STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455528	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo West Nursing and Rehabilitation Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 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 record reviews and interviews, the facility failed to notify, consistent with his or her authority, the resident representative(s) when there was a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for one (Resident #1) of five residents reviewed for notification of changes.The facility failed to notify Resident #1's guardian when (RN A) administered 5ml (10mg) of Lorazepam instead of the physician ordered 0.5ml (1mg) of Lorazepam to Resident #1 on 04/27/25.This failure could result in resident's family/RP not being aware of the resident's condition.The findings included:Record review of Resident #1's admission record reflected a [AGE] year-old male initially admitted to the facility on [DATE] and most recently admitted on [DATE]. The only contacts listed for him were his guardian (Bill to, Responsible Party, and Emergency Contact #1) with two phone numbers, a fax number, and an email address, and himself. His diagnoses included epilepsy (a long-term (chronic) disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), bipolar disorder (mental health condition that causes clear shifts in moods from extremely elated, irritable, or energized to sad, indifferent, or hopeless), unspecified psychosis not due to a substance or know physiological condition (psychotic symptoms not aligned with a specific psychotic disorder or mental illness), mood disorder due to known physiological condition (a mental health condition characterized by a disturbance in mood (like depression or mania) that is directly caused by a medical or physiological condition), mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age), cognitive communication deficit (difficulty with communication), cerebellar stroke syndrome (impairments in motor control and posture), and dementia (loss of memory, language, problem solving and other thinking abilities which significantly impairs a person's ability to perform daily activities). Record review of Resident #1's quarterly MDS assessments dated 04/22/25 and 06/25/25 reflected BIMS scores of 2 and 7 which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's care plan dated 07/19/17 reflected he had a seizure disorder, potential for mood problem, was resistive to care, displayed verbal behaviors, had a communication problem and unclear speech related to diagnoses of bipolar disorder, psychosis, and history of stroke. Interventions included administer medications as ordered and observe/document for side effects and effectiveness, behavioral health consults as needed, observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity, and praise the resident when behavior was appropriate. Record review of Resident #1's Order Summary Report on 08/13/25 reflected the following orders:1. Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Phone Give 0.5 milliliter by mouth three times a day related to mood disorder due to known physiological condition ordered on 08/04/24. 2. Narcan Nasal Liquid 4 MG/0.1 ML 1 spray Alternating nostrils STAT for Adverse Reaction/Overdose ordered on 04/27/25. 3. Neurological Checks every one hour for 24 hours, report any significant changes to hospice provider ordered on 04/27/25 to start on 04/28/25 at 12:00 am. 4. Vital Signs every hour for 24 hours, report any significant changes to hospice provider, for monitoring due to medication error ordered on 04/27/25 to start on 04/28/25 at 12:00 am. Record review of Resident #1's April 2025 eMAR reflected the following:1. RN A documented an administration of 0.5ml of Lorazepam oral concentrate 2mg/ml (1mg) by mouth on 04/27/25 at 5:30 pm. 2. RN A documented an administration of 0.2ml/8mg of Narcan 0.1ml/4mg spray to each nostril at 11:33 pm. Record review of Resident #1's handwritten Lorazepam narcotic administration log sheet reflected RN A initially documented he gave 0.5 ml (1mg) of Lorazepam oral concentrate 2mg/ml to Resident #1 by mouth at 5:30 pm, however RN A wrote over the amount given to show he gave Resident #1 5ml (10mg) of Lorazepam oral concentrate 2mg/ml by mouth at 5:30pm. Record review of Resident #1's progress notes reflected the following entries:1. 04/27/25 at 11:33 pm RN A documented, Narcan Nasal Liquid 4 MG/0.1 ML 1 spray Alternating nostrils STAT for Adverse Reaction/Overdose Narcan 4 mg to each Nostril given.2. 04/27/25 at 11:49 pm RN A documented, 1800 Medication Lorazepam 0.5 ml scheduled. Medication error--Lorazepam 5 ml was given. During Narcotic count--Error was discovered -2225. Pt. was checked and Patient was very Lethargic. V/S--B/P=130/62, P=85, R=21 and 02 at 100% via Nasal cannula D.O.N was called and informed of situation. Hospice provider was called, RN on call called back, she gave Telephone orders as follows: give Naloxone 4mg Nasal spray. Resident was assessed. Naloxone 4mg of which was

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	455528	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo West Nursing and Rehabilitation Center	1200 Lane Laredo, TX 78043

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews the facility failed to ensure residents were free from abuse for three (Resident #2, Resident #4, and Resident #6) of 10 residents reviewed for abuse.1. The facility failed to ensure Resident #2 was not hit on the arm and chest by Resident #3 on 04/04/25.2. The facility failed to ensure Resident #4 was not slapped on the arm by Resident #5 on 07/05/25.3. The facility failed to ensure Resident #6 was not hit on the arm and kicked on the leg by Resident #7 on 07/08/25.4. The facility failed to ensure Resident #2 was not slapped on the arm by Resident #3 on 08/06/25.These failures could place residents at risk for physical, mental, and psychosocial harm.The findings included:1. and 4. Record review of Resident #2's admission record reflected a [AGE] year-old female originally admitted to the facility on [DATE] and most recently admitted on [DATE]. Her diagnoses included Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), dementia (loss of memory, language, problem solving and other thinking abilities that significantly impairs a person's ability to perform daily activities), cognitive communication deficit (difficulty with communication), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), and pseudobulbar affect (neurological condition that causes brief, intense uncontrollable episodes of laughing or crying).Record review of Resident #2's annual MDS assessment dated [DATE] reflected a BIMS was not conducted because she was rarely/ never understood and her cognitive skills for daily decision making were severely impaired. Record review of Resident #2's care plan dated 04/27/20 reflected she needed a structured environment in a secure unit, was a wanderer, had poor safety awareness, and had a communication problem related to her diagnoses of Alzheimer's and dementia. Record review of Resident #3's admission record reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cognitive communication deficit (difficulty with communication), dementia, moderate, with other behavioral disturbance (loss of memory, language, problem solving and other thinking abilities with behaviors beyond the typical cognitive decline associated with dementia, which significantly impairs a person's ability to perform daily activities), and anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life). Record review of Resident #3's quarterly MDS dated [DATE] and 07/18/25 reflected a BIMS score of 13 which indicated Resident #3's cognition was intact.Record review of Resident #3's care plan dated 12/29/16 reflected she needed a structured environment in a secure unit, was a wanderer, had poor safety awareness, had the potential to be verbally and/or physically aggressive, had a behavior problem of hitting other residents at times with interventions that included analyze of key times, places, circumstances, triggers, and what de-escalate behavior and document, assess resident's coping skills and support system, caregivers to provide opportunity for positive interaction, attention, stop and talk with her as passing by, and if reasonable, discuss the resident's behavior; explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Resident #2 also had a communication problem related to her diagnoses of Alzheimer's and dementia. Record review of the provider investigation report dated 04/11/25 reflected both Resident #2 and Resident #3 resided in the secured unit. Resident #2 had attempted to enter Resident #3's room and Resident #3 struck Resident #2's left arm several times with a closed fist. The residents were immediately separated by CNA D. LVN C completed a skin assessment and pain assessment, with no adverse injury or concern noted to either resident. Resident #3 was placed on one to one monitoring. The residents' families and physicians as well as the local police department were notified of the incident. On 04/04/25, the Admin attempted to interview Resident #2 about the incident, however she was unable to be interviewed as she could not respond to questions appropriately. When Resident #3 was interviewed by the Admin and later by a police officer, she denied hitting anyone. On 04/04/25, Resident #3 was seen by a licensed psychologist regarding the incident and she again denied hitting anyone. It was noted by the psychologist that Resident #3's cognition and judgment were impaired. Resident safety surveys were completed with a sample of residents residing throughout the facility and no negative findings or concerns were noted. The facility initiated abuse/neglect, fall prevention, and resident to resident altercation in-service education on 04/04/25. The licensed psychologist provided in-service education to staff on 04/07/25 regarding caring for residents with dementia, behaviors, and difficult situations and how to address them. Resident #3 was seen by psychiatric services on 04/09/25 with new orders that included discontinue 1:1 monitoring, add Depakote ER 250mg at

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents were free of any significant medication errors for one (Resident #1) of five residents reviewed for medication errors. The facility failed to ensure that (RN A) did not administer 5ml (10mg) of Lorazepam (a benzodiazepine medication used to treat anxiety disorders that slows down the nervous system) instead of the physician ordered 0.5ml (1mg) of Lorazepam to Resident #1 on 04/27/25.This failure could result in residents not receiving the physician ordered dose of medications which could lead to an adverse reaction, overdose, hospitalization, or death.The findings included:Record review of Resident #1's admission record reflected a [AGE] year-old male initially admitted to the facility on [DATE] and most recently admitted on [DATE]. The only contacts listed for him were his guardian (Bill to, Responsible Party, and Emergency Contact #1) with two phone numbers, a fax number, and an email address, and himself. His diagnoses included epilepsy (a long-term (chronic) disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), bipolar disorder (mental health condition that causes clear shifts in moods from extremely elated, irritable, or energized to sad, indifferent, or hopeless), unspecified psychosis not due to a substance or know physiological condition (psychotic symptoms not aligned with a specific psychotic disorder or mental illness), mood disorder due to known physiological condition (a mental health condition characterized by a disturbance in mood (like depression or mania) that is directly caused by a medical or physiological condition), mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age), cognitive communication deficit (difficulty with communication), cerebellar stroke syndrome (impairments in motor control and posture), and dementia (loss of memory, language, problem solving and other thinking abilities which significantly impairs a person's ability to perform daily activities). Record review of Resident #1's quarterly MDSs dated 04/22/25 and 06/25/25 reflected BIMS scores of 2 and 7 which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's care plan dated 07/19/17 reflected he had a seizure disorder, potential for mood problem, was resistive to care, displayed verbal behaviors, had a communication problem and unclear speech related to diagnoses of bipolar disorder, psychosis, and history of stroke. Interventions included administer medications as ordered and observe/document for side effects and effectiveness, behavioral health consults as needed, observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity, and praise the resident when behavior was appropriate. Record review of Resident #1's Order Summary Report on 08/13/25 reflected the following orders:1. LORazepam Oral Concentrate 2 MG/ML (Lorazepam) Phone Give 0.5 milliliter by mouth three times a day related to mood disorder due to known physiological condition ordered on 08/04/24. 2. Narcan Nasal Liquid 4 MG/0.1 ML 1 spray Alternating nostrils STAT for Adverse Reaction/Overdose ordered on 04/27/25. 3. Neurological Checks every one hour for 24 hours, report any significant changes to hospice provider ordered on 04/27/25 to start on 04/28/25 at 12:00 am. 4. Vital Signs every hour for 24 hours, report any significant changes to hospice provider, for monitoring due to medication error ordered on 04/27/25 to start on 04/28/25 at 12:00 am.Record review of Resident #1's April 2025 eMAR reflected the following:1. RN A documented an administration of 0.5ml of Lorazepam oral concentrate 2mg/ml (1mg) by mouth on 04/27/25 at 5:30 pm. 2. RN A documented an administration of 0. 2ml/8mg of Narcan 0.1ml/4mg spray to each nostril at 11:33 pm.Record review of Resident #1's handwritten Lorazepam narcotic administration log sheet reflected RN A initially documented he gave 0.5 ml (1mg) of Lorazepam oral concentrate 2mg/ml to Resident #1 by mouth at 5:30 pm, however RN A wrote over the amount given to show he gave Resident #1 5ml (10mg) of Lorazepam oral concentrate 2mg/ml by mouth at 5:30pm.Record review of Resident #1's progress notes reflected the following entries:1. 04/27/25 at 11:33 pm RN A documented, Narcan Nasal Liquid 4 MG/0.1 ML 1 spray Alternating nostrils STAT for Adverse Reaction/Overdose Narcan 4 mg to each Nostril given.2. 04/27/25 at 11:49 pm RN A documented, 1800 Medication Lorazepam 0.5 ml scheduled. Medication error--Lorazepam 5 ml was given. During Narcotic count--Error was discovered -2225. Pt. was checked and Patient was very Lethargic. V/S--B/P=130/62, P=85, R=21 and 02 at 100% via Nasal cannula D.O.N was called and informed of situation. Hospice provider was called, RN on call called back, she gave Telephone orders as follows: give Naloxone 4mg Nasal spray. Resident was assessed. Naloxone 4mg of which was administered to each nostril--3 minutes apart. Resident