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	04/01/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was developed within 7 days after completion of the comprehensive assessment and reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 5 residents (Resident #1) reviewed for care plan revisions. The facility failed to develop Resident #1's comprehensive care plan within 7 days after completion of the comprehensive assessment. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #1's face sheet dated 03/31/26 revealed a [AGE] year-old female with admission date of 03/05/26. Diagnoses included schizophrenia (Disorder leading to psychosis such as hallucinations, delusions, social withdrawal, lack of motivation and cognitive impairment) and heart failure (chronic condition where the heart cannot pump enough blood to meet the body's needs). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 7 which indicated severe cognitive impairment. Record review of Resident #1's comprehensive care plan dated 03/31/26 revealed the care plan only addressed Resident #1's code status, sitting on the floor, a fall on 03/21/26, fall risk, bowel incontinence, a rib fracture related to a fall, bladder incontinence, and oxygen therapy. Record review of Resident #1's Care Plan history on 03/31/26 revealed Resident #1's next review date for her care plan was 03/23/26. In an interview with LVN A at 2:00 PM on 03/31/26, LVN A stated she was the Care Management Specialist at the facility. LVN A stated Resident #1 was admitted to the facility on [DATE]. LVN A stated she completed the initial MDS Assessments for residents as soon as possible, but no later than 14 days after admission. LVN A stated the initial assessment for Resident #1 was completed on 03/17/26. LVN A stated they had 7 days to complete the comprehensive care plan once the assessment was completed. LVN A stated the comprehensive care plan for Resident #1 should have been completed by 03/24/26. LVN A stated the interdisciplinary team provided input into the care plan but ultimately it was her responsibility to complete the comprehensive care plan once the assessment was completed. LVN A stated she did not complete the comprehensive care plan for Resident #1 until 03/31/26. LVN A stated she waited to complete the comprehensive care plan because she was not sure if the resident needed a change of condition assessment after a recent fall. LVN A stated a delay in completing a comprehensive care plan may lead to nurses not being up to date on how to properly care for a resident. In an interview with the DON at 2:35 PM on 03/31/26, the DON stated the comprehensive care plan contained everything a nurse needed to know to care for a resident such as ADL's, medications, diet, treatments, goals, and interventions. The DON stated it was important to complete the comprehensive care plan on time so all nurses would have the pertinent information needed to care for a resident. The DON stated the care plan Resident #1 had on the morning of 03/31/26 was insufficient as a comprehensive care plan. The DON stated the comprehensive care plan for Resident #1 should have been completed by 03/24/26. The DON stated the MDS nurse built the comprehensive care plans. Record review of the facility policy Comprehensive Care Plans dated (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/24/22 revealed the following policy: .2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment.