

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 01/10/2026
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** Based on interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents, for one of five residents (Resident #3) reviewed for accidents and supervision. The facility failed to prevent Resident #3 from attaining alcohol-based hand rub on 12/21/2025. This failure could place residents at risk of ingesting potentially harmful ingredients due to its high alcohol content. Record review of Resident #3's admission record, dated 01/10/2026, revealed Resident #3 was admitted to the facility on [DATE]. Resident #3 was a [AGE] year-old male who was admitted to the facility with multiple diagnoses which included alcohol dependence with alcohol-induced mood disorder, alcohol dependence with unspecified alcohol-induced disorder, and alcoholic cirrhosis of liver without ascites (liver damage). Record review of Resident #3's admission MDS, dated [DATE], revealed Resident #3 had a BIMS score of 4, which indicated Resident #3 was severely cognitively impaired. Resident #3 was also coded for needing partial/moderate assistance with ADLs. Record review of Resident #3's care plan, date initiated 01/08/2026, revealed The resident has a mood problem r/t Alcohol dependence dx Goal: The resident will have improved mood state happier, calmer appearance, no s/sx of depression, anxiety or sadness) through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Monitor/record/report to MD PRN acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills Monitor/record/report to MD PRN mood patterns s/sx of depression, anxiety, sad mood. Monitor/record/report to MD PRN risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. Care plan did not document any history of resident consuming items he was not supposed to. Record review of Resident #3's progress notes revealed on 12/21/2025 at 04:33AM, RN A documented Note Text: Pt found stacking furniture at his bedroom door. I noticed an open bottle of hand sanitizer on his bedside table Pt stated, 'Yes I'm F***** up.' I asked the patient where he got hand sanitizer from, he stated 'Come on I'm not [bullshitting] you man.' There was no indication that Resident #3 consumed hand sanitizer only that it was in Resident #3's possession. Record review of the facility's provider investigation report, date of incident 12/21/2025, revealed the facility administrator was notified by the facility director of nursing that a bottle of hand sanitizer had been found in a resident's room on the facility's secured unit by the charge nurse. The bottle</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>of hand sanitizer that was found had been opened and the resident vocalized to the nurse that he had ingested hand sanitizer. The resident also stated he had ingested other items which were not located in the resident's room. During the course of monitoring Resident #3, there was never any indication that emergent services were warranted nor was there any indication that Resident #3 consumed the hand sanitizer. During an interview and observation on 01/10/2026 at 10:03AM revealed Resident #3 was sitting calmly in his wheelchair with no exhibition of distress. Resident #3 stated he did not recall any event regarding hand sanitizer, and continued to state no person has ever hit, hurt, or scared him. Resident #3 stated the nurses were nice to him and was not fearful of living at the facility. Resident #3 stated he had never ingested any form of alcohol/hand sanitizer while at the facility. There was no hand sanitizers observed in Resident #3's room. During an observation on 01/10/2026 at 9:56AM observed the memory unit and all mobile hand sanitizers were locked within the nurse's medication carts under lock and key. There were no other mobile bottles of hand sanitizers in the memory unit. During an attempted phone interview on 01/09/2026 at 6:12PM and 01/10/2026 at 10:42AM and 1:18PM with RN A were unsuccessful. RN A did not return call prior to exit conference. During an attempted phone interview on 01/09/2026 at 5:04PM and 01/10/2026 at 1:11PM with CNA B, who was noted to be working on 12/21/2025 during the incident, was unsuccessful. CNA B did not return call prior to exit conference. During an attempted phone interview on 01/09/2026 at 5:08PM and 01/10/2026 at 1:14PM with CNA C, who was noted to be working on 12/21/2025 during incident, was unsuccessful. CNA C did not return call prior to exit conference. During an interview on 01/10/2026 at 1:59PM, the DON and Administrator stated RN A notified on 12/21/2025 that Resident #3 verbalized drinking multiple substances that were not kept within the facility. The DON stated RN A notified her that he saw a small bottle of hand sanitizer on Resident #3's bedside table on 12/21/2025. The DON and Administrator stated the facility quickly conducted a thorough head to toe assessment, neurological assessment, notified the physician, as well as notified the poison control hotline and per the recommendation of poison control to monitor Resident #3 for any adverse effects of hand sanitizer, and during the 72 hour course of monitoring Resident #3, there was never any adverse effects. The DON and Administrator stated there was never any indication of actual ingestion as the cap was secured on the bottle and there was no apparent large amount of hand sanitizer missing. The DON and Administrator stated they researched the effects of ingesting hand sanitizer and stated the hand sanitizer did not have detrimental consequences. The DON and Administrator stated while they conducted the investigation, they concluded the hand sanitizer was in a drawer in the nurses' station, however, they could not definitively state where the hand sanitizer was situated. The DON stated she also completed a thorough head to toe assessment herself, and there was never any evidence of Resident #3 ingesting any caustic chemicals, additionally Resident #3 never smelled of alcohol nor did he present with any change of neurological deficits or intoxication. The DON and Administrator stated the facility monitored Resident #3 for 72 hours and maintained the same cognition from when Resident #3 was admitted. The DON and Administrator reiterated there was never any evidence that Resident #3 consumed the hand sanitizer only that the hand sanitizer was in Resident #3's possession. The DON and Administrator stated the incident was an isolated event and since the event the facility has ensured all non-fixed hand sanitizer bottles were kept within the nurse's locked medication carts and no longer kept within the nurses' stations. The DON and Administrator stated Resident #3 should not have had access to the hand sanitizer as it was potentially a chemical hazard. Both stated Resident #3 may have retrieved the hand sanitizer bottle from a drawer within the nurse's station. Both stated there could have been a negative consequence on Resident #3's well-being had Resident #3 ingested the hand sanitizer, however there was</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	never any indication of Resident #3 consuming the hand sanitizer. Both stated after the incident they educated the clinical staff that any hand sanitizer bottle not affixed on the walls must be kept in the nurse's medication cart under lock and key. Record review of the facility's, undated, general housekeeping policies, revealed all bleaches, detergents, disinfectants, insecticides, and other potentially hazardous substances are labeled and kept in a safe place accessible only to employees.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infection for one of five residents (Resident #2) reviewed for infection control.1. The facility failed to ensure CNA A removed her contaminated gloves and performed hand hygiene after touching multiple surfaces prior to initiating Resident #2's perineal care on 01/10/2026.2. The facility failed to ensure CNA A performed hand hygiene when completing perineal care to cleaning bowel movement. These failures could place residents at risk for contamination and infection. The findings include: Record review of Resident #2's admission record, dated 01/10/2026, revealed Resident #2 was admitted to the facility on [DATE]. Resident #2 was a [AGE] year-old female who was admitted to the facility with multiple diagnoses which included type 2 diabetes mellitus (persistent high level of sugar in blood), lack of coordination and muscle wasting and atrophy (loss of muscle mass and strength). Record review of Resident #2's Comprehensive MDS, dated [DATE], revealed Resident #2 had a BIMS Score of 15, which indicated Resident #2 was cognitively aware. Resident #2 needed substantial/maximal assistance with ADLs. Record review of Resident #2's care plan, date initiated 01/16/2025, revealed Problem: the resident has bowel and bladder incontinence related to Impaired Mobility, Physical limitations. Goal: the resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: BRIEF USE: The resident uses disposable briefs. Change as necessary. Clean peri-area with each incontinence episode. Monitor/document for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Monitor/document/report PRN any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects. During an observation on 01/10/2026 at 11:25AM revealed CNA A washed hands, placed clean gloves on, utilized Resident #3's bed remote to lay the resident down, removed Resident #3's blanket and gown, and proceeded to retrieve cleansing wipes without changing gloves nor performing hand hygiene. CNA A then cleaned Resident #3's perineal area, rolled the front of Resident #3's brief up, turned Resident #3 to her right side, and proceeded to clean Resident #3's visible bowel movement, CNA A did not perform glove change or hand hygiene prior to turning Resident #3 to her right side. During an interview on 01/10/2026 at 11:48AM, CNA A stated during the perineal care she should have changed her gloves and performed hand hygiene after she touched the bedside remote and Resident #2's immediate surroundings. CNA A stated she forgot to perform glove change and hand hygiene because she was nervous. CNA A stated secondly, she should have changed her gloves and performed hand hygiene when going from clean area to dirty area. CNA A stated for both instances the reason she should have changed gloves and performed hand hygiene was to minimize the potential introduction of bacteria. CNA A said she would be more diligent about implementing hand hygiene throughout perineal care. During an interview on 01/10/2026 at 11:51AM, the DON stated CNA A should have removed her contaminated gloves once she touched Resident #2's immediate surroundings and when she cleaned the perineal area to the gluteal area. The DON stated the reason CNA A should have performed glove changes and hand hygiene was to mitigate the potential exposure to infectious microorganisms. The DON stated the facility followed the CDC guidelines regarding hand hygiene. The DON stated she would rectify the perineal concern and commence a facility wide hand hygiene in-service. Record review of the facility's perineal care policy, date implemented 10/24/22, revealed</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no specific steps when to perform hand hygiene.Record review of the facility's Hand Hygiene policy and procedures, date implemented 10/24/22, revealed no specifics on when to perform hand hygiene.Record reviewed the facility's CNA's rounding in-service dated 05/30/2025 which revealed the facility educated the staff on incontinent care policy and procedures.Record review of the CDC guidelines Clinical Safety: Hand Hygiene for Healthcare Workers, updated on 02/27/2024, revealed Know when to clean your hands,Immediately before touching a patient.Before moving from work on a soiled body site to a clean body site on the same patientAfter touching a patient or patient's surroundingsAfter contact with blood, body fluids, or contaminated surfacesImmediately after glove removal.		