resident has multiple purple bruises to bilateral arms. Review of Resident #19's weekly skin assessment dated [DATE] revealed the answer to question 1. Skin intact with no visible injury, discoloration, or change from previous assessment was marked as (a. Yes). Further review revealed there were no notes indicating the resident still had bruising. In an observation and interview on [DATE] at 1:34 PM with Resident # 19 she stated the large bruises on her arm near her left elbow crease was from the metal nut that held the bars together on the stand aid. She stated her arm hit the nut on the stand aid and bruised her and she told her CNA, (CNA D), and sometimes a nurse would look at it. She stated sometimes the CNA's used a gait belt but not all the time. She stated the RN had looked at the bruises but there was not much they could do about it. In an interview on [DATE] at 1:45 PM with CNA M she stated that Resident # 19 had told her the bruising on her arm was from the stand aid and she (CNA M) had verbally told her charge RN, but at that time she was unable to say which charge RN it was, just that it was whichever one was working at the time of the report. In an observation on [DATE] at 1:10pm of the 2 of 2 stand aides in the shower room of station 2 revealed 3 of the 4 nuts/bolts that protruded from the outsides of the stand aide machine (where a resident would reach up to begin grabbing onto the bars) were missing their plastic caps. In an interview on [DATE] at 1:47 PM with Nurse Supervisor A she stated that Resident # 19 took a blood thinner and bruised easily and that she had not been informed that the resident was being bruised by the stand aid. When shown the stand aid nut cover on 1 of the 4 nuts, she stated that they could put in a maintenance request for them to order more covers to prevent more residents from being bruised or cut. In an interview on [DATE] at 1:49PM with the MS he stated he would get the handwritten maintenance requests from the nurses' stations but that no one had ever requested the plastic caps to be replaced before. He stated it was maintenances responsibility to inspect the stand aid machines to look for wear and tear on the kneepads, seat pads, and they would replace the bolts, but it was not their practice to look at the plastic caps. Resident #36 Review of Resident #36's comprehensive MDS assessment dated [DATE], reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses arthritis (inflammation of the joints), hemiplegia (total or nearly complete paralysis on one side of the body neuropathy (nerves do not function normally), and amnesia (loss of memories). His BIMS score was a 14, indicating intact cognition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #36's care plan indicated he was a high risk for falls related to balance problems and hemiplegia. He was care planned for using the stand aide assistive device to maximize independence with transferring. During an interview an observation on [DATE] at 2:49 PM with Resident #36 and their family, the resident stated that CNA Q would not use a gait belt and she would just grip under his arms when getting him off the shower chair, and when transferring him out of his recliner and into the stand-aid she would pull on his belt loop/belt on his pants. He stated that recently the CNA's would have a gait belt around their waists when they would enter his room, but would not always use it, and would still pull on his belt loops to transfer him into the stand aid. During an observation on [DATE] at 3:17 PM with CNA V she informed the resident of what she was going to be doing, washed her hands, and put on gloves. She did not use a gait belt when transferring the resident out of his recliner and into the stand aid. In an interview on [DATE] at 3:20 PM with CNA V she stated they were to put a gait belt on the residents for transfers. She stated she should have gotten a gait belt for the transfer, but she did not. She pulled out a slip of paper which indicated what kind of assist the residents she was assigned to were to receive, but Resident #36 was not on her list. She stated a negative outcome could be that the resident could fall. CNA V stated she was handed a gait belt by her nursing supervisor but was provided no instruction on how to use it, nor was she asked if she knew how to use one. Resident #39 Record review of Resident #39's comprehensive MDS assessment dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including arthritis (swelling and tenderness of one or more joints), , cataracts (clouding of the lends in the eye), mild cognitive impairment, and legal blindness. Resident #39 had a BIMS score of 11 which indicated she had moderately impaired cognition. Review of Resident #39's care plan revealed the resident required limited assistance by 1 staff using stand aid to move between surfaces as necessary. During an observation on [DATE] at 10:34 AM CNA O was observed assisting Resident #39 transfer using the stand aide to get into bed. CNA O was not using a gait belt to assist the resident during the transfer, nor was the resident wearing slip resistant footwear, she was wearing fuzzy socks. A gait belt was observed lying on the shelf of the resident's bookcase. In an interview on [DATE] at 11:19 AM with CNA O, she stated she knew what kind of assistance Resident #39 required based on the CNA assignment sheet at the nurse's station. She stated when using the stand aid, the CNAs are also supposed to be supporting the resident's by using a gait belt, she had forgotten to use the gait belt because she was answering the call light for one of her coworkers who was tending to another resident at that time. She stated without the use of a gait belt and slip resistant footwear the resident could fall and injure themselves. Review of the Stand Assist Assembly and Operation Manual dated [DATE] revealed that plastic caps were a part of the pictured fasteners and tools that came with the machine. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated Transfer Activities Assisting Resident to Transfer to Chair or Wheelchair policy reflected under 'Purpose': To assist the resident to transfer from bed to chair, toilet, or other surface safely or without trauma or avoidable pain. Review of the facility's undated Resident Falls Protocol policy reflected under 'Fall Prevention': Assist residents with ADLs as needed. Inservice staff as needed over Fall Prevention. The assistant ADM and DON were notified on [DATE] at 5:45pm that an Immediate Jeopardy had been identified due to the above failure and an IJ template was provided. The following POR was accepted on [DATE] at 4:44pm: On [DATE] an abbreviated survey was initiated at facility. On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Threat states as follows: F689 - The facility must ensure each resident receives adequate supervision and assistant devices to prevent accidents. The facility failed to ensure Resident #43 was provided contact guard assistance during sit to stand transfers with resulted in an actual fall with injuries including multiple rib fractures, a closed nondisplaced fracture of the fourth cervical vertebrae, and a frontal scalp laceration that required sutures on [DATE]. Action: All nursing staff verbally and by in-service were made aware of how to find a resident's transfer status and level of assistance needed. Start Date: 06-25-2025 Completion Date: 06-26-2025 Responsible: Administrative Nursing and Training Coordinator Action: Nursing Administration ensured there are adequate gait belts available on each station for each CNA. Charge nurses will show CNAs at the beginning of each shift where they can locate a gait belt and when to properly use one. Nursing Supervisors distributed a gait belt to each nursing staff member on duty to use and showed them on their group assignment how to locate a resident's transfer status. The Training Coordinator in-serviced all nursing staff on proper transfers and the use of all transfer devices in the facility. Training will be completed upon hire, yearly and as needed for retention to ensure ongoing proper use of equipment and in-services will be provided to all nursing staff. Charge nurses will be responsible for educating/in-servicing agency staff to ensure they are aware of a resident's level of assistance and will ensure proper transfers and use of all transfer devices in the facility. A test will be required at the end of each in-service for proof of retention. Start Date: 06-25-2025 Completion Date: 06-26-2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Responsible: Administrative Nursing and Training Coordinator Action: In-Service on proper transfers for nursing staff and neglect for all staff. Training coordinator is a Licensed Vocational Nurse as well as a NATCEP Instructor, as well as 40 years as a LVN at our facility. Her NATCEP was completed on 02-14-2024 and skills review was completed on 05-10-2024. In-service will be completed quarterly and as needed for retention; a test will be required at the end of each in-service for proof of retention. Upon hire, quarterly and as needed for retention, to ensure ongoing proper transfers and education on neglect in-services will be provided to all staff; a test will be required at the end of each in-service for proof of retention. All staff, including agency will be required to attend all in-services and will be checked off quarterly for retention, a test will be required at the end of each in-service for proof of retention. Start Date: 06-25-2025 Completion Date: 06-26-2025 Responsible: Training Coordinator Action: New protocol in place to complete an interdisciplinary post fall investigation within 72 hours on each fall in this facility. Form will be completed by nursing supervisor and kept electronically on our shared computer drive that is accessible on any computer in our facility. The Interdisciplinary post fall investigation will be reviewed at the following QAPI meeting. Administrative nursing will follow up on all interdisciplinary post fall investigations every 6 months. Administrator will monitor investigation is being performed within 72 hours. Pending outcome of investigation will warrant if further action is needed. Start Date: 06-25-2025 Completion Date: 06-25-2025 Responsible: Director of Nursing Action: QAPI Committee met to discuss new implementations and new QAPI processes of reviewal of the interdisciplinary post fall investigation monthly at each meeting. All members agreed form was a good addition and to implement. DOR suggested that someone from therapy coordinate with the training coordinator and when we hire a new CNA, a therapist would demonstrate on the proper use transfer aides. Attendees of QAPI: Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Director of Rehab, MDS, Business Office Manager, Dietary Manager, Social Services, Environmental Services Manager and Activity Director. Dr. [name] met with Assistant Administrator and Director of Nursing separately due to not being able to attend the QAPI meeting to go over his expectations of the importance of recognizing neglect and investigating falls appropriately. Start Date: 06-25-2025 Completion Date: 06-25-2025 Responsible: Administrator (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Action: Director of Rehab will coordinate with Training Coordinator on all new hires for CNAs to train for proper use of transfer aides. To ensure completion added to Nurse Aide performance record check off list for new hires. A therapist from the therapy department will demonstrate the proper use of transfer aides with the new hires. The new hire will then demonstrate back the proper use of transfer aides. This will be checked off in their new hire packet. Start Date: 06-25-2025 Completion Date: 06-25-2025 Responsible: Training Coordinator Action: Charge Nurse will be responsible for ensuring agency staff will be made aware of the resident's level of assistance and proper use of transfer devices. Form will be signed off showing they have been educated on the different levels of assistance and proper use of transfer devices. We will in-service agency quarterly and as needed for retention. All care plans will be updated to be individualized with their specific transfer needs and levels of assistance needed. A detailed legend that describes the definition of each level of care will be posted explaining different levels of assistance required at all CNA monitors and nursing monitors at all stations. Start Date: 06-25-2025 Completion Date: 06-25-2025 Responsible: Nursing Supervisors The surveyor monitored the POR on [DATE] as follows: An observation on [DATE] at 9:15 AM nurses' station #2 was observed to have multiple gait belts lying on the countertop, and majority of the nursing staff were observed wearing a gait belt draped around them or on their person. A CNA assignment sheet dated [DATE] revealed what type of assistance the residents on the halls required and if a gait belt was required for their transfers. An observation on [DATE] at 11:04 AM CNA M assisted Resident #43 out of her bed and onto the stand aid. She washed her hands and then applied gloves to her hands. The CNA put shoes on the resident. CNA M put a gait belt around the resident's waistline and tightened it, she checked with the resident to make sure it was not too tight. She informed the resident where to grab the stand aid and lifted the resident's bed to help her into the stand aid, they then helped lower her into her wheelchair. The resident's knees were not buckling, there were no signs of stress, and she assisted the aide in getting herself into the stand aid. An observation on [DATE] at 11:55 AM PTA was assisting Resident #36 into his w/c from his recliner. PTA was using a gait belt that was placed at the resident's waistline, and the PTA assisted the resident out of his recliner and the resident pivoted to sit down into his wheelchair. The resident appeared steady with no weakness in his knees and was wearing tennis shoes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on [DATE] at 1:25 PM revealed CNA K and CNA L transferred Resident # 100 from the wheelchair to the bed using the mechanical lift. The CNAs explained the procedure to the resident before they initiated the transfer and throughout the transfer. The CNAs adjusted the lift in front of the resident and connected the purple loops on the sling to the lift. CNA L pushed the buttons to raise the resident and CNA K held the handle on the back of the sling and steadied the resident. When the resident was at the proper height, the CNAs adjusted the position of the lift until the resident was properly centered over the bed. They lowered the resident on to the bed then disconnected the sling from the lift. The CNAs moved the lift away from the bed and positioned the resident for comfort. In an interview on [DATE] at 11:17 AM with CNA M she stated that she was in-serviced on using a gait belt during all transfers for residents who were indicated as needing a gait belt on their CNA assignment sheet. They report ANE to the ADM or charge RN or the DON. She stated they could locate a gait belt at the nurse's station at the beginning of each shift. In an interview on [DATE] at 11:18 AM with Nurse Supervisor A she stated that she was taught how to implement gait belts during transfers for patient safety, during the in-services they went over types of ANE and to report it to their ADM, or their assistant ADM, or the DON. She stated that the CNA's were to pick up a gait belt at the RN station at the beginning of their shifts and the CNAs were to have the gait belt on their person during their shift and what kind of assistance a resident needed was mentioned on the assignment sheet at the nurse's station. In an interview on [DATE] at 11:25 AM with Agency LVN Y she stated she worked at the facility a lot. She stated on [DATE] they were given an in-service to sign, and a book was left at the nurse's station that she signed to acknowledge that she understood safe resident transfer devices, when to use a gait belt, who required the use of gait belts, and what method of transfer to use for which residents. In an interview on [DATE] at 11:30 AM with CNA P she stated he had 2 - 3 in-services in the last 2 days on safe transfers and preventing and reporting ANE. She was told that at the beginning of her shift she should go to the nurse's station and obtain a gait belt to keep on her for resident transfers. She stated if a gait belt was not available, she would ask the charge nurse or supervisor to get one for her. She stated she was in-serviced on ANE and provided examples to the state surveyor. She stated she was in-serviced on proper transfers to include gait belt, mechanical lifts and stand aide. In an interview on [DATE] at 11:58 AM with PTA he stated that he was recently in-serviced, a situation of ANE was when lights are ignored, therapy always uses gait belts for standing, transfers, anything pertaining to standing, he stated they will start showing new employees how to use gait belts. They report ANE to ADM or DON. In an interview on [DATE] at 11:59 AM with CNA N she stated she recently received in-servicing where she was informed they always had to have the stand aid and wheelchairs locked, then put the gait belts on residents who require them (indicated on the CNA assignment sheet), if the resident was a 2 person assist, 2 people must assist. The only time they do not use a gait belt was during a mechanical lift or for a resident who was independent. She stated that a gait belt was a part of their uniform to assist with the resident. She stated the training coordinator provided training on how to properly put the gait belt on the residents. She took a posttest after doing receiving the in-service. (continued on next page)

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	06/27/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 12:01 PM with CNA I she stated she had been trained [DATE] on proper transfers. She stated she was told to ensure the resident had shoes on and to make sure the gait belt was on the resident and fitted properly before a transfer. She stated she was told to use her leg to block or steady the resident's legs then she would hold the gait belt to assist the resident to stand. She stated she had received training on the stand aid and the mechanical lift. She was told if the resident required assistance of two staff for transfers, there had to be two staff there for the transfer. She stated she was told that ANE had to be reported immediately to the ADM who is the abuse coordinator. She stated she was told to report to the nurse if the ADM was not available. In an interview on [DATE] at 12:05 PM with CNA L stated she had been trained this morning on transfers and she took a test. She stated she was told their daily assignment sheets had the information on the type of assist each resident required. She had a copy of the assignment sheet in her pocket. She stated she was told that the gait belts were located behind the nurse's station. She stated she was told if a resident required two staff for transfers, two staff had to do the transfer. She stated she had training on how to use the stand aid and the mechanical lift and was told were they were located. She stated she was told to immediately report any ANE to the ADM who was the abuse coordinator. In an interview on [DATE] at 12:08 PM with LVN G he stated that he had received training on transfers [DATE]. He stated the transfer information was located on the assignment sheets at the nurses station. He stated he learned the gait belts were kept behind the nurse's station and that gait belts were used for all transfers except for mechanical lift transfers or independently ambulatory residents. He stated he was told any suspected ANE was to be reported immediately to the ADM. In an interview on [DATE] at 12:12 PM, with CNA K she stated on [DATE], she was trained on proper transfers. She stated she learned how and when to use a gait belt for transfers. She stated the gait belts were kept behind the nurse's station and that the daily assignment sheet told her what type of assistance each resident required. She stated she learned two staff were required to perform a mechanical lift transfer. She stated in the training she learned all ANE was reported to the abuse coordinator who was the ADM. In an interview on [DATE] at 12:20 PM with the Restorative Aide, she stated that she was trained by the training coordinator on how to identify what kind of assistance a resident required, and she was in-serviced on ANE and provided examples to the state surveyor. In an interview on [DATE] at 12:29 PM with the DON she stated she instructed the nursing supervisors to pass out gait belts to all staff and placed them at nurses' station to ensure a gait belt was available to each CNA. She stated the IDT will bring up any issues in the morning meetings to ensure access to gait belts. She stated she had the nursing supervisors print out current transfer status and had each resident assessed and care plan updated. In an interview on [DATE] at 12: 32 PM with HK X she stated that she was in-serviced recently on ANE being that anything like not answering call lights, raising her voice or and talking ugly was not meeting resident's needs, and should report to the Administrator immediately. (continued on next page)

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	06/27/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 12:45 PM with CNA Z. She stated she was in-serviced on ANE recently, and on the different transfer devices to include mechanical lift and stand aide. She stated the assignment sheets were located at the nursing station and it indicated if a resident was independent, or required 2-person transfer, stand aid with gait belt or mechanical lift. She stated gave examples of ANE and that she would report any ANE to her ADM or designee. In an interview on [DATE] at 1:47 PM with Nurse Supervisor A she stated she had just been trained on the new post fall protocol and was given a copy of the fall protocol form. She stated she was told the form must be completed within 72 hours of any fall, witnessed and unwitnessed and that the completed forms were to be given to the DON. She stated she was told the forms would be reviewed at the QAPI meetings. In an interview on [DATE] at 01:48 PM with Nurse Supervisor B. She stated that she was in-serviced by the DON, informing her that she was going to be responsible for the newly implemented post fall forms. She stated she would be notified by the nurse of a fall, and she would have up to 72 hours. to complete the post fall form and turn it into the DON or ADON so it could be discussed in their QAPI. She stated if she was off or if the fall happened during the weekend, another nurse supervisor would complete the post fall form and ensure it was turned in within 72 hours. In an interview on [DATE] at 02:27 PM with the DOR he stated that rehab would coordinate with the Training Coordinator on all new hires for CNAs to receive training on proper use of transfer assistive devices (mechanical lifts, stand aide, gait belts). He stated that a therapist from the therapy department would demonstrate the proper use of transfer aides and that the new hire would return demonstration. Observation on [DATE] at 9:25 AM and 9:37 AM of the 2 nurses stations revealed CNA assignment sheets revealed what kinds of assistance each resident required. Review of Resident #43's care plan last updated on [DATE] revealed that her care plan was changed to The resident requires extensive assistance by 1 staff with stand aide and gait belt to move between surfaces and as necessary. Review of a list of residents was provided to the state surveyors on [DATE], revealing that all residents had their care plans reviewed and updated if applicable. Review of the facility's updated policy titled; Resident Care Plan revealed the following updates: Addressing additional care planning areas that are relevant to meeting the resident's need in the long-term care setting. Any changes in condition that are reported by the nursing staff will be updated within 72 hours of notification. Review of an in-service titled Care Plan Updates In-Service conducted by the ADM on [DATE], revealed that the DON and MDS coordinator were counseled on the timely updates of care plans to be individualized, the importance of recognizing when a resident had a change in their specific care needs and method of transfer had changed. It reflected those things would be discussed during each morning meeting held and that care plans needed to be updated accordingly and timely, if needed. The signatures of the ADM, DON, and MDS were reflected. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Resident Transfer in-service dated [DATE] reflected the in-service covered before beginning work, make sure you have a resident assignment sheet to see how each resident transfers. This is provided in a notebook at the nurses station if you need further assistance, see charge nurse. The in-service covered the Mechanical lift transfer, stand aide transfer and the procedural guideline for assisting resident to transfer to chair or wheelchair. The signatures of CNA's I, K, L, M, N, O, P, PTA, LVN G, LVN H, Agency LVN Y, Nurse Supervisor A and B, restorative aide, HK X, and the DOR were observed. Review of in-service posttests revealed tests for CNA's I, K, L, M, N, O, P, PTA, LVN G, LVN H, Agency LVN Y, Nurse Supervisor A and B, restorative aide, HK X, and the DOR. Review of an Employee Status Report dated [DATE] revealed that CNA Q was terminated[TRUNCATED]

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	676386	A. Building B. Wing	06/27/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 (Resident #10) of 6 reviewed for trauma-informed care. The facility failed to identify possible triggers when Resident #10 had a history of trauma. This failure could place residents at risk for severe psychological distress due to re-traumatization, decreased quality of life and psychosocial emotional harm. Findings include: Review of Resident #10's face sheet, printed on 06/27/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis of post-traumatic stress disorder (PTSD). Review of Resident #10's quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 which indicated moderately impaired cognition. The MDS reflected Resident #10 had a diagnosis of PTSD. Review of Resident #10's comprehensive care plan, revised on 12/11/24, reflected in part, Resident #10 has lived a long life and has potentially suffered a traumatic event as some time in her life. Goal - Resident #10 will remain calm/stress free during their stay in the facility. Interventions - Always approach resident calmly and speak clearly by announcing what is happening prior to performing task; Do not sneak up behind and try not to startle resident; Get to know resident and his/her preferences or triggers; Given resident choices when possible . Further review revealed there were no triggers identified in the care plan. Review of Resident #10's Psychiatric Subsequent Assessment, dated 06/13/25, reflected previous mental health diagnosis included PTSD. During an observation and an attempted interview on 06/25/25 at 09:30 AM, Resident #10 was observed in her bed. She stated she was comfortable, but her feet hurt. When asked about stressors or trauma, she stated she just wanted to rest, and she closed her eyes. In an interview on 06/27/25 at 10:33 AM, the Social Worker stated staff had been in-serviced about trauma informed care and she asked residents about trauma when she completed the resident's social history upon admission. She stated the regulations on trauma and PTSD had recently changed. She stated she did not remember if Resident #10 had a diagnosis of PTSD. She stated she could not remember if she had assessed or screened the resident after the regulations changed. The Social Worker, after looking into the electronic medical record, she stated she did not have any information about PTSD or triggers on the social history from when the resident was admitted in 2015. She stated she did not see an assessment for trauma. Stated it was important to identify a resident's triggers, so staff were aware. She stated if staff were not aware, staff could do something to upset or scare the resident and put them back in the situation that caused their trauma. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/27/25 at 10:49 AM, the DON stated she expected residents with a diagnosis of PTSD were assessed for trauma. She stated they usually referred residents with PTSD to psychological services. She expected care plans to include triggers specific to the resident. She stated residents may reexperience the trauma if staff were not aware of each resident's triggers. In an interview on 06/27/25 at 12:40 PM, the Assistant Administrator stated, You have to know what the trauma was, so we know how to prevent it from happening again. She stated she expected residents were assessed and the triggers identified on the care plan. A policy for trauma informed care was requested but not received prior to exit from the survey.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications when used in excessive doses (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued for 1 of 5 residents (Resident #8) reviewed for unnecessary medications. The facility failed to ensure Resident #8 did not received Keflex (is used to treat urinary tract infections (is a bacterial infection in the urinary system)) for prophylactic use. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections (happens when germs like bacteria and fungi develop the ability to defeat the drugs designed to kill them). Findings included: Review of Resident #8 face sheet dated 06/27/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of urinary tract infection (bladder infection). Review of Resident #8's quarterly MDS assessment dated [DATE] reflected Resident #8 was assessed to have a BIMS score of 11 indicating moderate cognitive impairment. Resident #8 was assessed to always be incontinent of urine. Resident #8 was assessed to not have any infections and was assessed to be on antibiotics. Review of Resident #8's comprehensive care plan initiated on 12/20/2023 and last revised on 04/23/2025 reflected no entries related to urinary tract infections or antibiotic use. Review of Resident #8's consolidated physician orders dated 06/26/2025 reflected an order dated 08/15/2024 Keflex 500mg give one capsule by mouth at bedtime for prevention. Review of Resident #8's UTI's from 08/15/2024 through 06/26/2025 reflected she was diagnosed with a UTI on three separate occasions: -01/10/2025 reflected an individual resident infection surveillance report dated 01/08/2025. Symptoms listed: AMS (altered mental status) Culture: Yes; Organism: Pseudomonas Aeruginosa >100,00 CFU/ml. Medication Cipro 500 mg BID x 7 days. Further review of the infection surveillance report reflected no other symptoms were documented. -04/25/2025 reflected an individual resident infection surveillance report dated 04/25/2025. Symptoms listed: increased confusion: Culture yes: organism Enterococcus faecium 50-100,00 CFU/ml. Medication: Amoxicillin 500 mg TID x 10 days. -05/29/2025 reflected an individual resident infection surveillance report dated 05/28/2025. Symptoms listed: Resident not feeling well. antibiotics orders for ciprofloxacin HCL 250 mg one tablet two times daily for 7 days. Review of Resident #8's culture report reflected Pseudomonas Aeruginosa >100,00 CFU/ml. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/26/2025 the ADON IP stated the only form she used for antibiotics was infection surveillance report. She stated she did not have any other form to document symptoms or track infections. She stated the facility did not track symptoms that she was aware of. In an interview on 06/26/2025 at 1:40 PM the DON stated with Resident #8 the family was requesting she be on antibiotics. She stated she thought the pharmacist was reviewing antibiotic use. The DON stated the facility used the McGeer Criteria for UTI's but did not have a form the staff used at the onsite of UTI symptoms. In an interview on 06/26/2025 at 4:08 pm the Medical Director stated the facility pharmacist did a review of the resident medications monthly. He stated he was not sure if he was looking at antibiotics. He stated the pharmacist should review every 6 months. He stated he could not recall if the pharmacist sent anything on Resident #8. He stated he felt like the routine antibiotic on Resident #8 was helping with her UTI's to decrease frequency and further stated she has had several UTI's since being on the prophylactic antibiotic. In an interview on 06/26/2025 at 4:56 PM the Pharmacy Consultant stated he had not been reviewing the residents on prophylactic antibiotics or sending the MD recommendations regarding this. He stated he would check the antibiotics in use against the cultures to ensure the right antibiotic was being used if stated if the lab was available for review. He stated he looked at new antibiotics prescribed but does not necessarily review the ones the residents have been on as prophylactic. In an interview on 06/27/2025 at 12:34 PM the Administrator stated it was her expectation that residents should be care planned and monitored for antibiotic use. She stated the pharmacy consultant should be monitoring antibiotic use and follow up and send recommendations to the MD's during monthly reviews to ensure the medication is monitored to see if the medication is working and to make sure they are on the right medication which could lead to untreated infections in residents or medication SE. Review of the facility undated policy McGeers Criteria reflected The McGeer criteria developed in collaboration with CDC, are a set of surveillance definitions used in long term care facilities to standardize the identification of infections. These criteria help in consistently tracking and reporting healthcare associated infections. The criteria focus on specific signs and symptoms, considering both infectious and non-infectious causes, and aim to distinguish between new or worsening infections and pre-existing conditions. Standardized Definitions: The McGeer criteria provide a uniform set of definitions for various infections ensuring consistency in surveillance and reporting across different facilities. Focus on New or Worsening Symptoms: The criteria emphasize the importance of identifying new or acutely worsening signs and symptoms, as opposed to relying solely on chronic conditions. Consideration of Alternative Causes: Clinicians are encouraged to consider non-infectious causes of symptoms before attributing then to an infection. Multifaceted Approach: The criteria recommend considering both clinical presentation (signs and symptoms) and laboratory findings (microbiological or radiological) when determining if and infection is present. Application in Long-Term Care: The McGeer criteria are particularly relevant n long term care facilities for tracking and managing HA's For urinary tract infections, at least two of the following signs or symptoms are required: fever, chills, new flank or suprapubic pain or tenderness, and a change in the character of urine. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated policy Antibiotic Stewardship reflected Antibiotics are among the most commonly prescribed drugs in long-term care settings, yet reports indicate that a high proportion of antibiotic prescriptions are unnecessary. The goal of this procedure can help reduce unnecessary prescribing and lead to fewer antibiotic failures and/or adverse events. A. The Antibiotic Stewardship Committee will: 1.Support and promote antibiotic use protocols which include: a. Assessment of residents for infection using standardized tools and criteria. b. Therapeutic decisions regarding antibiotic prescriptions based on evidence (eg, guidelines and consensus statements from clinical and academic societies) that is appropriate for the care of long-term care facility residents. c. Specifying a dose, duration and indication on all antibiotic prescriptions. d. Reassessment of empiric antibiotics after 2-3 days for appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports and/or changes in the clinical status of the resident. e. Whenever possible, choosing narrow-spectrum antibiotics that are appropriate for the condition being treated. Develop and maintain a system to monitor antibiotic use, which includes a. Review antibiotics prescribed to residents upon their admission or transfer to the facility and those during the course of evaluation by an outside prescribing practitioner (example ER). b. Periodically review a subset of antibiotic prescriptions for inclusion of dose, duration and indication (or for length of therapy, documentation of an antibiotic time-out, appropriateness based on antibiotic use protocols and written documentation of clinical justification for antibiotic use that does not comply with the facility antibiotic use protocols). c. Periodically review rates of prescriptions for any antibiotics or conditions identified by the committee as being of special interest.

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	676386	A. Building B. Wing	06/27/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure all drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 4 (Station 1 south-hall, Station 1 east-hall, Station 2 south-hall, Station 2 north-hall, of 5 medication carts reviewed for medication storage. - The facility failed to ensure an undated bottle of Systane eye drops without a resident name or label were removed from the Station 1 South-hall medication cart. - The facility failed to ensure the Station 1 east-hall med cart did not contain three loose pills, the Station 2 south-hall med cart did not contain one loose pill, and the Station 2 north-hall med cart did not contain 18 loose pills. - The facility failed to ensure an expired bottle of magnesium oxide, best by 02/2025, was removed from the Station 2 north-hall med cart. These failures could place residents at risk for not recceiving prescribed medications as ordered and adverse effects of medicaitons due to incorrect labeling. Findings included: An observation of the Station 1 south-hall medication cart on [DATE] at 4:11 PM revealed an opened bottle of Systane eye drops. The bottle did not have a label, name, or date when opened. In an interview on [DATE] at 4:26 PM, RN C stated she did not know who the Systane eye drops belonged to. She stated the nurses were responsible for keeping the medication carts in order. She stated she cleaned her cart before and after use. She stated multi-dose vials or bottles were dated when opened. An observation of the Station 1 east-hall medication cart on [DATE] at 4:34 PM revealed three loose, unidentified pills in the bottom of a drawer. In an interview on [DATE] at 4:35 PM, LVN W stated there should not have been loose pills in the cart. LVN W stated dropping pills may lead to needing to reorder the medication from the pharmacy. She stated it was their practice that medication bottles were dated when opened. An observation of the Station 2 south-hall med cart on [DATE] at 9:47 AM revealed one loose unidentified white pill in the bottom of a drawer . An observation of the Station 2 north-hall med cart on [DATE] at 9:56 AM revealed 18 loose, unidentified pills. In an interview on [DATE] at 10:00 AM, LVN E stated if a pill was dropped in the cart, it should have been removed immediately. (continued on next page)

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	676386	A. Building B. Wing	06/27/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 10:49 AM, the DON stated each nurse and the nursing supervisor on the station were responsible to ensure the medication carts were clean, free from loose. She stated it did not meet her expectations that there were loose on the carts. In an interview on [DATE] at 12:40 PM, the Assistant Administrator stated she expected medications were stored properly. Review of the facility's undated Procedure for Medication Room reflected in part, 1. Drugs shall be stored in an orderly manner in cabinets, cubicles, drawers, or carts . 11. The medication of each patient shall be kept and stored in their originally received containers .

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	676386	A. Building B. Wing	06/27/2025

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's nourishment refrigerators for 2 (Station #1, and Station #2) of 2 nourishment room refrigerators reviewed for food and nutrition services. 1. The facility failed to ensure the nourishment room refrigerator temperature log was maintained in station #2's nourishment room. 2. The facility failed to ensure station #2's refrigerator stayed within a temperature range to maintain effective refrigeration. 3. The facility failed to ensure all items in station #1's refrigerator was labelled and dated. These failures could place residents at risk for health complications, foodborne illnesses and decreased a quality of life. Findings include: Observation of the station #2's nourishment room refrigerator on 6/26/2025 at 10:07am revealed, on the outside, a temperature log that had been maintained up until 6/23/2025. Inside, a thermometer read 52 degrees, and 7 nutritional shakes that felt a little cooler than room temperature were observed. Observation of the station #1's nourishment room refrigerator on 6/26/2025 at 10:12am revealed, on the outside a sign that read, Attention family members! If you bring in any outside food or drink you must put the resident's name, date you brought it, and product name on the label provided. On the inside there was a small container of cut up watermelon that was not labeled or dated, a medium sized container that contained an unknown white/yellow substance with chunks of granola or oat like substance, and a carton of almond milk that had no label. In an interview on 6/26/2025 at 10:20am with HK X she stated that housekeeping was responsible for maintaining the cleanliness of the nourishment room, refrigerator, and ensuring all items were labeled and dated, and if they were not, she reported it to her supervisor, who would report it to nursing. In an interview on 6/26/2025 at 11:00am with Nurse Supervisor A she stated that she was responsible for checking off on the thermometer log for the nourishment refrigerator for station 2. She stated that she thought the refrigerator door may have been left open for a period because the refrigerator had been maintaining the correct temperature. (continued on next page)

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	06/27/2025

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated 'Use and storage of foods brought to residents' policy revealed, Refrigerated food or drink must be labeled with the resident's name, the date it was brought, and product name.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rational, by the provider, when an antibiotic was used despite criteria, to determine the appropriate use of an antibiotic for 1 of 2 residents reviewed for antibiotic stewardship. (Resident #8). The facility failed to ensure they were using an established and accepted criteria to determine if her UTI met the criteria for antibiotic use and failed to ensure she was not receiving a prophylactic antibiotic without written justification for use regards to Resident #8's prophylactic antibiotic Keflex. This failure could place residents at risk of inappropriate antibiotic use, medication side effects and increased antibiotic-resistant infections. Findings Included: Review of Resident #8 face sheet dated 06/27/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the diagnosis of urinary tract infection (bladder infection). Review of Resident #8's quarterly MDS assessment dated [DATE] reflected Resident #8 was assessed to have a BIMS score of 11 indicating moderate cognitive impairment. Resident #8 was assessed to always be incontinent of urine. Resident #8 was assessed to not have any infections and was assessed to be on antibiotics. Review of Resident #8's comprehensive care plan initiated on 12/20/2023 and last revised on 04/23/2025 reflected no entries related to urinary tract infections or antibiotic use. Review of Resident #8's consolidated physician orders dated 06/26/2025 reflected an order dated 08/15/2024 Keflex 500mg give one capsule by mouth at bedtime for prevention. Reivew of Resident #8's MAR dated June 2025 reflected she was getting Keflex 500 mg one capsule by mouth at bedtime. Review of Resident #8's UTI's from 08/15/2024 through 06/26/2025 reflected she was diagnosed with a UTI on three separate occasions: -01/10/2025 reflected an individual resident infection surveillance report dated 01/08/2025. Symptoms listed: AMS (altered mental status) Culture: Yes; Organism: Pseudomonas Aeruginosa >100,00 CFU/ml. Medication Cipro 500 mg BID x 7 days. Further review of the infection surveillance report reflected no other symptoms were documented. -04/25/2025 reflected an individual resident infection surveillance report dated 04/25/2025. Symptoms listed: increased confusion: Culture yes: organism Enterococcus faecium 50-100,00 CFU/ml. Medication: Amoxicillin 500 mg TID x 10 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-05/29/2025 reflected an individual resident infection surveillance report dated 05/28/2025. Symptoms listed: Resident not feeling well. antibiotics orders for ciprofloxacin HCL 250 mg one tablet two times daily for 7 days. Review of Resident #8's culture report reflected Pseudomonas Aeruginosa >100,00 CFU/ml. In an interview on 06/26/2025 the ADON IP stated the only form she used for antibiotics was infection surveillance report. She stated she did not have any other form to document symptoms or track infections. She stated the facility did not track symptoms that she was aware of. In an interview on 06/26/2025 at 1:40 PM the DON stated with Resident #8 the family was requesting she be on antibiotics. She stated she thought the pharmacist was reviewing antibiotic use. The DON stated the facility used the McGeer Criteria for UTI's but did not have a form the staff used at the onsite of UTI symptoms. In an interview on 06/26/2025 at 4:08 pm the Medical Director stated the facility pharmacist did a review of the resident medications monthly. He stated he was not sure if he is looking at antibiotics. He stated the pharmacist should review every 6 months. He stated he could not recall if the pharmacist sent anything on Resident #8. In an interview on 06/26/2025 at 4:56 PM the Pharmacy Consultant stated he had not been reviewing the residents on prophylactic antibiotics or sending the MD recommendations regarding this. He stated he would check the antibiotics in use against the cultures to ensure the right antibiotic is being used if stated if the lab was available for review. He stated he looks at new antibiotics prescribed but does not necessarily review the ones the residents have been on as prophylactic. In an interview on 06/27/2025 at 12:34 PM the Administrator stated it was her expectation that residents should be care planned and monitored for antibiotic use. She stated the pharmacy consultant should be monitoring antibiotic use and follow up and send recommendations to the MD's during monthly reviews to ensure the medication was monitored to see if the medication was working and to make sure they are on the right medication which could lead to untreated infections in residents or medication SE. Review of the facility undated policy McGeers Criteria reflected The McGeer criteria developed in collaboration with CDC, are a set of surveillance definitions used in long term care facilities to standardize the identification of infections. These criteria help in consistently tracking and reporting healthcare associated infections. The criteria focus on specific signs and symptoms, considering both infectious and non-infectious causes, and aim to distinguish between new or worsening infections and pre-existing conditions. Standardized Definitions: The McGeer criteria provide a uniform set of definitions for various infections ensuring consistency in surveillance and reporting across different facilities. Focus on New or Worsening Symptoms: The criteria emphasize the importance of identifying new or acutely worsening signs and symptoms, as opposed to relying solely on chronic conditions. Consideration of Alternative Causes: Clinicians are encouraged to consider non-infectious causes of symptoms before attributing then to an infection. Multifaceted Approach: The criteria recommend considering both clinical presentation (signs and symptoms) and laboratory findings (microbiological or radiological) when determining if and infection is present. Application in Long-Term Care: The McGeer criteria are particularly relevant n long term care facilities for tracking and managing HA's For urinary tract infections, at least two of the following signs or symptoms are required: fever, chills, new flank or suprapubic pain or tenderness, and a change in the character of urine. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated policy Antibiotic Stewardship reflected Antibiotics are among the most commonly prescribed drugs in long-term care settings, yet reports indicate that a high proportion of antibiotic prescriptions are unnecessary. The goal of this procedure can help reduce unnecessary prescribing and lead to fewer antibiotic failures and/or adverse events. A. The Antibiotic Stewardship Committee will: 1.Support and promote antibiotic use protocols which include: a. Assessment of residents for infection using standardized tools and criteria. b. Therapeutic decisions regarding antibiotic prescriptions based on evidence(eg, guidelines and consensus statements from clinical and academic societies) that is appropriate for the care of long-term care facility residents. c. Specifying a dose, duration and indication on all antibiotic prescriptions. d. Reassessment of empiric antibiotics after 2-3 days for appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports and/or changes in the clinical status of the resident. e. Whenever possible, choosing narrow-spectrum antibiotics that are appropriate for the condition being treated. Develop and maintain a system to monitor antibiotic use, which includes a. Review antibiotics prescribed to residents upon their admission or transfer to the facility and those during the course of evaluation by an outside prescribing practitioner (example ER). b. Periodically review a subset of antibiotic prescriptions for inclusion of dose, duration and indication (or for length of therapy, documentation of an antibiotic time-out, appropriateness based on antibiotic use protocols and written documentation of clinical justification for antibiotic use that does not comply with the facility antibiotic use protocols). c. Periodically review rates of prescriptions for any antibiotics or conditions identified by the committee as being of special interest. Review of the CDC's Criteria for defining non-catheter associated symptomatic UTI dated 01/2025 reflected, Resident without an indwelling catheter (Meets criteria 1 OR 2 OR 3): Criteria 1: Either of the following: 1. Acute dysuria; 2. Acute pain, swelling, or tenderness of the testes, epididymis or prostate. Criteria 2: Either of the following: 1. Fever; 2. Leukocytosis and ONE or more of the following: Costovertebral angle pain or tenderness; New or marked increase in suprapubic tenderness; Gross hematuria; New or marked increase in incontinence, New or marked increase in urgency; New or marked increase in frequency. OR Criteria 3: TWO or more of the following: Costovertebral angle pain or tenderness; New or marked increase in suprapubic tenderness; Gross hematuria; New or marked increase in incontinence; New or marked increase in urgency; New or marked increase in frequency. AND A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of greater than 105 CFU/ml. NOTE: Yeast and other microorganisms, which are not bacteria, are not acceptable UTI pathogens.