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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo West Nursing and Rehabilitation Center	1200 E Lane St 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation.1. The facility failed to ensure that eggs were stored on the bottom shelf of the refrigerator.2. The facility failed to ensure food items in refrigerator 2 were labeled and dated.3. The facility failed to ensure that there were no personal items stored in refrigerator 2.4. The facility failed to ensure that leftovers were discarded within 72 hours.5. The facility failed to ensure that items labeled keep frozen were kept in the freezer.6. The facility failed to ensure that food items in freezer 3 were labeled and dated. 7. The facility failed to ensure the kitchen was following their policies.These failures could place residents who consumed food from the kitchen at risk for food borne illness. Observation of the facility's reach in refrigerator 1 on 5/19/2026 at 6:05am revealed A blue carton of 18 eggs was on the top shelf instead of the bottom shelf in the refrigerator.Observation of the facility's reach in refrigerator 2 on 5/19/2026 at 6:10am revealed the following:A Sysco plastic 2-gallon sized bag containing approximately 20 hot dogs was not labeled or dated.A grocery-type plastic bag was not dated or labeled and contained a plastic container with an unknown substance, in which the DA stated was her personal item.An original container labeled Smoked Chicken Salad had been opened with a date of 3/31 written on top in black marker had not been discarded within 72 hours after being opened.Observation of the facility's reach in refrigerator 3 on 5/19/2026 at 6:15am revealed an original full box of Eggo frozen buttermilk pancakes and a partial open box of Eggo frozen buttermilk pancakes stated Store frozen at 0 degrees.Observation of the facility's reach in freezer on 5/19/2026 at 6:21am revealed a white box containing approximately 10 ice cream sandwiches that were not dated.During an interview with the DA on 5/19/2026 at 6:05am, she stated they were out of eggs, and they had to run to the store and get the eggs and did not place the eggs on the correct shelf.During an interview with DA on 5/19/2026 at 6:10am, the DA stated the hot dogs should have been labeled and dated before placing the hot dogs in the refrigerator and that her personal items should be stored in the employee refrigerator, and that the chicken salad should have been discarded. The DA also stated they regularly store the Eggo pancakes in the refrigerator because microwaving the pancakes out of the freezer does not cook the pancakes evenly. The DA stated residents could get sick from eating items that are expired or have spoiled during storage.During an interview with the DM on 5/19/2026 at 2:00pm, the DM stated the expectations are for staff to follow the proper food storage processes including labeling and dating all food, keeping personal items out of the kitchen refrigerators, and to throw items away within a timely manner. The DM stated that the ice cream sandwiches and the chicken salad were bought for the residents to consume during activities, and all staff should be aware of the food storage policy and process.During an interview with the DM and the RD on 5/21/2026 at 9:00am they both stated in-services for proper storage of items (including the Eggos stored frozen, the label and dating of hotdogs, and discarding items after they are open) were in process. The RD stated it is expected for staff to throw items in the trash that have no label, are expired, or have been opened for an unknown amount of time. The RD stated if a resident was given undated or expired food, the resident could get sick but stated she had not seen that happen at this (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility.During an interview with the Administrator on 5/21/26 at 2:30pm, he stated it is the responsibility of and expectation that the dietary staff followed the policy and standards set in labeling and storing food items in the kitchen. The Administrator stated he did not think the food would be served to residents as staff should be checking items again to ensure the item is safe for consumption. The Administrator stated this was a storage error, not a service error.Record review of the facility's Food Storage Policy, Policy Number 03.003, dated October 1,2018 and revised on June 1, 2019, that was provided by the facility when asked for stated in part: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes and HACCP guidelines.2. Refrigeratorsd. Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.e. Use all leftovers within 72 hours. Discard items that are over 72 hours old.f. Store raw meats and eggs on the bottom shelf to prevent contamination of other foods. To avoid cross-contamination, store raw or uncooked food and produce away from and below prepared or ready-to-eat food.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for 1 (Resident #95) of 25 residents reviewed for call lights. The facility failed to ensure Resident #95 had the call light within reach while in bed in their room. This failure could place residents at risk of being unable to obtain assistance or help when needed and in the event of an emergency. Findings included: Record review of Resident #95's face sheet, dated 05/20/2026, reflected a [AGE] year-old male with diagnoses of Type 2 Diabetes Mellitus with Hyperglycemia (a chronic condition where your body either resist the effects of insulin or does not produce enough of it, causing sugar to build up in your bloodstream), Muscle Wasting And Atrophy Multiple (a systemic condition, a nerve disorder, or severe physical deconditioning rather than a localized injury). Record review of Resident #95's Quarterly MDS assessment, dated 04/03/2026, reflected a BIMS score of 14 indicating intact cognition. Record review of Resident #95's care plan, dated 03/20/20, reflected has ADL self-care performance deficit related to disease process history of Cerebrovascular Accident (a medical term for stroke. It happens when blood flow to a part of the brain is blocked), Impaired balance, interventions: resident was totally dependent on 2 staff for transferring. During an observation on 05/19/2026 at 8:40 a.m., Resident #95's call light device was behind the bed frame and Resident #95 was not able to reach it. During an interview on 05/19/2026 at 8:45 a.m., RN D said Resident #95 usually used the call light when he needed something. She said she always made sure residents had the call light within his reach and reminded him to use it. RN D said that if a resident could not reach the call light, then they cannot get help, they may have a fall and be at risk of getting hurt. During an interview on 05/21/2026 at 12:10 p.m., the DON said that if call lights were not within reach, residents might need help and could not get it. The DON said Resident #95 was not able to call if he needed something. Record review of facility's policy titled, Call Lights: accessibility and timely response, dated: 10/13/2022, stated: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for 1 (Resident #67) of 6 residents reviewed for foot care. The facility failed to provide adequate foot care to Resident #67. This failure could put residents at risk for infection, impaired mobility, and poor foot health as well as a decline in their quality of life. Findings included:Record review of Resident #67's admission record, dated 05/20/26, reflected a [AGE] year-old male admitted on [DATE]. His relevant diagnoses included chronic systolic heart failure (occurs when the heart's main pumping chamber weakens and cannot contract effectively), cognitive communication deficit (difficulty with communication arising from underlying impairments in thinking process), hemiplegia (a form of paralysis that affects only one side of the body), hemiparesis (a weakness or partial loss of movement on one side of the body), and reduced mobility.Record review of Resident #67's quarterly MDS assessment, dated 04/14/26, reflected a BIMS score of 2, which indicated his cognition was severely impaired. Resident #67 was coded as dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for personal hygiene. Record review of Resident #67's quarterly care plan, dated 04/08/26, reflected:Problem: The resident has an ADL self-care performance deficit t hemiplegia, limited ROM, stroke, and cognitive impairment. Date initiated and revised 03/01/24. His interventions included bathing/showering: check nail cleanliness, length, and trim as needed on bath day and prn. Report any changes to the nurse. Date initiated 05/16/24.Record review of Resident #67's weekly skin assessments dated 04/28/26, 05/05/26, and 05/12/26, authored by the WCN reflected Foot evaluation completed and no new skin issues found on this evaluation.During an observation and interview on 05/19/26 at 7:42 a.m., Resident #67 was observed lying in bed awake. His right food was uncovered and noted his right great toenail was approximately 1.5 inches long, discolored, and curled. Resident #67 said there had been times when his bed sheet would get tangled with his long toenail and caused pain. Resident #67 was not able to say if he had notified staff his toenail was too long. During an interview on 05/19/26 at 8:05 a.m., CNA H said she was assigned to Resident #67's hall. CNA H said if she were to notice a resident needed to have their toenails trimmed, she would inform their charge nurse. She said Resident #67 was bathed by hospice CNAs. She said she provided care to Resident #67 on a daily basis and had not noticed his right foot toenail. CNA H was not able to say if there were any negative outcomes to Resident #67 having his right foot toenail long. During an interview and observation on 05/20/26 at 3:31 p.m., LVN I said she had recently been hired and was assigned to Resident #67's hall. She was observed as she assessed Resident #67's right great toe and said, It's about 2 inches long, gray with yellow in color. She was observed as she reviewed Resident #67's electronic medical record and said he did not have any orders preventing him from receiving foot care. LVN I said she had not been informed by CNAs that Resident #67 needed foot care, and she had not noticed either. LVN I said a negative outcome for Resident #67 having any toenail that long would be he could stub his toe on something, skin tear, and overall, just uncomfortable.During an interview and observation on 05/20/26 at 4:27 p.m., the ADON was observed as she entered Resident #67's room to assess his right great toenail and said, Oh wow. The ADON described Resident #67's great toenail as 5 cm long, off white, yellowish with a little dark color. The ADON said Resident #67 received hospice care. She said the hospice agency sent their CNAs to bathe him three times a week. The ADON said the hospice CNAs had not informed the facility Resident #67 needed his toenails trimmed. The ADON said even though Resident #67 received hospice, it was still the facility's responsibility to ensure proper foot care was provided. The ADON said the facility's CNAs and nursing staff had daily contact with Resident #67 and they should have noticed and reported his long toe nail. The ADON said the WCN conducted weekly skin assessments on all residents. The ADON said the facility staff had several opportunities to notice Resident #67's toenails (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and missed it. The ADON the facility contracted with a podiatrist to provide footcare to residents. She said facility staff would include the resident's that needed foot care on the podiatrist list. She said she did not recall Resident #67 being on the podiatrist list for a while. The ADON said a negative outcome to Resident #67 having his right great toenail that long would be pain and possibly infection.During an interview on 05/21/26 at 3:05 p.m., the WCN said she conducted weekly skin assessments on all residents. She said she would normally not note long toenails on her assessments unless they looked infected. She said during her weekly skin assessment she would look for skin breakdown, redness, bruising and discoloration. The WCN said even though Resident #67's long toenail had not been noted on his weekly skin assessments, she should have advised his charge nurse to ensure he was put on the podiatrist list. The WCN said a negative outcome to Resident #67 having his right foot great toenail that long would be the possibility of getting infected. During an interview on 05/21/26 at 3:40 p.m., the DON said Resident #67 was a hospice patient. She said even though, Resident #67 was under hospice, it was the facility's responsibility to ensure proper foot care was provided. The DON said a negative outcome to Resident #67 having his toenails long would be pain. The DON said the facility did not have a policy on foot care. During an interview on 05/21/26 at 3:40 p.m., the DON said Resident #67 received hospice care. She said even though Resident #67 received hospice, it was the facility's responsibility to ensure proper foot care was provided. The ON said a negative outcome to Resident #67 having his toenail long would be pain. The DON said the facility did not have a policy on Foot Care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 8 residents (Resident #61) reviewed for hazards: The facility failed to ensure Resident #61 did not have a disposable razor in his restroom. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health.Findings included: Record review of Resident # 61's admission record, dated 05/19/26, reflected an [AGE] year old male admitted [DATE]. His relevant diagnoses included need for assistance with personal care, muscle weakness, and lack of coordination. Record review of Resident #61's quarterly MDS assessment, dated 04/15/26, reflected a BIMS score of 14, which indicated his cognition was intact. Resident #61 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for personal hygiene. Record review of Resident #61's quarterly care plan, dated 03/30/26 reflected:Problem: [Resident #61] has an ADL self-care performance deficit r/t left BKA, left upper limb amputation, dementia. Date initiated/revised 11/15/23. Interventions included personal hygiene routine: [Resident #61] prefers to perform own personal hygiene/oral care. Date initiated/revised on 08/19/24. During an interview and observation on 05/19/26 at 8:07 a.m., Resident #61 was observed sitting on his bed watching television. Resident #61 said he was able to dress, groom, and shave on his own. With Resident #61's permission, this Surveyor observed his restroom. A clear plastic cup with one disposable blue razor and three small tubes of toothpaste was observed on the sink. Resident #61 said he would use the razor to shave. Resident #61 was not able to say how long the razor was in the restroom. During an interview on 05/19/26 at 8:13 a.m., CNA H said Resident #61 was independent for all ADLs and only required set-up for shaving. She said whenever Resident #61 needed to shave, a CNA would get a razor from the supply room and when done, CNAs were supposed to ensure the razor was disposed of. CNA H said she would round residents every two hours or as needed and had not noticed the disposable blue razor in Resident #61's restroom and was not able to say how long it was there. CNA H said residents were not allowed to have razors in their rooms for their safety and the safety of others. She said all sharps were kept in the supply room under lock and key and only charge nurses had the key. CNA H said a negative outcome for Resident #61 having a razor in his restroom could be the possibility of cutting himself or others. CNA H said she had been in-serviced on the topic of resident safety and sharps. During an interview on 05/19/26 at 8:37 a.m., LVN G said Resident #61 was independent for his ADLs and only required set up for shaving. LVN G said sharps were not allowed in residents' rooms. LVN G said all sharps were stored in the supply room under lock and key and only charge nurses had the key. LVN G said all staff that went into Resident #61's room were responsible for to ensure no sharps were kept in residents rooms. LVN G said she would round residents every two hours or as needed but had not noticed the disposable blue razor in Resident #61's room and was not sure how long it had been there. LVN G said nursing staff had been in-serviced on the topic of resident safety and sharps. LVN G said a negative outcome for Resident #61 having a razor in his room could be that he court hurt himself or others. During an interview on 05/20/26 at 4:44 p.m., the ADON said Resident #61 was independent for most ADLs and only required set-up for shaving. The ADON said razors were not allowed to be stored in resident's rooms. She said all razors were kept under lock and key in the supply room, and only charge nurses had the key. The ADON said whenever a resident wanted to shave, their CNA would request the key from the nurse to get a razor. The ADON said Resident #61 would frequently go out on pass and when would come back he would bring things. She said they did not inspected his bags of purchased goods and that maybe he had purchased the razors and kept them in his room without letting staff now. The ADON said (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ultimately, it was the facility's responsibility to ensure no razors or any type of sharps were kept in a resident's room. She said housekeeping staff, CNAs, and other staff that would go into a resident's room had the responsibility of ensuring no razors or any type of sharps were in their rooms. During an interview on 05/21/26 at 8:05 a.m., the DON said Resident #61 was independent for ADLs and only required set-up for shavings. She said Resident #61 would frequently go out on pass and when he returned to the facility he would bring bags of items he had purchased. She said the nursing would not inspect his bags and they would not know what was in the bags unless Resident #61 told them. The DON said nonetheless, it was the facility's responsibility to ensure no sharps which included razors were stored in the resident's rooms. She said the facility's protocol for razors were to keep them under lock and key and only the charge nurses had the key. The DON said it was the CNAs responsibility to ensure that once a resident was done shaving, the razor was disposed of. The DON said ultimately, all staff were responsible to ensure resident's safety. The DON said all staff were in-serviced on the topic of resident safety, which included sharps. The DON said a negative outcome for Resident #1 keeping a razor in his room would be that he could hurt himself. The DON said the facility did not have a policy regarding resident safety or sharps.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 1 of 3 resident (Resident#7) reviewed for indwelling catheters. The facility failed to prevent Resident#7's urinary catheter tubing (bag) from touching the floor. This failure could place residents at risk for cross contamination and urinary tract infections. Findings included: Record review of Resident#7's face sheet, dated 05/20/2026, revealed a [AGE] year-old female admitted on [DATE]. Resident #7 had admitting diagnosis of neuromuscular dysfunction of the bladder, unspecified (a loss of bladder control caused by nerve damage from diseases or injuries like stroke, diabetes or spinal cord damage). Record review of Resident #7's care plan, dated 10/2/2025, revealed Resident #7 has a indwelling catheter r/t to neurogenic bladder (occurs when nerve damage interrupts the communication between your nervous system and bladder muscles), initiated 03/19/2026 and revised on 03/19/2026, with interventions including position catheter bag and tubing below the level of the bladder and away from entrance room door. Record review of Resident #7's Quarterly MDS assessment, dated 3/6/26, Section C-Cognitive patterns, revealed Resident #7 had a BIMS score of 99 which indicated Resident #7 was unable to complete the interview. Section H-Bladder and bowel revealed Resident #7 had an indwelling catheter. Record review of Resident #7's Physician Order Summary, dated 05/20/2026, revealed an order for an indwelling catheter 16 # French with 10 milliliters balloon as needed for plugged or out (a flexible, sterile tube inserted through the urethra into the bladder to continuously drain urine. The [NAME] is inflated with sterile water inside the bladder to act as an anchor, preventing the catheter from slipping out). The order instructed indwelling catheter care every shift and as needed starting 02/28/26. During an observation and interview on 05/19/2026 at 8:35 a.m., Resident #7's indwelling catheter bag was noted dragging on the floor while the resident was in her bed. Resident was not able to verbalize. During an interview on 05/19/2026 at 8:38 a.m., RN E was informed catheter bag was dragging on the floor. She stated it should not be touching the floor. She replied that a negative outcome of indwelling catheter bag being on the floor the catheter wouldn't drain well and pick up bacteria from floor. During interview with DON on 05/21/2026 at 12:10 p.m., she stated that no, it should not be touching the floor, if on the floor, the tubing and the bag should be changed immediately. She stated the negative outcome was that Resident #7 could get an infection or the bag could get ripped. The DON stated that the facility did not have a policy for indwelling catheters.

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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** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 2 (Resident #11 and Resident #39) of 5 residents reviewed for enteral feeding.1. The facility failed to ensure Resident #39's enteral feeding administration supplies were labeled and dated on 05/19/26.2. The facility failed to ensure Resident #11's enteral feeding administration supplies were labeled and dated on 05/20/26.These failures could affect residents receiving enteral nutrition and hydration and place them at risk of health complications and decline in health.The findings included:Record review of Resident #39's admission record on 05/21/26 reflected an [AGE] year-old male who was originally admitted to the facility on [DATE] with most recent admission on [DATE] and discharged on 05/20/26. His diagnoses included vascular dementia (problems with thought processes and memory caused by brain damage from impaired blood flow), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high), unspecified protein-calorie malnutrition (a state of inadequate nutrient intake), aphasia and dysphagia following cerebral infarction (an impairment in the ability to speak and difficulty swallowing after a stroke), and gastrostomy status (a tube surgically implanted through the abdomen into the stomach used to provide nutrition, hydration, and medication).Record review of Resident #39's care plan on 05/21/26 dated 05/12/26 reflected he required tube feeding (nutrition provided through his gastric tube). The goal was he would be free of aspiration (inhalation of tube feed formula into the windpipe and lungs) through the review date. There were no interventions listed.Record review of Resident #39's order summary on 05/19/26 reflected the following orders:Enteral feed order: every 8 hours for 3 days related to gastrostomy status- Start Jevity 1.5 at 20 ml/hr and gradually advance tube feed by 10 ml every 8 to 9 hours to goal rate of 70 ml/hr for 18 hours. Downtime: 7:00 am to 1:00 pm. Ordered 05/18/26 to start 05/19/26 at 7:00 am.Enteral feed order: every 6 hours related to gastrostomy status- Flush tube with 180 of ml of water every 6 hours. Ordered 05/18/26 to start 05/18/26 at 8:00 pm.An observation on 05/19/26 at 8:56 am reflected Resident #39's tube feed administration bag was hanging on a pole with administration tubing going into a feeding tube pump running at 20 ml/hr and connected to his gastric tube. The tube feed administration bag was not labeled with his name, his tube feed formula, the rate it was supposed to be administered, how much water he was supposed to receive and how often, or the date and time the tube feed formula was started. The bag contained approximately 800 ml of tube feed formula.An inspection on 05/21/26 at 3:09 pm of the cabinet where resident's tube feed formula containers and supplies were stored reflected the cabinet contained approximately 35- 8 ounce (237 ml) cartons of Resident #39's tube feed formula. The back of the carton stated in part, Instructions for use: .Once opened, reclose, refrigerate, and use within 48 hours.Record review of Resident #11's admission record on 05/21/26 reflected a 51-[NAME]-old male originally admitted to the facility on [DATE] with most recent admission on [DATE]. His diagnoses included nontraumatic intracerebral hemorrhage in subcortical hemisphere (bleeding in the functional tissue of the brain not caused by an external force), muscle wasting and atrophy (loss of muscle mass and strength), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high), and gastrostomy status (a tube surgically implanted through the abdomen into the stomach used to provide nutrition, hydration, and medication).Record review of Resident #11's quarterly MDS dated [DATE] reflected no BIMS score and a Cognitive Skills for Daily Decision Making score of 3 which indicated he was severely impaired and never/rarely made decisions.Record review of Resident #11's care plan dated 01/29/26 reflected he required a feeding tube due to dysphagia related to a stroke. His goals included he would be free of aspiration, side effects or complications related to tube feeding. Interventions included Resident #11 was dependent (continued on next page)

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	455528	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo West Nursing and Rehabilitation Center	1200 E Lane St 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 1 staff member with tube feeding and water flushes. All initiated on 02/13/26.Record review of Resident #11's order summary on 05/19/26 reflected the following orders:Enteral Feed Order: One time a day- Glucerna 1.5 at 75 ml/hr for 20 hrs via gastric tube stationary pump. Down time: 7:00 am to 11:00 am. Turn off pump at 7:00 am. Turn on pump at 11:00 am. Started on 04/13/26 at 11:00 am.Enteral Feed Order: Every 6 hours- Flush tube with 240 ml of water. Started on 04/13/26 at 12:00 pm.An observation on 05/20/26 at 4:45 pm, reflected Resident #11's tube feed administration bag was hanging on a pole with administration tubing going into a feeding tube pump running at 75 ml/hr and connected to his gastric tube. The tube feed administration bag was not labeled with his name, his tube feed formula, the rate it was supposed to be administered, how much water he was supposed to receive and how often, or the date and time the tube feed formula was started. Resident #11's enteral feed syringe (used for medication administration and water flushes) was not dated.In an interview on 05/21/26 at 8:52 am, LVN A stated he did not notice the tube feeding formula bag was not labeled on 05/20/26. He stated it was important enteral feeding bags or containers were labeled to keep up with infection control and make sure the tube feeding formula was changed every day. LVN A stated the label was also important to know the correct formula, the rate, and when and how much water to flush.In an interview on 05/21/26 at 11:12 am, LVN G stated usually the night nurse changed the tube feeding and supplies. She stated it was the responsibility of all of the nurses to ensure everything was changed and dated correctly. LVN G stated she had not been the nurse for Resident #39.In an interview on 05/21/26 at 1:19 pm, the DON stated it was important to label tube feed bags to know what formula the resident was receiving, the flow rate and date it was changed to prevent the tube feed from spoiling. The DON stated nurses were checked off on tube feed administration upon hire and annually.In an interview on 05/21/26 at 2:06 pm, RN D stated she worked on 05/19/26 from 6:00 am to 2:00 pm. She stated she did not hang Resident #39's bag of tube feed formula. RN D stated she turned the tube feeding pump off when she got to work and she did not check the tube feed bag to see if it was labeled because she forgot. RN D stated she did not turn the tube feeding pump back on, but she did inform the nurse that she gave report to about the gradual increase in the tube feed rate. She stated it was the night nurse's responsibility to change out and label the tube feed bags. She stated it was important to label tube feeds to ensure the right resident, the right formula and that it was not hung for over 24 hours. RN D stated if the tube feed formula was up for over 24 hours it could cause stomach upset or vomiting and if the wrong formula was given it could cause gastrointestinal issues or blood sugar issues. RN D stated if she found unlabeled tube feed supplies, she discarded what was used and get all new supplies.A policy on tube feeding (enteral feeding) was requested; however, the facility was not able to provide it.A skills check off for tube feeding (enteral feeding) administration was requested; however, the facility was not able to provide it. The facility provided an Enteral Tube Site Care Competency Assessment, but it did not address enteral feeding administration or supply usage.

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Laredo West Nursing and Rehabilitation Center	1200 E Lane St Laredo, TX 78043

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 6 (Resident #51 and Resident #29) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #51's oxygen tubing was not touching the floor on 05/19/2026. 2. The facility failed to post an Oxygen sign indicating Resident #51 received oxygen on 5/19/2026. 3. The facility failed to ensure Resident #29's oxygen was administered at the correct setting of liters per minute on 05/19/26 as ordered by the physician. These failures could place residents at risk of developing respiratory complications, a decreased quality of care, and fire hazards by not posting oxygen signs outside the residents' rooms. Findings included: 3.Record review of Resident #29's admission record, dated 05/19/26, reflected a [AGE] year-old female readmitted [DATE] and admitted [DATE]. Her relevant diagnoses included pneumonia (an infection that inflames the air sacs in one or both lungs), and respiratory failure (when lungs cannot get enough oxygen into the blood or fail to properly remove carbon dioxide from it). Record review of Resident #29's quarterly MDS assessment, dated 04/1/26, reflected a BIMS score of 13, which indicated her cognition was intact; and was on respiratory therapy. Record review of Resident #29's quarterly care plan indicated it was still in progress. Record review of Resident #29's physician's order summary, dated 05/18/26, reflected an order for Oxygen at 3 LPM via nasal cannula continuously, every shift for hypoxia related to acute and chronic respiratory failure, unspecified whether with hypoxia (deprived of adequate oxygen supply) or hypercapnia (high levels of carbon dioxide in bloodstream). Order date and start date of 05/18/26. During an interview and observation on 05/19/26 at 12:25 p.m., Resident # 29 was observed lying in bed awake, receiving oxygen via nasal cannula. Resident #29 said she required continuous oxygen. Observation indicated Resident #29's oxygen concentrator was set at 2 LPM. Resident #29 said she was not in distress. During an interview and observation on 05/19/26 at 12:32 p.m., LVN G was observed as she reviewed Resident #29's electronic medical record and said Resident #29 had an oxygen order for 3 LMP effective 05/18/26. LVN G was observed as she checked Resident #29's oxygen concentrator and said it was set at 2 LPM. LVN G said she I just checked [Resident #29's] O2 at 11:43 a.m., and it was at 98% via an oximeter. LVN G said she failed to check Resident #29's O2 settings when she had gone in her room at 11:43 a.m., to check her O2 level. LVN G said nursing staff were supposed to check the oxygen concentrator's setting per shift. LVN G said nursing staff regularly received in-services on the topic of respiratory care which included oxygen settings. LVN G said a negative outcome for Resident #29 not having her oxygen setting as ordered could be her oxygen level could drop. During an interview on 05/19/26 at 12:40 p.m., the ADON said Resident #29 was dependent on continuous oxygen. She sand nursing staff were supposed to check a resident's oxygen concentrator settings per shift to ensure it's at the correct settings. The ADON said nursing staff were regularly (continued on next page)

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Laredo West Nursing and Rehabilitation Center	1200 E Lane St Laredo, TX 78043

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-serviced on the topic of respiratory services which included oxygen settings. During an interview and observation on 05/21/26 at 7:44 a.m., the DON said Resident #29 had recently been re-admitted after a hospital stay. The DON said nursing staff were responsible in checking a resident's O2 settings per shift. The DON was observed as she reviewed Resident #29's electronic medical record and said she had a continuous oxygen order for 3 LPM via nasal cannula. The DON said a negative outcome for Resident #29 not having her O2 setting as ordered could be desaturation. The DON said the facility did not have a policy related to oxygen. Findings included: 1/2. Record review of Resident #51's face sheet, dated 05/20/2026, revealed an [AGE] year-old female admitted [DATE]. Pertinent diagnosis included Chronic Respiratory Failure with Hypoxia (an ongoing condition where your lungs cannot adequately transfer oxygen into the blood). Record review of Resident #51's Care Plan, dated 12/15/2023, revealed, Resident #51 has oxygen therapy r/t Chronic Respiratory failure with hypoxia with interventions oxygen settings: O2 via nasal Cannula, as per MD order. Record review of Resident #51's physician orders, dated 05/20/2026, revealed an order for O2 at 2-5 LPM as needed for SOB. During an observation on 05/19/2026 at 8:25 a.m., Resident #51 was in her room lying on the bed. She was wearing a nasal canula and was receiving oxygen at 2 liters per minute. The oxygen tubing was touching the floor without a protective sleeve. There was no oxygen sign posted outside of his room. During an interview on 05/19/2026 at 8:27 a.m., RN D stated she was the nurse for Resident #51. She stated that all the staff were responsible for posting the oxygen sign outside the residents' rooms. RN D stated Resident #51 did not have an oxygen sign posted outside his room. She stated all residents who were on oxygen regardless of needing it continuously or prn, they all need a sign. RN D stated that it was important for the oxygen tubing not to touch the floor because it could get contaminated and Resident #51 could get an infection. RN D stated that it was important for posting an oxygen sign outside the resident's rooms, so no one smoked and to make everyone in the facility aware there was oxygen in use inside the room for safety. During an interview on 04/14/2026 at 8:45 a.m., the DON stated that anybody could post the oxygen sign on the outside of the residents' room, but it was the responsibility of the admitting nurse. The DON stated that it was important for the oxygen sign to be posted for everyone to know that there was oxygen in use in that room. She stated that she did random compliance rounds. The DON stated she was not sure if the tubing touching the floor was against their policy. Record review of facility's policy titled, Oxygen Safety, dated 01/26/2024, revealed: It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. No smoking signs will be utilized to clearly identify oxygen is in use before connecting the oxygen supply, and will remain in place until oxygen administration has been discontinued.

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Laredo West Nursing and Rehabilitation Center	1200 E Lane St Laredo, TX 78043

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were labeled and stored appropriately for 1 of 3 residents (Resident #11) reviewed for labeling and storage. The facility failed to put an open date for Resident #11's Insulin Glargine Solution 100 UNIT/ML on 5/19/2026. These failures could have placed residents at risk of not receiving the therapeutic effects of the medication. The findings included: Review of Resident #11's admission Record, dated 05/20/26, revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] with diagnosis including Type 2 Diabetes Mellitus with Hyperglycemia (a chronic condition where your body either resist the effects of insulin or does not produce enough of it, causing sugar to build up in your bloodstream). Review of Resident #11's Care Plan dated 01/29/26 revealed: initiated on 02/13/26 Focus: Resident #1 has Diabetes Mellitus Interventions: diabetes medication as ordered by doctor. Review of Resident #11's quarterly MDS Assessment, dated 05/06/26 revealed he had a diagnosis of Diabetes Mellitus. Review of Resident #11's Order Summary Report, dated 05/20/26, revealed Insulin Glargine Solution 100 UNIT/ML inject 20 unit subcutaneously at bedtime for Diabetes Mellitus. During an observation on 05/19/2026 at 6:13 a.m., of the A wing Hall Medication Cart with LVN C , revealed the Resident #11's Insulin Glargine Solution 100 UNIT/ML did not have an open date. During an interview on 03/18/26 at 10:32 a.m., LVN F stated that the insulin should be labeled with an open date. He stated that the person responsible for labeling the bottles was the person who initially opened them. LVN F stated that they need to know when the insulin was opened, so they know when it expires. During an interview on 05/21/2026 at 12:00 p.m., the DON stated that Insulin Glargine should have an open date. DON stated that it was important to have an open date because the medications had a life span and without an open date could not track when the insulin was opened. Record review of the facility's Medication Storage and Disposal policy, with a revision date 10/01/19, revealed all medications received from the pharmacy will have an expiration or beyond use date clearly stated on the label or medication container.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption for 1 of 8 resident refrigerators reviewed for refrigerator sanitation. The facility failed to ensure resident's personal refrigerators were maintained. Resident #96's personal refrigerator had 1 half pint 1 % low fat milk carton with an expiration date of 04/06/26.This failure could place residents who store food items in resident refrigerators, at risk of cross-contamination and food-borne illnesses if consumed. Finding included:Record review of Resident #96's admission record, dated 05/21/26, reflected a [AGE] year old male with an admit date of 04/15/26 and an admission date of 05/29/25. His relevant diagnoses included cerebral infarction (when blood flow to an area of the brain is disrupted, causing brain tissue to die from a lack of oxygen and nutrients), and epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures).Record review of Resident #96's quarterly MDS assessment, dated 05/07/26, reflected a BIMS score of 10, which reflected his cognition was moderately impaired.Record review of Resident #96's Refrigerator Temperature Log reflected his personal refrigerator was last inspected on 05/17/26. During an interview and observation on 05/19/26 at 8:32 a.m., Resident #96 was observed lying in bed awake. He said he was personal refrigerator where he liked to keep drinks he said the facility staff would inspect it daily and would check it's contents. Resident #96 said he was dependent on his wheelchair for mobility. He said he was dependent on staff to place something in or out of his personal refrigerator. With Resident #96's permission, this surveyor inspected the inside of his personal refrigerator and found a half a pint 1 % milk carton with an expiration date of 04/06/26. Resident #96 said he was not sure hold long the expired milk carton had been in the refrigerator. During an interview and observation on 05/19/26 at 8:40 a.m., the Environmental Supervisor said housekeeping staff were responsible to all personal refrigerators on a daily basis and to check it's contents for any expired food. The Environmental Supervisor said all personal refrigerators had a log taped to the door where the housekeeping staff would log the daily temperature. The Environmental Supervisor was not able to say how having an expired milk carton in Resident #96's personal refrigerator could negatively impact him. During an interview on 05/21/26 at 8:30 a.m., the DON said residents were allowed to have personal refrigerators in their rooms. She said the housekeeping staff were responsible to check their temperature and to check it's contents for any expired food. The DON said a negative outcome to Resident #96 for having expired food in his personal refrigerator could be he could have gotten sick. Record review of the facility's Resident Refrigerators policy dated 07/03/23, reflected:Policy: This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerator.Policy Explanation and Compliance Guidelines:.3. Staff shall clean the refrigerator weekly and discard any foods that are out of compliance. Nursing staff shall clean up spills as needed or refer to housekeeping staff.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices, on each resident that are- complete; accurately documented; readily accessible; and, systematically organized for 2 of 6 residents (Resident #130 and Resident #115).1. The facility failed to maintain medical records for Resident #130's progress notes, and dialysis communication sheet from 3/31/26, 4/2/26 and 4/4/26 that were complete and accurate.2. The facility failed to accurately document Resident #115's verbal behaviors towards staff in his electronic medical record This failure could place residents at risk of not recording a proper account of medical interventions, treatments, and outcomes during a residents' stay. The Findings included: 2.Record review of Resident #115's admission record, dated 05/19/26, reflected a [AGE] year-old male with an admission date of 08/10/18. His relevant diagnoses included dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life), cerebral infarction (occurs when blood flow an area of the brain in disrupted, causing brain tissue to die from a lack of oxygen and nutrients), absence of left upper limb, and absence of left leg below knee. Record review of Resident #115's quarterly MDS assessment dated [DATE], reflected a BIMS score of 12, which indicated his cognition was moderately impaired. Record review of Resident #115's quarterly care plan, dated 03/03/26, reflected: Problem: [Resident #115] has hx of being physically aggressive.date initiated 01/21/26 and revised on 02/13/26. Interventions included when [Resident #115] becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff walk away calmy, and approach later, date initiated 01/21/26. During an interview and observation on 05/19/26 at 8:00 a.m., Resident #115 was observed sitting in wheelchair watching television. His room had pile of items against the wall and his trash can was half full. Resident #115 emphasized he did not like anyone touching his personal belongings. During an interview on 05/19/26 at 8:21 a.m., Housekeeper J said Resident #115 would regularly curse at her and would not allow her to enter his room to clean it. She said she would report his behaviors to his charge nurse and she would notify her supervisor. Housekeeper J said Resident #115's verbal aggression towards staff was a known behavior. During an interview on 05/21/26 at 2:56 p.m., CNA H said Resident #115 had a pattern of refusing care and would get upset if staff tried entering his room. She said Resident #115 had a known behavior of yelling and cursing at staff only. CNA H said she would report his behavior to his nurse. During an interview on 05/19/26 at 8:46 a.m., LVN G said Resident #115 used his wheelchair to ambulate, preferred to stay in his room, not participate in activities, refused care, and had a known behavior of being verbally aggressive towards staff. LVN G said Resident #115 was known to yell, curse, and scream at staff if they tried to assist him or enter his room. She said CNAs would notified his charge nurse of his refusal of care and verbal aggression. LVN G said nursing staff should have documented his behavior in his electronic medical record. LVN G was not able to say who not (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documenting Resident #115's behavior on his electronic medical record could negatively impact him. During an interview on 05/21/26 at 3:11 p.m., LVN K said Resident #115 was hard to deal with because he had a history of being verbally aggressive towards staff. He said LVN K said whenever Resident #115 refused care, the CNAs would notify him but he had stopped documenting Resident #115's verbal behavior on his electronic medical record because it's a no win situation with him. LVN K said not documenting Resident #115's verbal behavior on his electronic medical record could negatively impact him by painting a true picture of his behaviors. During an interview on 05/21/2 at 3:50 p.m., the DON said Resident #115 was a long term resident. She said Resident #115 often refused care and had a known behavior of being verbally aggressive towards staff only. She said should document a resident's daily occurrences accurately and consistently to paint a clear picture of the resident's behavior. The DON said a negative outcome to Resident #115 not having his verbal behaviors documented could affect his MDS assessments. The DON said staff had been regularly in-serviced on the topic of documentation. Record review of the facility's Documentation in Medical Records Policy, dated 10/24/22 reflected: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include Enough information she provided picture of the residents fathers through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: Licensed staff and interdisciplinary team members shall document all assessment, observations, and services provided in the resident's medical record in accordance with state law and facility policy Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation or care service occurred. Findings included: 1.Record review of Resident #130's face sheet dated 05/21/26 revealed the resident was a [AGE] year-old male originally admitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease (is the final, permanent stage of chronic kidney disease), Diabetes Mellitus (high blood sugar), and Heart Failure. Record review of Resident #130's care plan dated 06/17/2025 reflected focus: the resident needed hemodialysis r/t ESDR . Interventions: encourage resident to go to the scheduled dialysis appointments. Record Review of Resident #130's Quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Resident #130 was on dialysis while a resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1s Order Summary Report dated 05/21/2026 revealed Resident #130 had dialysis on Tuesdays, Thursdays, and Saturdays. Record review of Resident #130's dialysis communication sheets revealed no communication sheet or documentation of refusal were available for 3/31/26, 4/2/26 and 4/4/26. Record review of Resident #130's MD notes dated 4/7/26 at 3:41 p.m., revealed Patient was seen today for change in condition according to nursing patient refused hemodialysis today again since 3/28. Called patients daughter X2 left voicemail to notify of patient refusal for today. Patient seen at bed side, alert and oriented to self, place, not to time or situation, educated patient on the need to go to dialysis due to increased confusion, patient said no, wound care nurse and med aid confirmed patient refusing to go to HD. Daughter returned the call and was updated on situation, including refusal of hemodialysis, medications and on dialysis center notification of patient needing to go to ER if patient changed mind and accepted to get dialyzed. Explained and educated daughter on expected confusion due to self refusal of hemodialysis. Daughter became aggravated, requested to speak to the patient, and verbalized he was going to die if he wouldn't go to hemodialysis now. Despite this, patient continued to refuse treatment. Daughter stated she would contact emergency services despite wishes. Staff nurse notified ambulance, paramedics arrived, patient refused and daughter was notified at the time a family member was on 3way and requested transfer and fluids due to patient being an emergency despite educating patient is a dialysis patient with heart failure which fluids will be a health risk. Patients vitals stable at the moment BP: 105/ 59, resp: 18, SPO2: 96% in room air, Temp: 97.5, Heart rate 60. Patient was taken to ER and report was given by NP to charge nurse. During an interview on 5/19/26 at 6:18 p.m., LVN F stated after reviewing the progress notes there was no progress notes on the following dates 3/31/26, 4/2/26 and 4/4/26, he stated that Resident #130 was scheduled to dialysis. He stated he could not recall why and stated there should be. He said the risks of not documenting properly was the next person would not know what happened. During an interview on 5/21/26 at 12:30 p.m., the DON stated progress notes could be found in the electronic medical record. She stated her expectation was that they included the time and condition of the resident prior to leaving the facility and when the resident refused to go to the dialysis center. She stated that her expectation was that documentation would accurately paint a picture of what was going on with the resident and included the proper information. Resident #130's progress notes reviewed and revealed no documentation on 3/31/26, 4/2/26 and 4/4/26 in residents' electronic medical records. Record review of the facility's Documentation in Medical Records Policy, dated 10/24/22 reflected: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include Enough information she provided picture of the resident's behaviors through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: Licensed staff and interdisciplinary team members shall document all assessment, observations, and (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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo West Nursing and Rehabilitation Center	1200 E Lane St Laredo, TX 78043

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services provided in the resident's medical record in accordance with state law and facility policy Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation or care service occurred.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections, for 1 of 5 residents (Resident #11) reviewed for infection control.1. The wound care nurse failed to place a barrier between Resident #11's buttocks and his brief while providing wound care.2. The wound care nurse failed to wash her hands with soap and water after providing wound care for Resident #11.These failures could place residents at risk for infection through cross contamination of pathogens. The findings included: Record review of Resident #11's admission record on 05/21/26 reflected a [AGE] year-old male originally admitted to the facility on [DATE] with most recent admission on [DATE]. His diagnoses included nontraumatic intracerebral hemorrhage in subcortical hemisphere (bleeding in the functional tissue of the brain not caused by an external force), muscle wasting and atrophy (loss of muscle mass and strength), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high), and gastrostomy status (a tube surgically implanted through the abdomen into the stomach used to provide nutrition, hydration, and medication). Record review of Resident #11's quarterly MDS dated [DATE] reflected no BIMS score and a Cognitive Skills for Daily Decision Making score of 3 which indicated he was severely impaired and never/rarely made decisions. Record review of Resident #11's care plan dated 01/29/26 reflected he had a pressure ulcer on his sacrum (tailbone). His goal was the pressure ulcer would show signs of healing and remained free from infection, initiated 05/08/26. Interventions included administer treatments as ordered and monitor for effectiveness, initiated 05/08/26. Record review of Resident #11's order summary on 05/19/26 reflected an order for wound care to his sacrum to be done daily ordered on 03/02/26. During an observation of wound care for Resident #11's sacral wound (a wound located on the tailbone area) on 05/20/26 at 4:36 pm, the WCN only unfastened Resident #11's brief from one side and pulled it down. She did not place a barrier between his brief and his buttocks. When the WCN finished with Resident #11's wound care, she did not wash her hands with soap and water prior to exiting his room. In an interview on 05/20/26 at 4:56 pm, the WCN stated she did not put a barrier between the wound and the brief because the wound did not touch the brief at all and the wound was covered until she removed the dressing. She stated her gloved hand did not touch the brief, either. The WCN stated there should have been a barrier between the wound and the brief in case something happened to contaminate the wound. She stated if the wound accidentally got contaminated it could cause infection. The WCN stated she did not wash her hands when she exited the room because she thought sanitizer was an option. She stated she understood the policy to indicate either hand sanitizer or hand washing. The WCN stated if hands were not washed it could cause infection. She stated in-services on wound care were done about every 2 weeks by the out of facility wound care team. She stated the facility did infection control in-services at least once a month and as needed. (continued on next page)

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	455528	A. Building B. Wing	05/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/21/26 at 1:19 pm, the DON stated per the wound care competency check off form (which was also the policy), hand hygiene was done before wound care was started. The DON stated hand hygiene was defined as hand washing or the use of hand sanitizer. She stated the check off/policy stated hands were to be washed with soap and water once wound care was finished and before the nurse exited the room. The DON stated the nurse was supposed to place a clean barrier between the resident's wound and the resident's brief to ensure the wound did not get contaminated. She stated it was important to wash hands and place a barrier to prevent the possible spread of infection. The DON stated the WCN was checked off on wound care annually and as needed and her last check off was 04/17/26. Record review of the WCN's Wound Treatment Competency assessment dated [DATE] reflected in part: 6. Position the area to be treated. Place a clean barrier next to the resident to protect bed linen. 14. Wash hands.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to conduct regular inspections and maintenance of resident bed frames, mattresses, and bed rails, leading to potential entrapment hazards for 1 of 8 (Resident #123) residents reviewed for safety in rooms. The facility failed to ensure Resident #123's hospital bed functioned properly, as the knee and foot sections could not be elevated. This failure could place residents at risk of injury resulting from equipment malfunction. Findings included: Record review of Resident #123's admission record, dated 05/19/26, reflected a [AGE] year-old male with an admission date of 05/15/26. His relevant diagnoses included hyperlipidemia (high levels of lipids (fats), such as cholesterol and triglycerides, in the blood), atherosclerotic heart disease of native coronary artery without angina pectoris (a condition where plaque builds up in the original heart arteries, reducing blood flow, but without causing chest pain), and rheumatoid arthritis (a chronic autoimmune disorder where the immune system mistakenly attacks the lining of the joints). Record review of Resident #123's MDS assessment was in process. Record review of Resident #123's baseline care plan, was in progress. During an interview and observation on 05/19/26 at 8:35 a.m., Resident #123 was observed lying in bed awake with his head elevated at a 30-degree angle. Resident #123 said he was upset because the knee and foot section of his hospital bed would not elevate. He said he felt his feet were swollen due to not being able to elevate them. Resident #123 stated he had been admitted to the facility short term to received physical therapy on 05/15/26. Resident #123 said that when he was first admitted , the hospital bed did not have the rails he needed to help reposition himself. He said that the facility replaced the bed the following day (05/16/26). Resident #123 was observed holding the hospital bed's hand controller and pressed the knee and foot section button, but the sections did not elevate. During an interview and observation on 05/19/26 at 8:46 a.m., LVN G was observed as she tried to press the elevate Resident #123's knee and foot section of his hospital bed using the hand controller. LVN G said, it's not working. She said the maintenance director was responsible to ensure all hospital beds were working properly. LVN G was observed as she removed Resident #123's socks to assess his feet and ankles. She said Resident #123's left ankle was a little swollen and said she was not sure if it was because he had not been able to elevate his feet, because that's where he had a surgical incision, or the sock was too tight. LVN G said Resident #123's right ankle was not swollen. LVN G was observed as she called the facility's maintenance director to Resident #123's room. LVN G said a negative outcome to Resident #123 not being able to elevate his knees and/or feet would be swelling or pain During an interview and observation on 05/19/26 at 9:00 a.m., the ADON was observed as she tried elevating Resident #123's bed using the hand controller and said, it's not working. The ADON said Resident 123's bed had been changed on 05/16/26 to one that had rails. She said she had not been advised the bed was not working properly. The ADON said she would be going to request a different bed for Resident #123 immediately. The ADON said a negative outcome for Resident #123 not being able to elevate his knees and or his feet would be pain and or swelling. During an interview on 05/19/26 at 9:20 a.m., the Maintenance Director was observed working on Resident #123's bed. The Maintenance Director said it was his responsibility to ensure all hospital beds in the facility were in working condition. He said he did not have a set schedule of when he would inspect the hospital beds. He said he would only inspect them for new admissions or when reported to him a bed was not functioning. The Maintenance Director said he had not received any work orders for Resident #123's bed. During an interview on 05/21/26 at 8:30 a.m., the DON said Resident #123 was admitted on [DATE] short term for physical therapy. She said the maintenance director was responsible to ensure all hospital beds were functioning. The DON said a negative outcome for Resident #123 not having a functioning bed could be edema (swelling). The DON said the facility did not have a policy regarding hospital beds.