

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2024
NAME OF PROVIDER OR SUPPLIER Laredo West Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Lane Laredo, TX 78043	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371</p> <p>Based on interview and record review, the facility failed to ensure each resident was free of accidental hazards for 1 (Resident #1) of 10 residents reviewed for accidental hazards.</p> <p>The facility failed to securely store chemicals on 05/15/2024 which resulted in Resident #1 gaining access to a bottle of bleach.</p> <p>This failure could place residents at risk for ingesting poisonous chemicals which could cause vomiting, diarrhea, or illness requiring hospitalization .</p> <p>The finding include:</p> <p>Record review of Resident #1's Face Sheet dated 05/19/2024 documented a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with the diagnoses of: Alzheimer's Disease (cognitive memory impairment), unspecified injury of head, dementia (cognitive memory impairment) and cognitive communication deficit.</p> <p>Record review of Resident #1's Minimum Data Set (MDS) dated [DATE] revealed, Resident #1 had a BIMS score not filled as though unable to complete interview. Further review of the MDS indicated Resident #1 was solely dependent on staff for all activities of daily living.</p> <p>Record review of Resident #1's comprehensive care plan revision date 11/08/2023 documented the resident has impaired cognitive function/dementia or impaired thought processes related to Alzheimer's. Goal: The resident will remain oriented through the review</p> <p>date. Administer medications as ordered. Monitor for side effects. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. Interventions: Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Cue, reorient and supervise as needed. Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's comprehensive care plan revision date 02/05/2024 documented [Resident #1] has history of behaviors related to pseudobulbar affect disorder, places objects in mouth (ex. paper). Goal: I will have no evidence of behavior problems by review date. Interventions: Administer medications as ordered. Observe/document for side effects and effectiveness, allow choices within individual's decision-making abilities, anticipate and meet the resident's needs, caregivers to provided opportunity for positive interaction, attention, stop and talk with him/her as passing by, keep small items away from resident reach.</p> <p>Record review of Resident #1's change in condition communication form dated 5/15/2024 documented Resident #1 suspected of taking Clorox bleach liquid gel. Resident was noted with Clorox bleach liquid gel in her hands while sitting on her wheelchair. Resident was promptly assessed, respiratory rate is 17 breaths/minute unlabored, regular. No retractions noted accessory muscle or nasal flaring. Chest rises and fall are equal bilaterally. Skin is pink, warm, and dry. Upon auscultation lung sounds clear in all lobes anteriorly and posteriorly. No adventitious sounds. Spo2 saturation 98% room air. No liquid was noted on resident's clothing, resident was clean and dry. Resident's mouth was evaluated no foul odor noted. Residents was sent to [hospital] for further evaluation.</p> <p>Record review of Resident #1's [hospital] record printed date 5/17/2024 documented no immediate concern of actual ingestion of chemical agent.</p> <p>During an interview on 05/17/2024 at 3:20PM, Housekeeper A, stated she normally secures cleaning chemicals within her works carts, and are secured with a lock and key. Housekeeper A stated chemicals are only allowed to be stored within her locked cart or within the locked storage closet. Housekeeper A stated carts are checked daily by supervisor and are locked away daily. Housekeeper A stated she worked for the facility for [AGE] years and this was the first situation that she had been a part of regarding a resident getting ahold of a cleaning agent. Housekeeper A stated she wrote a report that she was always careful with her supplies but stated she was in an emotional distraught situation regarding her family member, and stated she believed due to her emotional situation, could have left her cart unlocked before leaving early and Resident #1 may have gotten a hold of her cleaning chemicals. Housekeeper A stated she would bring in additional cleaning agents to make the unit smell better. Housekeeper A stated she had been given training and education prior to the event date about not bringing in outside chemicals in general, and stated she was knowledgeable that she was not supposed to bring in unapproved cleaning chemical agents but brought them in to diminish the lingering odors within the memory locked down unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/19/2024 at 11:25AM, LVN A stated on 05/15/2024 around 5PM an loteria BINGO event was happening and Resident #1 was observed to be in the same room throughout the entire activity. The Activity Director was conducting activity and had seen Resident #1 and was in a wheelchair and does not get up to ambulate. LVN A stated Resident #1, like many of the residents in the memory unit, would grab random items at times. LVN A stated she saw the housekeeper in the hallway cleaning prior to the commencement of loteria that began a little bit before 4PM. LVN A stated the housekeeper was observed to be pacing back and forth, and was on the phone, and stated she started to feel that something was going on with her. LVN A stated 5-8minutes after 5PM, after the loteria activity finished, she heard a CNA who was next to her state, look what Resident #1 has. LVN A stated she was immediately able to see that Resident #1 had a small bottle of off brand Clorox bleach in her hands in between the middle of her legs, with bottle cap still on bottle. LVN A stated she asked, [Resident #1] what is this, what are you doing with this? and that Resident #1 just laughed. LVN A stated she quickly removed the bottle from Resident #1's possession, and began thoroughly assessing her, including auscultating lung sounds, checked clothing they were dry, and smelled her breathe multiple times and did not smell of any chemical smells. LVN A stated clothes were dry and no indication that bottle was opened at all. LVN A stated Resident #1's baseline vital signs were within Resident #1's normal range. LVN A stated after her thorough assessment, LVN A notified poison control, notified the Director of Nurses, doctor, and responsible person, and prior to all called ambulance as a precautionary to ensure her safety. LVN A stated she saw the resident with bottle, never saw her ingesting just holding item. LVN A stated ingesting chemicals can affect a resident's vital organs, airway (close airway, throat), skin, or worse a person can die from ingesting bleach. LVN A stated she could not figure out how the resident got ahold of the bottle. LVN A stated when the event occurred the housekeeper cart was not within the hallway and could not figure out how Resident #1 got ahold of bottle.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/19/2024 at 2:56PM, the Director of Nurses (DON) stated he got called from wing that Resident #1 had a bottle of bleach in hand. The DON stated Resident #1 was in her wheelchair, and Resident #1's baseline vital signs were within normal limits. The DON stated Resident #1 did not appear to be exhibiting any signs or symptoms of immediate distress. The DON stated the clinical staff immediately called poison control and were told because the chemical agent was diluted Resident #1 did not need to go to the Emergency Department. The DON stated he, with the help of his administration staff, reported to the proper chain of command which included notification to, corporate, risk management, regional administrator, physician, and responsible person, followed by Resident #1 being sent out to [hospital]. The DON stated he, as well as his administration clinical staff immediately started an investigation sweep, which consisted of looking at all housekeeping cleaning carts, and found that all carts were secured in Wing C, positioned away from the residents, and found that all carts were secured under lock and key. The DON stated he, in conjunction of the administration staff requested that all housekeepers return to the facility and began to conduct an interrogation as to who brought the unapproved cleaning agent. The DON stated Housekeeper A confessed to bringing in the unapproved item, however, could not figure out how Resident #1 attained the chemical cleaning agent. The DON stated Housekeeper A theorized that maybe during her emotional familial episode, she may have forgotten to secure her cleaning cart. The DON stated however the timeline does not help solve the question, how Resident #1 attained the item. The DON stated on 05/15/2024 Housekeeper A clocked out at 2:48PM, Resident #1 was seen in the dining room/activity room around 4PM with nothing in her hands, leaves the activities room, and after 5-7minutes after 5PM (on the same day), Resident #1 is seen with the chemical cleaning agent. The DON stated nobody could state with certainty how Resident #1 attained the chemical cleaning agent, only that Resident #1 did have the chemical cleaning agent in her possession. The DON stated during his investigation of the event, no clinical staff verbalized any observation of any chemical cleaning agents in residents' rooms within the memory locked down unit. The DON stated that it was unacceptable for any resident to have chemical cleaning agents in their possession. The DON stated ingesting any inorganic chemical can affect a person differently, and that reactions vary. The DON stated during Resident #1's assessment on 05/15/2024, the evidence attained did not provide with certainty, that Resident #1 ingested the chemical, however stated the chemical should never have been in Resident #1's possession. The DON stated any chemical is not meant to be consumed and could lead to detrimental effects on a resident's well-being and would be a major safety concern. The DON stated new implementations to mitigate the issue of any cart left unlock as well as ensuring that staff do not bring unauthorized cleaning items, the administration clinical staff will be rounding daily. The DON stated all housekeeping carts will be evaluated sporadically and unannounced daily. The DON stated the administration clinical staff provided an in-service/education on not bringing in unauthorized chemical agents as well as what to do if a resident ingests chemicals, or resident has change in condition.</p> <p>Record review of the written statement dated 5/16/2024 indicated To whom it may concern, I [Housekeeper A], want to say that at about 2:45PM, got a call from my [family member] that he had an emergency at home which made me rush before leaving at 3:00PM which might of made me not think clearly and put my chemicals under lock and key. And sorry to say that this made me be negligent when I always try to be careful and not leave anything to reach of patient. Signed [Housekeeper A]</p> <p>Record review of the facility's in-service dated 5/15/24 indicated Do not use outside chemicals for cleaning/deodorizing, fragrance sprays are not allowed, all cleaning supplies must be clearly labeled and appropriate. Report to administrator/Environmental supervisor/DON/ADONs if any outside chemicals are found in facility. All chemicals must be properly secured and out of resident reach.</p> <p>(continued on next page)</p>		

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