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	04/03/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51216 Based on observation, interview, and record review the facility failed to ensure each resident had the right to be free from abuse for two residents (Resident #3, Resident #43) of 10 residents reviewed for abuse. The facility failed to ensure: Resident #3 and Resident #43 were free of abuse. Residents #3 and #43 were involved in a Resident-to-Resident altercation. Both residents sustained minor injuries from the altercation. These failures have the potential to result in serious injury because of abuse. The findings included: Resident #3 Record review of Resident #3's facesheet revealed a [AGE] year-old male initially admitted on [DATE] with diagnosis of anxiety disorder, cognitive communication deficit, and vascular dementia. Record review of Resident #3's Minimum Data Set Quarterly assessment dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status Score of 07- severe cognitive impairment and needed extensive assistance with all activities of daily living. The assessment did not indicate any prior resident to resident altercations. Record review of Resident #3's Care Plan initiated on 10/30/24 revealed Resident #3 had an activities of daily living self-care performance deficit related to unsteady gait requiring supervision, impaired balance, and weakness. Resident #3 was dependent on staff for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits. Resident #3 required extensive assistance by x 1 staff to help him get dressed, bathing/ showering, oral care, personal hygiene care, and toileting frequently and as necessary. The care plan did not indicate any prior resident to resident altercations. Record review of Resident #3's Weekly Skin Evaluation conducted by the RN C dated 03/04/25 at 21:43 PM (9:43 PM) indicated Resident #3 revealed no injuries detected. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Weekly Skin Evaluation dated 03/05/25 revealed resident had two new wounds. The evaluation did not include a detail description or location of Resident #3's two new wounds. Record review of Resident #3's Progress Note dated 03/05/25 at 19:00 (7:00 PM) revealed the resident was in his room when Resident#43 entered the room asked him about a taxi service he did not respond so Resident #43 hit the resident in the face. Resident #3 hit resident #43 back and tripped and fell during the altercation both sustained an injury. The incident indicated Resident #3 had a reddened area to left upper cheek and reddened area to his upper forehead. Doctor was notified along with Facility administrator and director of nursing. Patient family member was also notified. Patient showing no signs of distress noted at this time. Record review of Resident#3's Pain Evaluation dated 03/05/2025 indicated the resident denied pain. Resident denied any lost in of level of consciousness when he was hit in the face. Denied any other injuries. During assessment no obvious deformities/injuries noted. Represent of resident made aware. Charge nurses were made aware. Record review of Resident #3's incident report dated 03/10/25 indicated Injuries Report Post incident (conducted by interim administrator): Injury Type: reddened area to left upper cheek and reddened area left upper forehead. Other info: patient was hit by another resident. Record review of the facility's Incident and Accident log dated 02/01/25 - 03/19/25 indicated Resident #3 did not have any prior altercations/incidents. Resident #43 Record review of Resident #43's facesheet revealed resident was a [AGE] year-old male initially admitted on [DATE] with diagnoses of other speech and language deficits following cerebral infarction; vascular dementia unspecified; psychotic disturbance; mood disturbance and anxiety; cognitive communication deficit; needed for assistance with person care; and muscle wasting and atrophy. Record review of Resident #43's Progress Note dated 2/7/2025 at 20:07 (8:07 PM) revealed Resident #43 was involved in a resident to resident altercation with another male resident with no physical contact confirmed. Record review of the facility's incident report regarding resident-to-resident altercation dated 02/07/2025 at 20:00 (8:00 PM) revealed Resident #43 was involved in a verbal resident to resident altercation with another male resident however no physical altercation was confirmed. Record review of Resident #43's Care Plan date initiated on 02/19/25 Resident #43 is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits. Resident #43 requires extensive assistance by x 1 staff to help him get dressed, bathing/ showering, oral care, personal hygiene care, and toileting frequently and as necessary. The plan indicated on 02/07/25 resident struck another male resident who entered his room. Interventions included: - Behavioral health consults as needed. - Do not argue with resident but redirect by asking benign questions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Placed under 1:1 supervision. - Plan activities that draw on resident's experience and knowledge. - Resident in room by himself due to not wanting roommate. - Resident was re-directed to surroundings he was separated from the other resident. Resident # 43's care plan revised 03/10/2025 revealed, the resident had a mood problem r/t Disease Process Dementia, episodes of anxiety Behavior: 2/7/25 Resident struck another male resident who entered room. Goal: the resident will have improved mood state calmer appearance, no s/sx of anxiety 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.). Do not argue with resident, but redirect by asking benign questions. Placed under 1:1 supervision. Plan activities that draw on resident's experience and knowledge. Resident in room by himself due to not wanting roommate. Resident was re-directed to surroundings he was separated from the other resident and made safe. Record review of Resident #43's Weekly Skin Evaluation dated 03/05/25 revealed one wound documented to his chin. The evaluation did not include a detail description or location of Resident #43's one new wound. Record review of Resident #43's Progress Note dated 03/05/2025 18.50 (6:50 PM) indicated Resident lying in bed. No distress noted. Respiration non labored. Resident stated his account of events. Resident's vital signs taken. no documentation of wound to chin and head to toe assessment noted. Record review of Resident #43's Incident Report dated 03/05/25 and Injuries Reported Post Incident revealed resident #43 nurse's notes from 03/06/2025 revealed none of the notes included a documentation, description, or location of any injury. Record review of Resident 43's Weekly Skin Evaluation conducted by the nurses dated 03/05/2025 at 18:50 (6:50) PM revealed Resident # 43 sustained a 0.5cm injury to right side of chin. Record review of Resident #43's Provider Investigative Report dated 03/10/25 conducted by the Interim Administrator indicated A head-to-toe assessment on Resident #3 and Resident #43 completed. Psychiatric service was called, and primary care physician was notified, and he gave no new orders. The incident report revealed Resident #3 was in his room when Resident #43 entered his room and hit him in the face. Resident #3 hit resident #43 back and tripped and fell during the altercation. Both residents sustained injuries according to the head-to-toe assessment when completed. Resident #3 injuries consisted of a redden area to left upper cheek and reddened area left to upper forehead. Resident #43 had a 0.5cm abrasion on right side of chin. Doctor was notified along with Facility administrator and director of nursing. Patient family member was also notified. Patient showing no signs of distress noted at this time administrator and director of nursing. Patient family member was also notified. Patient showing no signs of distress noted at this time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 04/01/2025 at 9:05 AM of Resident #43 revealed he was appropriately dressed. He kept looking around his room pacing in circles. Resident #43 was alert and oriented to self but was unaware of the date, time, and his location. He could not recall any altercation and asked where his room was. The one to one assigned staff member to Resident # 43 told him he was in his room. Resident #43's was on one to one supervision at all times and did not have a roommate. In an observation and interview on 04/01/25 at 09:55 AM revealed Resident #3 was well dressed, groomed, shaved and his hair was combed. The resident was well spoken and alert to his name and surroundings. Resident #3 stated he was lying in bed and Resident #43 entered his room asking about taxi service and he did not respond. Resident #3 said Resident #43 hit him (could not recall location of contact) and he got up and hit Resident #43 on the face with his fist then lost his balance and tripped over his bed and fell to the floor. In an interview on 04/02/25 at 03:16 PM with RN C stated she was called by CNA A and asked to help as Resident #43 had entered the room of Resident #3. The two residents were being pulled apart as she entered the room to help. She stayed with Resident #3 and CNA A took Resident #43 back to his room. She assessed Resident #3 and asked him if there was any pain he said no. She asked if he was dizzy, he said no. She asked resident #3 what happened he stated Resident #43 just walked into his room was talking and then started hitting him for no reason. RN C said she assessed his eyes, hands, and knees for any injuries and said Resident #3 had a scratch to his cheek. She stated Resident #3 was very quiet and kept to himself. She stated Resident #3 was not confrontational with any resident and just stayed in his room. She stated Resident #43 wondered around the locked unit at times. In an interview on 04/02/2025 at 3:56 PM with CNA A revealed he was picking up trays and heard someone calling for help. As he entered Resident #3's room, he saw Resident #3 on the floor and Resident #43 was walking out. He instructed Resident #3 to remain on the floor, but he refused and got up by himself. Then as he was standing, he asked Resident #3 to sit on the chair until the nurse came in. He then called for help and RN C walked in and attended to Resident #3. CNA A stated he stayed with resident until RN C came in and assisted Resident#3. CNA A then went to attend to Resident #43 in his room. In an interview on 04/03/25 at 03:46 PM the DON stated she was not employed at time of the incident; therefore; she could not provide specific details of the incident. The DON stated Resident #43 was placed on a one to one supervision at all times for the protection of all residents until his transfer to another facility. Record review of the facility policy titled Abuse, Neglect and Exploitation dated 08/15/22 reflected the following: VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on interview and record review the facility failed to incorporate the recommendations from the PASRR Level II determination and the PASRR evaluation report for 1 of 5 residents (Resident #47) reviewed for PASRR. The facility failed to initiate an NFSS within 20 business days following the date the services were agreed upon in the IDT meeting. This failure could cause residents with mental health disorders and psychiatric conditions to have a delay in services or not receive specialized services or equipment that may be needed. Findings included: Record review of Resident #47's face sheet, dated 04/02/25, revealed a [AGE] year-old female originally admitted [DATE], a recent admitted [DATE], and a discharge date of [DATE]. Her diagnoses included Schizophrenia (a serious mental health condition that affects how people think, feel, and behave), Mild Intellectual Disabilities, and Bipolar with Psychotic Features (mental health condition characterized by significant mood swings). Record review of Resident #47's Quarterly MDS assessment, dated 01/27/25, revealed a BIMS score of 12, indicating moderately impaired cognition. The MDS assessment also revealed Resident #47 had impairment to an upper extremity on one side and utilized a wheelchair, as well as Resident #47 was dependent in toileting and needed maximal assistance with dressing. Record review of Resident #47's care plan, initiated 09/21/2017 and revised 05/18/2024, revealed resident as PASRR positive related to IDD and Schizophrenia. It also revealed a PCSP meeting completed 05/17/2024. Record review of Resident #47's PASRR evaluation, dated 05/10/25, revealed resident had an intellectual disability which manifested before the age of 18, and she had a developmental disability other than the intellectual disability that manifested before the age of 22. Specialized service recommendations included: self-monitoring and coordinating treatments; self-help with ADLs such as toileting, grooming, dressing, and eating; and sensorimotor development with ambulation, positions, transferring, or hand eye coordination; and independent living skills such as cleaning, shopping, and money management. Record review of Resident #47's progress notes revealed no progress notes concerning IDT meetings or PASRR updates for dates 05/10/24 through 02/25/25 in which they notified the HHS PASRR Program Specialist that specialized services had been completed and needs met, or that needs and services were no longer warranted or needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #47's PASRR PCSP, dated 02/25/25, revealed a recommendation for DME, ongoing habilitation coordination, and independent living skills. During this meeting it was noted that the Habilitation Coordinators met with Resident #47 to discuss services. Resident #47 reported not needing or wanting a customized wheelchair due to having a wheelchair that she liked, and if there was a need for a new one in the future, the habilitation coordinators would be notified. In an interview on 04/02/25 at 1:24 PM with the HHSC PASSR Program Specialist, she stated the complaints were timeframe related, and if the PASRR specialized services that were recommended at the IDT meeting were not initiated, the complaint would include that as well as the services not being completed. She stated the facility must initiate specialized services within 20 business days following the date that the services were agreed to in the IDT meeting, and Resident #47 did not receive a PASSR specialized service (a customized manual wheelchair). She stated the facility was given an additional specific timeframe to submit the NFSS request or update the service by having a meeting and removing and documenting the service as not needed to avoid a regulator complaint. The facility did not meet this additional timeframe in addition to the previous 20 business days they had been given. In an interview on 04/02/25 at 10:09 AM with MDS Nurse - A, she stated she was not aware that there had been a request for extra information regarding Resident #47's PASRR specialized service for a wheelchair, and she was also unaware that a form or any extra information had to be submitted showing that this resident no longer wanted or needed the customized wheelchair. She stated she understood that someone should have been informed that the resident refused this service so that it was not left pending or looked like the resident was not receiving services. In an interview on 04/02/25 at 10:13 AM with MDS Nurse - B, she stated she was also not aware that there had been a request for extra information regarding Resident #47's PASRR specialized service for a wheelchair, and she was also unaware that a form or any extra information had to be submitted showing that this resident no longer wanted or needed the customized wheelchair. She stated someone should have been informed that the resident refused this service so that it was not left pending. In an interview on 04/02/25 at 1:10 PM with the COTA, she stated she was unsure of who made the recommendation for the wheelchair, but PT did an evaluation on Resident #47, then called PASRR to have a meeting. During this meeting Resident #47 refused the wheelchair and stated she wanted to keep her old chair. The COTA also stated she was not sure who was supposed to follow-up with the HHSC PASSR person to let them know that this service was no longer needed, but it was not something she followed up on. In an interview on 04/02/25 at 1:30 PM with the Administrator, he stated he was not here when all the PASRR stuff occurred with Resident #47, but looking through the notes, he saw there was a recommendation for a specialized wheelchair, and the resident refused this service. He also stated he could see that the ball was dropped as no one ever notified the HHSC PASRR Program Specialist that there was no longer a need for the wheelchair. He stated he could see how this would like the resident never received the needed services. The PASRR policy was requested from the DON on 04/02/25 at 1:15 PM, and she stated there was no PASRR policy.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services for 2 of 4 residents (Residents #11 and #23) reviewed for tube feeding management. The facility failed to ensure there were labels or instructions on Resident #11 and Resident #23 ' s enteral nutrition supplemental feeding bags on 04/01/25. These failures could place residents at risk for non-therapeutic responses to enteral feeding, as well as receiving the wrong feeding or receiving a feeding at the wrong rate. Findings included: Record review of Resident #11's face sheet, dated 04/03/25, revealed a [AGE] year-old male with an original admitted [DATE] and a current admitted [DATE]. Diagnoses included Gastrostomy Status (a surgical procedure that creates an opening into the stomach, allowing for access to the stomach for feeding), and Severe Protein-Calorie Malnutrition. Record review of Resident #11's Significant Change MDS Assessment, dated 01/08/25, revealed no BIMS score as resident was rarely or never understood. The MDS assessment also revealed Resident #11 had a feeding tube. Record review of Resident #11's care plan, initiated 09/20/24 and revised 10/16/24, revealed a care plan for tube feeding with a goal the resident would remain free of side effects or complications related to tube feeding, and an intervention stating the resident was dependent with tube feeding and water flushes and to see physician orders for current feeding orders. Record review of Resident #11's physician orders, dated 03/31/25, revealed an order for Jevity (therapeutic nutrition) 1.5 at 60 milliliters per hour for 18 hours via G-tube stationary pump. During an observation on 04/01/25 at 9:30 AM it was revealed Resident #11's enteral feeding bag was not labeled, and there was no label on the ground. Record review of Resident #23's face sheet, dated 04/03/25, revealed an [AGE] year-old female with an original admitted [DATE] and a current admitted [DATE]. Diagnoses included Dysphagia (difficulty swallowing), Gastrostomy Status, and Muscle Wasting and Atrophy (wasting away of a body part or tissue). Record review of Resident #23's Significant Change MDS Assessment, dated 01/31/25, revealed no BIMS score as the resident was rarely or never understood. The MDS assessment also revealed Resident #23 had a feeding tube and received 51% or more of total calories through tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #23's care plan, initiated 02/17/25, revealed Resident #23 required tube feeding related to Dysphagia with a goal the resident would maintain adequate nutritional and hydration status with no signs or symptoms of malnutrition or dehydration. Record review of Resident #23's physician orders, dated 03/31/25, revealed an order for Jevity 1.5 at 58 milliliters per hour for 18 hours. During an observation on 04/01/25 at 9:37 AM it was revealed Resident #23 ' s enteral feeding bag was not labeled, and there was no label on the ground. In an interview on 04/01/25 at 9:00 AM with MA B, he stated the feeding bags were supposed to be labeled with the resident's name, the feeding type, the feeding rate, and the time and date the feeding was initiated. He stated sometimes the labels fell off because they did not stick very well. He stated if this information was not listed, then the nurse or medication aide would not be able to verify if the feeding was correct, and this could cause the resident harm. In an interview on 04/01/25 at 10:00AM with ADON B, she stated the labels fell off the feeding bags frequently because they did not stick very well. She stated the feeding bags should always be labeled so the nurses were aware the resident was receiving the correct feeding at the correct rate. She stated the bag could not be checked with another nurse or verified against the order without a proper label on it, and this could cause the resident harm. In an interview on 04/02/25 at 10:26 AM with the DON, she stated the labels needed to be on the enteral feeding bags so that nurses were aware the resident received the correct feeding because if it was not labeled appropriately, a resident could receive the wrong feeding, which could cause the resident harm. Record review revealed the facility policy titled Medication Administration implemented on 10/24/22 stated the following: Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Record review of the Enteral Tube Medication Administration Policy, revised 10/01/19, stated the following: the facility assures the safe and effective administration of enteral formulas and medication via enteral tubes. Check the medication administration record to confirm the order: note the medication, dose, route, and volume of water for flushing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observations, interviews, and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 16 residents (Residents #105) reviewed for pharmacy services. MA A failed to reconcile the instructions written on Resident #105's blister pack with the physician's order for cefpodoxime (antibiotic) before it was administered despite them having different directions for administration on 04/02/25. This failure could place residents at risk for non-therapeutic responses to medications, receiving the wrong feeding or receiving a feeding at the wrong rate. Findings included: Record review of Resident # 105's face sheet dated 04/03/25 revealed a [AGE] year-old male with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included follicular lymphoma (slow-growing, chronic blood cancer that affects B-lymphocytes which play a crucial role in the immune system). Record review of Resident #105's Quarterly MDS Assessment section C, cognitive patterns, dated 03/20/25 revealed a BIMS score of 15 (cognition intact). Section M, medications, revealed Resident #105 was using an antibiotic. Record review of Resident #105's care plan dated 03/20/25 revealed the problem Resident has the need for reverse isolation due to Follicular Lymphoma dx, Cirrhosis (severe irreversible scarring) of the liver history of chronic leukocytosis (elevated number of white blood cells in the system) initiated on 01/06/25 and revised on 03/19/25. Interventions for the problem included: - Administer medications as ordered, cefpodoxime prophylaxis initiated on 01/06/25 and revised on 03/20/25. - Assess for signs and symptoms of infection of infection [sic] such as: Increased white blood cell count, Fever, redness, swelling, purulent drainage of areas on non-intact skin, changes in urine or sputum and report to the [nurse practitioner]/[medical director] as indicated initiated on 01/06/25. - Assist with ADL care as indicated initiated on 01/06/25. - Use non-shared resident medical equipment if possible. Disinfect shared resident use equipment with the appropriate disinfectant initiated on 01/06/25. Record review of Resident #105's order summary revealed an active order dated 03/18/25 for Cefpodoxime Proxetil Oral Tablet 200 MG. Give 1 tablet by mouth one time a day for prophylaxis. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of medication administration at 8:13 AM on 04/03/25, this state surveyor observed MA A administer one 200 MG tablet of cefpodoxime to Resident #105. The pharmacy label on the blister pack of cefpodoxime stated Give 1 tablet by mouth at bedtime for prophylaxis. In an interview with MA A at 10:08 AM on 04/02/25, MA A stated she was supposed to compare the label on the blister pack to what was written in the MAR before administering any medication. MA A stated she typically compared the resident ' s name, medication name, dose, and directions to ensure they were the same. MA A stated if she saw a discrepancy between the label on the blister pack and the MAR, she would notify the nurse and put a sticker on the label that stated Directions changed refer to chart on the blister pack. MA A stated it was important to compare the MAR to the blister pack label to ensure the resident received the right medications and right dose at the right time. MA A stated she did notice the directions on the blister pack were different from the MAR for the cefpodoxime, but she forgot to let the nurse know at the time. MA A stated not checking to ensure the label on the blister pack matched the MAR could result in giving a resident the wrong medication or dose at the wrong time. In an interview with RN A at 10:17 AM on 04/02/25, RN A stated MA A had informed her that the label on the blister pack of cefpodoxime for Resident #105 was different from what was stated in the MAR. RN A stated she went into Resident #105 ' s MAR to look at the directions and confirmed with the doctor the label on the blister pack was incorrect, and the correct directions were in the MAR. RN A stated she called the pharmacy and they instructed her to put a sticker over the blister pack that stated Directions changed refer to chart. In an interview with the DON at 10:26 AM on 04/02/25, the DON stated medication aides compared what the MAR stated to what the label on the blister pack stated before administering medications. The DON stated medication aides compared the dose, medication, route, and resident name to ensure they both stated the same information. The DON stated if the medication aide saw a discrepancy they should immediately stop and find the nurse to determine whether the blister pack label or MAR is correct. The DON stated the nurse should then put a sticker that stated Directions changed, refer to chart on the blister pack as needed. The DON stated they compared the MAR to the blister pack to ensure the right resident received the right medication. The DON stated if a medication was administered incorrectly, it could cause a resident unnecessary side effects or harm. The DON stated the labels needed to be on the enteral feeding bags so that nurses were aware the resident received the correct feeding because if it was not labeled appropriately, a resident could receive the wrong feeding, which could cause the resident harm. Record review revealed the facility policy titled Medication Administration implemented on 10/24/22 stated the following: Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Record review of the Enteral Tube Medication Administration Policy, revised 10/01/19, stated the following: the facility assures the safe and effective administration of enteral formulas and medication via enteral tubes. Check the medication administration record to confirm the order: note the medication, dose, route, and volume of water for flushing.

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	04/03/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50039 50969 Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of 7 medication carts and 1 of 3 medication rooms reviewed for medication storage. 1) Medication room on B-hall was left unlocked at 7:37 AM on 04/01/25. 2) Medication room on B-hall was left unlocked at 5:01 PM on 04/02/25. 3) Medication cart on A-hall was observed unlocked at 4:33 PM on 04/02/25. These failures could place residents in the facility at risk of drug diversion or misuse of medications leading to harm. Findings included: During an observation at 7:37 AM on 04/01/25, the medication room on B-hall was left unlocked. This state surveyor opened the door without any key and gained entrance. A basket of various medications was found inside the medication room. During an observation at 4:33 PM on 04/02/25, the medication cart on A-Hall was observed unlocked, and at 4:35 PM ADON-B was observed walking by and locked this cart. During an observation at 5:01 PM on 04/02/25, the medication room on B-hall was left unlocked. This state surveyor opened the door without any key and gained entrance. A basket of various medications was found inside the medication room. During an interview with ADON B at 4:36 PM on 04/02/25, she stated she noticed the cart unlocked, so she walked over to lock it. She stated the cart belonged to RN B. She stated some of the nurses were bad about leaving their carts unlocked, but this nurse was usually pretty good about locking her medication cart. She stated the nurses and medication aides had recently been in-serviced about locking the medication carts and medication rooms, so they knew better. ADON B stated if medication carts or rooms were left unlocked, a resident could access medications that did not belong to them, and this could cause them harm if ingested. During an interview with RN B at 4:50 PM on 04/02/25, she stated she never left her medication cart unlocked because she knew a resident could get into medication that could harm them. She stated she must have been distracted and did not pay attention when she walked away from her medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with ADON A at 5:03 PM on 04/02/25, ADON A stated medication rooms should have always been locked. ADON A stated she did not know there were any medications in the medication room on B-hall. ADON A stated she thought the facility was only using the medication rooms on A-hall and D-hall. ADON A stated the basket of medications looked like medications set for destruction. ADON A stated anybody could have gotten into the medication room and stolen or ingested some medications, causing them harm. During an interview with the DON at 5:17 PM on 04/02/25, the DON stated she did not know any medications were stored in the medication room on B-hall. The DON stated they had only been using the medication rooms on A-hall and D-hall. The DON stated any room with medications in it should be locked at all times. The DON stated employees should lock medication carts any time they step away from them. The DON stated medication rooms and carts were locked to keep any unauthorized people out of the rooms, so residents did not ingest any medications and to prevent any possible theft. During an interview with LVN A at 5:59 PM on 04/02/25, LVN A stated she was the current charge nurse for B-hall. LVN A stated she had not been in the B-hall medication room today. LVN A stated she found the medication room unlocked around 2:45 PM and proceeded to lock it at that time. LVN A stated a medication aide asked for the key to the room around 3:30 PM that day, so she gave it to him briefly. LVN A stated she did not observe the medication aide to see if he locked the door back after exiting the room. LVN A stated she did not think there were any medications in the medication room on B-hall. LVN A stated she did not use that room for anything. LVN A stated she thought the facility was only using the medication rooms on A-hall and D-hall. LVN A stated she had never seen anyone put medications in the medication room on B-hall. LVN A stated it was important to keep medications locked up to prevent any unauthorized person from gaining access to them and ingesting or stealing them. During an interview with the ADM at 1:01 PM on 04/03/25, this state surveyor asked for a facility policy regarding the proper storage and security of medications in medication rooms. The ADM stated he would look for an appropriate policy. During an interview with the ADM at 1:40 PM on 04/03/25, the ADM stated they did not have a policy on the proper storage of medications in medication rooms, but they would make one soon. Record review of the facility ' s Medication Administration: Medication Carts and Supplies for Administering Meds policy, revised 10/01/19, revealed The medication cart is locked at all times when not in use. Do not leave medication cart unlocked or unattended in the resident care areas.