Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/05/2026
Form Approved OMB
No. 0938-0391

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	02/18/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, for 1 (Resident #1) of 4 residents reviewed for care plans. The facility failed to ensure Resident #1's care plan reflected she refused to eat, to shower, wound care, medications, and was noncompliant with staying repositioned on her sides.This failure could place the residents at risk of not receiving appropriate interventions and care to meet their needs.The findings included:Record review of Resident #1's face sheet dated 02/18/26 reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), dysphagia (trouble swallowing), muscle wasting and atrophy, and other reduced mobility. Resident #1 was discharged home on [DATE]. Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 7, indicating severe cognitive impairment. Resident #1 had one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough). Resident #1 was dependent (helper does all of the effort) for toileting hygiene, required substantial/maximal assistance (helper does more than half the effort) for showering/bathing, personal hygiene, and required partial/moderate assistance (helper does less than half the effort) to roll left and right. Record review of Resident #1's care plan dated 02/18/26 reflected [Resident #1] had an ADL self-care performance deficit related to Alzheimer's disease. Date initiated: 07/24/25. Resident #1's care plan did not reflect Resident #1 refused to eat, to shower, wound care, medications, and was noncompliant with staying repositioned on her sides. Record review of Resident #1's progress notes dated 11/20/25-02/11/26 revealed progress notes:-On 11/20/25 at 8:31 AM, hospice aide in facility, resident refused shower/bed bath at this time-On 11/24/25 at 12:30 PM, resident refused to shower this morning. Hospice aide attempted but resident refused. Hospice then reported to nurse on duty to try and encourage resident to shower but resident refused again stating I just don't want to shower.-On 12/04/25 at 1:34 PM, resident continues to refuse showers. Hospice aide asked on duty nurse for assistance on trying to encourage resident to shower. Resident refused and began to get agitated.-On 12/21/25 at 1:30 PM, resident refusing lunch tray, substitute offered and declined.-On 12/24/25 at 4:42 PM, resident refused to eat breakfast, stated she will not eat. Nurse educated resident on importance of nutrition and not skipping meals, resident continued to refuse.-On 12/27/25 at 9:04 AM, resident ate 25% of meal, nurse explained to resident the importance of a nutritious meal, resident continued to refuse.-On 01/05/26 at 6:25 PM, resident has been allowing staff to provide incontinence care and repositioning but resident repositions self into supine position after a few minutes. Redirection ineffective. (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

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 02/18/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident stated that she will position self in the most comfortable position for her.-On 01/07/26 at 11:52 AM, resident refused breakfast, offered alternate plate but refused. RP made aware she voiced that her mother usually never ate breakfast, only a coffee with a piece of bread at time and ate until 11am.-On 01/23/26 at 6:31 PM, nurse called hospice nurse to inform of resident's poor appetite. Message left, nurse returned call and nurse informed her resident continues with poor appetite and requested a speech evaluation or other recommendations to help with residents poor appetite. Hospice nurse stated she would consult with her supervisor and call back with any orders.-On 01/25/26 at 1:30 PM, wound care to sacral ulcer completed after begging resident that dressing needed to be changed because it was soiled and peri care needed to be done. Resident refused initially but after repetitive begging resident accepted but did limit to 5 minutes.-On 01/25/26 at 2:01 PM, resident ate less than 25%, offered substitute, resident denied. Resident did drink coffee.-On 01/26/26 at 1:22 PM, resident refused to be repositioned. Attempted to educate due to sacral bedsore would promote healing. Resident continue to refuse. Denied pain.-On 01/26/26 at 6:29 PM, resident refused to eat dinner. Resident asked why she did not want dinner. Resident stated she is not hungry at the moment. Floor nurse offered an alternative meal from the kitchen resident refused and stated again she is not hungry.-On 01/27/26 at 2:48 PM, resident refused any substitutions. Attempted to encourage resident to eat but resident to decline. Resident tightens lips in order not to eat.-On 01/27/26 at 7:00 PM, resident refused to eat. Resident was offered alternative meal options and resident refused.-On 01/30/26 at 11:34 AM, resident refused medications x3.-On 02/06/26 at 8:33 PM, resident refused medications.-On 02/08/26 at 6:56 PM, resident was educated on the importance of having dressing changed, resident refusing and stating, not right now. Nurse attempted x3, however, resident continued to refuse.-On 02/09/26 at 5:26 AM, resident refused medications.-On 02/09/26 at 9:20 AM, resident refused meal. Resident was educated on importance of eating and resident still refused.-On 02/09/26 at 2:55 PM, resident refused meal. Resident was educated on importance of eating and resident still refused.-On 02/10/26 at 9:28 AM, resident refused all medications, nurse aware.-On 02/11/26 at 9:25 AM, resident refused medications x3.-On 02/11/26 at 9:28 AM, resident refused meal. In an interview on 02/18/26 at 2:50 PM, with the ADON, she said Resident #1 refused to shower and refused to eat. The ADON said if Resident #1 refused care, it should have been care planned. The ADON said the purpose of the care plan was to make sure they had the proper interventions. The ADON said the care plan explained to staff how to care for the resident. The ADON said she was not sure if Resident #1's refusals were care planned. The ADON said the MDS Nurse updated care plans. In an interview on 02/18/26 at 3:15 PM, with RN B, she said Resident #1 refused to eat, refused to shower, refused medications, and refused wound care at times. RN B said Resident #1 was noncompliant with staying on her sides when the staff would reposition her. RN B said these refusals did not help with the wound healing process. RN B said care plans were updated as needed by staff such as herself, the MDS Nurse, the ADONs, the DON, or a floor nurse. RN B said she was not sure if Resident #1's refusing care or being noncompliant was care planned. RN B said it was important to have refusals and noncompliance care planned to check the resident's progress and whether or not the interventions were working. An interview was attempted on 02/18/26 at 3:35 PM with the DON, she was unavailable as she was on personal time off. In an interview on 02/18/26 at 3:40 PM with the MDS Nurse, she said the care plans were updated by the team and different disciplinaries. The MDS Nurse said if there were any acute changes or the care plan needed to be updated, it was updated daily if needed. The MDS Nurse said if a resident was noncompliant with her care, including eating, showering, that should be included in the care plan. The MDS Nurse said she reviewed Resident #1's care plan and the behaviors as far as her refusing to shower, (continued on next page)

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	02/18/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusing wound care, refusing to eat, refusing medications, and refusing to stay on her sides, were not care planned. The MDS Nurse said that did not indicate that staff were not providing the care or attempting interventions. The MDS Nurse said there was no negative outcome for Resident #1, but it was important for refusals to be care planned. The MDS Nurse said the care plan was used to communicate with staff of how to care for the resident, and the goals and interventions based on the resident's needs. In an interview with on 02/18/26 at 4:00 PM with the ADM, he said Resident #1 refused meals and to be repositioned in bed. The ADM said he was unsure if Resident #1 refused other care. The ADM said staff tried to provide assistance, educated Resident #1, redirected her, and notified/followed up with the hospice agency and the RP about the refusals. The ADM said although the refusals were not care planned, there was no negative outcome for Resident #1 as staff attempted interventions. The ADM said the refusals should have been care planned so that everyone was aware. Record review of the facility's Comprehensive Care Plans policy dated 10/24/22 reflected - Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.