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	12/05/2025

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 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. (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 0609 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 interviews and record reviews, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources, were reported immediately to the administrator of the facility and to HHSC for 1 of 3 Residents (Resident #4) reviewed for abuse. The facility staff failed to report an allegation of abuse to the administrator and HHSC within 2 hours after the allegation was made per facility policy. This deficient practice could affect any resident and could contribute to further neglect. The findings were: Record review of Resident #4's face sheet dated 05/29/24 revealed a [AGE] year-old female with an original admission date of 02/18/19. Diagnoses included Alzheimer's, fainting, Unspecified injury of the head, stomach ulcer with perforation, Dementia with behavioral disturbance, anemia (low blood count), anxiety, Diabetes, High blood pressure, malnutrition, abnormal gait and balance, curvature of the spine, repeated falls, reduced mobility, unsteadiness of feet, and assistance with personal care. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. She was exit-seeking, utilized a wheelchair which she could self-propel slowly. She was dependent on staff for personal hygiene, dressing, including footwear, showering, toileting, transferring, and oral hygiene. She required set-up assistance with eating. She required substantial assistance with upper-body dressing and moderate assistance with positioning. She was always incontinent of bladder and bowel. Her active diagnosis was Non-traumatic Brain Dysfunction. Record review of Resident #4's care plan dated 04/27/20: Date Initiated: 02/01/23. The resident has an ADL self-care performance deficit. Interventions included: Date Initiated: 04/21/23 The resident requires extensive assistance by (2) staff to turn and reposition in bed, and the resident requires extensive assistance by (2) staff to move between surfaces (transfers). Date Initiated: 08/13/24. Needs a structured environment in a secure unit related to cognitive deficit. Interventions included Date Initiated: 08/13/24, Try to keep a routine such as bathing, dressing, and eating. Date Initiated: 02/01/2023. The resident has impaired cognitive function/dementia or impaired thought processes r/t Alzheimer's. Interventions included cue, reorient, and supervise as needed. Keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion. She required extensive and frequent redirection. Record review of Resident #4's active physician orders revealed Cilostazol Oral Tablet 100 MG (Cilostazol), Give 1 tablet by mouth one time a day for PVD (Peripheral Vascular Disease), Pharmacy, Active, 10/24/2024. Record review of Resident #4's fall risks dated from 06/16/20 to present had all been scored as high. During a phone interview with HSK C on 10/07/25 at 1:20 pm, she said she saw LVN A help Resident #4 in her seat. She said she told the resident to sit down, and LVN A put his hand on Resident #4's shoulders and lowered her back down and she got up again and LVN A put his fingers on Resident #4's chest to sit her back down. She said LVN A was not forceful with Resident #4. She said Resident #4 did not cry out or grimace. She said she did not think LVN A was trying to hurt her. She said she did not say anything to anyone. She said she told her supervisor the following afternoon because she had personal issues going on. She said she reported things to everyone all the time. She said the Abuse coordinator was the ADM. She said she was not reporting to the Abuse Coordinator because she had personal issues going on, and she just went home on [DATE], the day of the incident. She said the ADM told her she should have called him, no matter what. She said she forgot they were supposed to report things right away. Observation of Resident #4 on 10/07/25 at 9:15 am revealed she was self-propelling slowly in her wheelchair. She was smiling at nothing or no one in particular. She touched the furniture, other residents', and/or their wheelchairs as she rolled down the hallway and in the dining area. Resident #4 was easily redirected by staff. In an interview with RN E on 10/07/25 at 9:16 am, she said Resident #4 tried to get up a lot, unassisted, and often fell. She said Resident #4 could be aggressive with other staff and residents. She said sometimes, Resident #4 did not answer, but seemed to understand because she could be redirected. She said she knew LVN A and worked with him several times. She said she never saw LVN A being aggressive, but rather, had seen him being nothing but kind and patient with the residents. In an interview with LVN A on 10/07/25 at 10:50 am, he said he was the only nurse in the unit on 10/02/25 with 2 CNAs. He said CNA B was bathing residents; CNA D was in another room assisting another resident. He said he was documenting at the desk, saw the resident trying to stand from her wheelchair, and he was able to verbally redirect her. He said the resident propelled herself in her wheelchair. He said she got up again and started walking around the dining table. He said he followed her closely behind with her