STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675030	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Frontera Nursing & Rehabilitation	7001 McPherson Rd Laredo, TX 78041

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 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 4 of 4 residents (Resident #7, #24, #25, and #26) 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 for Resident #7, #24, #25, and #26. 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 #7 ' s Authorization Request for NFSS most recent form was dated and submitted 11/05/2020. Record review of Resident #7 ' s face sheet, dated 05/28/25, revealed a [AGE] year-old male with an admission date of 06/10/2019. His diagnoses included Unspecified Intellectual Disabilities, Mental Disorder, Functional Quadriplegia (the inability to move due to a disability or physical condition, not related to spinal or brain damage), Legal Blindness, and Mood Disorder. Record review of Resident #7 ' s Quarterly MDS Assessment, dated 03/02/25, revealed no BIMS score as resident was rarely or never understood. The MDS also revealed Resident #7 had a memory problem, difficulty focusing attention, and a mental disorder, not otherwise specified. Resident #7 was also completely dependent in hygiene and toileting. Record review of Resident #7 ' s care plan, initiated 09/17/24 and revised 05/22/25, revealed Resident #7 was at risk for self-care deficits, falls, skin concerns, pain, infections, nutritional and hydration concerns, and emotional distress. Resident #7 ' s interventions included coordinating all essential medical and/or mental health visits, provide care and safety checks throughout the shift, provide nutrition and hydration within prescribed diet, activities as tolerated, and collaborate with IDT and resident representative. Record review of Resident #7 ' s PASRR progress note, dated 03/14/25, revealed quarterly meeting was held with Border Region PASRR Habilitation Coordinator. No changes were noted or reported at that time. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7 ' s progress note, dated 05/14/25, revealed Quarterly/Monthly meeting held with the PASRR Habilitation Coordinator, and no changes were noted or reported. Record review of Resident #7 ' s Habilitation Service Plan, dated 03/14/25, revealed the Habilitation Coordinator met with the IDT regarding Resident #7 ' s renewal of services. Recommendations included continued independent living skills for one hour, twice per week, for 90 days. Record review of Resident #7 ' s PASRR PCSP Form, quarterly meeting, dated 03/14/25, revealed resident was PASRR positive for IDD. Attendance included Resident #7, LIDDA - Habilitation Coordinator, MDS nurse, and Provider Supervisor. Durable medical equipment and specialized service recommendations included customized manual wheelchair, habilitation coordination, and independent living skills training. In an interview on 05/28/25 at 4:30 PM with the PASRR Program Specialist, she stated if the NFSS PASRR specialized services were recommended at the IDT meeting but were not initiated within 20 business days following the date the services were agreed to in the IDT meeting, the resident would not receive a PASSR specialized service. She stated the facility was given a specific timeframe to submit the NFSS requests to avoid a regulatory complaint. The facility did not meet this timeframe. According to the PASRR Program Specialist, the last IDT meeting forms submitted for Resident #7 were 06/07/24. In an interview on 05/29/25 at 8:00 AM with the DON, he stated he was only able to find Resident #7 ' s PASRR level 1 from 2019, Resident #7 ' s NFSS form from 2020, and Resident #26 ' s NFSS form from 2021, but he was unable to find a current or recent NFSS form for any of the Residents #7, #24, #25, and #26 reviewed for PASRR. He stated there definitely would not be one after July 2024 since they had not had a current NPI number to be able to submit or upload forms due to the fact that the facility had switched ownership in September, 2024, and they were still waiting to get the NPI number. He stated they had submitted all the documents to for the NPI, but they were still waiting for it to be approved. Record review of Resident #26 ' s face sheet, dated 05/28/25, revealed a [AGE] year-old female with an admission date of 01/17/2018. Her diagnoses included Cerebral Palsy (a group of conditions affecting movement and posture caused by brain damage before birth), Epileptic Seizures (caused by abnormal electrical activity in the brain, leading to uncontrolled bursts of activity that could affect sensation, behaviors, awareness, and muscle movements), Unspecified Intellectual Disabilities, Functional Quadriplegia (the inability to move due to a disability or physical condition, not related to spinal or brain damage), and Dysphagia (difficulty swallowing). Record review of Resident #26 ' s care plan, initiated 09/19/24, revealed Resident #26 was at risk for self-care deficits, falls, skin concerns, pain, infections, nutritional and hydration concerns, and emotional distress. Resident #26 ' s interventions included coordinating all essential medical and/or mental health visits, provide care and safety checks throughout the shift, provide nutrition and hydration within prescribed diet, and report any need to re-evaluate specialized services and/or plan of care to service coordinator as well as resident representative. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #26 ' s Quarterly MDS Assessment, dated 04/21/25, revealed no BIMS score as resident was rarely or never understood. The MDS also revealed Resident #26 had a memory problem, severely impaired cognitive skills, difficulty focusing attention, and a mental disorder. Resident #26 was also completely dependent in hygiene and toileting. Record review of Resident #26 ' s Habilitation Service Plan, dated 04/23/25, revealed the Habilitation Coordinator met with the IDT regarding Resident #26 ' s PASRR services. Recommendations included continued independent living skills for one hour, twice per week, for 90 days. Record review of Resident #26 ' s progress note, dated 05/12/25, revealed monthly meeting held with Border Region PASRR Habilitation Coordinator, and no changes were noted or reported. Record review of Resident #26s PASRR and PCSP forms, quarterly meeting, dated 11/15/1924, revealed resident was PASRR positive due to his Spastic Quadriplegic Cerebral Palsy((SQCP). Attendance included Resident #26 LIDDA/Habilitation Coordinator, MDS nurse, and Provider Supervisor. Durable medical equipment(DME) and specialized occupational therapy(OT), specialized physical therapy(PT) and specialized speech therapy OT recommendations included customized manual wheelchair, habilitation coordination, and independent living skills training Record review of Resident #26's PASRR PCSP dated 01/10/25 revealed Resident #26 will continue to receive PASRR services, habilitation coordination, and Independent Living Skills. Resident #24 face sheet dated 05/29/25 reflected a [AGE] year old male who was admitted on [DATE]. Resident #26 records revealed he had a diagnosis Spastic Quadriplegic Cerebral Palsy((SQCP) is a severe form of cerebral palsy affecting all four limbs, resulting in stiff muscles and difficulty with movement and coordination. In record review of Resident #26 physician's order's dated 05/01/2025 and progress report summary dated 05/01/2025 revealed from 12/17/24 and 05/12/2025 no orders for any type of quarterly meeting the resident was noted to be sent to be processed . In record review of Resident #26 care plan revealed the resident was at risk for experiencing discomfort or pain related to cerebral palsy and morbid medical conditions. Resident #24 had chronic health conditions and morbid conditions that had affected my physical function and may further affect my quality of life. Refer to skilled therapy services for strengthening, mobility as well as oxygen conservation techniques as indicated. Resident is considered PASRR positive IDD- intellectual disability or development disorder. Interventions consist of administer my medication to relieve my pain as recommended by my doctor and attempt non-pharmacological interventions to promote comfort. relaxation Record review of Resident #25's admission record revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included conversion disorder with seizures or convulsions (a condition in which emotional or psychological stress causes physical symptoms such as shaking of the body), Down syndrome (a genetic condition that causes intellectual disability and developmental delays), unspecified epilepsy (a neurological condition that causes recurring seizures), and developmental disorder of speech and language (communication disorder that interferes with learning, understanding, and using language). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's quarterly MDS dated [DATE] revealed a BIMS score of 2 which indicated severe cognitive impairment. The MDS also revealed that Resident #25 was completely dependent on staff for eating, hygiene, toileting, and ADLs. Record review of Resident #25's care plan dated 09/23/24 and revised on 03/11/25 revealed Resident #25 had a self-care deficit, impaired cognitive function, problems communicating needs or wants, and was PASRR positive. Interventions included coordinating all essential medical and/or mental health visits, provide care and safety checks throughout the shift, provide nutrition and hydration within prescribed diet, and report any need to re-evaluate specialized services and/or plan of care to service coordinator as well as resident representative. Resident #25 ' s specialized service was agreed upon DME of a specialized wheelchair. Record review of Resident #25's progress notes revealed notes dated 01/10/25, 03/14/25, 04/09/25, and 05/14/25 which indicated a monthly meeting was held with the [Agency name] PASRR Habilitation Coordinator, and no changes were noted or reported. Record review of Resident #25's Restorative Review dated 02/24/25 revealed a periodic review of Resident #25 ' s restorative programs which included bed mobility and range of motion programs would be discontinued and rehabilitation services would be initiated. Record review of Resident #25's PASRR Level 1 screening dated 09/03/24 reflected there was evidence or an indicator that Resident #25 had an intellectual disability and a developmental disability. In an interview on 05/29/25 at 3:25 PM with the MDS nurse, she stated after reviewing and looking, they were only able to find two NFSS requests for PASRR specialized services forms for all the PASRR reviewed residents, and those two forms found were from 2020. She stated she knew for sure there had not been any NFSS forms submitted since at least July of 2024. She stated the facility continued to have the IDT PASRR meetings, they just were not able to submit or upload any of the forms to the portal because they had not had an NPI number since September of 2024, and prior to that, their systems had crashed in July or August of 2024. Record review of the facility 's policy Specialized Rehabilitative Services, implemented February 2017 and revised January 2023, revealed specialized rehabilitative services were administered by qualified personnel pursuant to a written physician order to ensure the rehabilitative services as prescribed by a physician and to maximize potential outcomes. Specialized rehabilitative services were provided according to the resident ' s assessment and care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident and/ or their representative and the IDT were invited to attend/participate in the care plan meetings including both the comprehensive and quarterly review assessments for 1 of 6 residents (Resident #25) reviewed for care plan timing and revision. The facility failed to ensure Resident #25 had quarterly care plan reviews or meetings that included the appropriate IDT members and resident and/or resident representative in February 2025 and May 2025 (2 out of 3). The facility failed to ensure the care plan was revised within 7 days after the quarterly assessment that was dated 2/19/25. These failures could place residents at risk of not being able to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. The findings included: Record review of Resident #25's admission record reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included conversion disorder with seizures or convulsions (a condition in which emotional or psychological stress causes physical symptoms such as shaking of the body), Down syndrome (a genetic condition that causes intellectual disability and developmental delays), unspecified epilepsy (a neurological condition that causes recurring seizures), and developmental disorder of speech and language (communication disorder that interferes with learning, understanding, and using language). Record review of Resident #25's quarterly MDS dated [DATE] reflected a BIMS score of 2 which indicated severe cognitive impairment. The MDS also reflected that Resident #25 was completely dependent on staff for eating, hygiene, toileting, all transfers, and all ADLs. Review of all of Resident #25's MDS reports on 05/29/25 reflected she had a quarterly MDS done on 11/19/24 and 2/19/24. A quarterly MDS dated [DATE] showed in progress. Record review of Resident #25's assessments tab in the EMR on 05/29/25 reflected two entries titled, IDT: Care Plan Conference and Advanced Care Planning Review that were dated 09/24/24 and 11/26/24. The form dated 09/24/24 and signed by the SW indicated the MDS nurse, dietary manager, social worker, activity director, and the RP participated in the meeting, however in the additional comments section it stated, Called RP via phone call no answer only VM left again. The form dated 11/26/24 and signed by the ADON indicated the dietary manager, social worker, activity director, ADON, and RP participated in the meeting. There were no other entries that indicated an IDT care plan conference was held for Resident #25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25's assessments tab also reflected entries dated 12/19/24, 01/24/25, and 02/24/25 that were titled, IDT: Restorative Review. The Restorative Review dated 12/19/24 reflected it was an initial therapy referral review and Resident #25 was to be discharged from OT on 11/19/24 and start a bed mobility program and an active range of motion program for deficits of bed mobility and positioning and limited ROM. The Restorative Review dated 01/24/25 reflected it was a periodic review of Resident #25's bed mobility and range of motion programs. This review reflected the IDT had reviewed the plan of care and the programs were appropriate and would be continued. The Restorative Review dated 02/24/25 reflected it was a periodic review of Resident #25's bed mobility and range of motion programs. This review reflected the IDT had reviewed the plan of care and the programs would be discontinued. Additional comments reflected Rehab services initiated. All the Restorative reviews were signed by the MDS nurse. These restorative reviews did not address Resident #25's desire to learn to write her name. Record review of Resident #25's care plan dated 09/23/24 and revised on 03/11/25 reflected Resident #25 had a self-care deficit, impaired cognitive function, problems communicating needs or wants, and was PASRR positive. Interventions included coordinating all essential medical and/or mental health visits, provide care and safety checks throughout the shift, provide nutrition and hydration within prescribed diet, and report any need to re-evaluate specialized services and/or plan of care to service coordinator as well as resident representative. Resident #25's specialized service was agreed upon DME of a specialized wheelchair. This care plan did not address Resident #25's desire to learn to write her name. This care plan indicated Resident #25 only required 1 person assistance with bathing/showering, bed mobility, dressing and grooming, eating and drinking, hygiene, turning and repositioning, and transfers which is not what her quarterly MDS dated [DATE] reflected. Record review of Resident #25's Habilitation Service Plan dated 09/25/24 reflected it was the initial meeting and discussion of PASRR services. This meeting was attended by Resident #25, the habilitation coordinator, the MDS nurse and the provider supervisor (who was not a facility staff member) and indicated the RP was unable to be reached. Identified IDD habilitative specialized services were habilitation coordination monthly and independent living skills for 1 hour, 2 times per week, to achieve Resident #25's goal of learning to write her name. It was signed by the habilitation coordinator on 05/17/24. (Not an error on the date by this writer). Record review of Resident #25's Habilitation Service Plan dated 12/18/24 reflected it was the quarterly meeting and discussion of PASRR services. This meeting was attended by Resident #25, Resident #25's RP, the habilitation coordinator, the MDS nurse and the provider supervisor (who was not a facility staff member). Identified IDD habilitative specialized services were habilitation coordination monthly and independent living skills for 1 hour, 2 times per week, to achieve Resident #25's goal of learning to write her name. It was signed by the habilitation coordinator on 12/18/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's Habilitation Service Plan dated 3/14/25 reflected it was the quarterly meeting and discussion of PASRR services. This meeting was attended by Resident #25, the habilitation coordinator, the MDS nurse and the provider supervisor (who was not a facility staff member). There was no documentation on whether or not the RP was contacted for this meeting. Identified IDD habilitative specialized services were habilitation coordination monthly and independent living skills for 1 hour, 2 times per week, to achieve Resident #25's goal of learning to write her name. In the pertinent information section it was documented, It is important to [Resident #25] to continue to receive her independent living skills because she wants to learn how to write in order to be able to write her name. It was agreed that the independent living skills is beneficial to [Resident #25] as it appears that she enjoys it and really wants to learn to write her name. It was signed by the habilitation coordinator on 03/14/25. Record review of Resident #25's progress notes reflected notes dated 01/10/25 (monthly), 03/14/25 (quarterly), 04/09/25 (monthly), and 05/14/25 (monthly) which indicated a monthly or quarterly meeting was held with the [Agency name] PASRR Habilitation Coordinator, and no changes were noted or reported. In an interview on 05/29/25 at 3:25 PM and at 4:29 PM, the MDS nurse stated the last IDT meeting for Resident #25 was 11/26/24. She stated she was going to look to see if there had been any more IDT meetings since then. The MDS nurse stated IDT consisted of the SW, dietary manager, activities director, nursing staff, the provider, and therapy staff. She stated that the habilitation coordinator was usually only here for the monthly PASRR meetings and were not part of the IDT care plan meeting. The MDS nurse stated she was the only facility staff member present for the PASRR meeting on 03/14/25 and it could not be considered an IDT meeting if all the disciplines were not present. The MDS nurse stated they did discuss her entire plan of care at the PASRR meeting. In an interview on 05/29/25 at 3:56 PM and 4:35 PM, the RMDS nurse gave this surveyor a printed page of Resident #25's progress notes that reflected the same progress notes documented above. The RMDS nurse stated that the quarterly meeting held with the [Agency name] PASRR Habilitation Coordinator was the quarterly IDT meeting for the facility. As documented above, Resident #25's RP was not present, and the only facility staff member present was the MDS nurse. The RMDS nurse stated IDT meant, we all sit down and discuss the resident's plan of care. It can consist of the nurse, SW, activities can attend, the DON, and the administrator, if needed. The RMDS further stated they tried to involve the LIDDA, also, for Resident #25. When asked why she considered the PASRR meeting on 03/14/25 an IDT meeting, the RMDS nurse stated because the MDS nurse was there. The RMDS nurse stated if the MDS nurse held the meeting alone, then she would not consider it an IDT meeting. The RMDS nurse stated the facility used a system called Care Feed to notify the RP of meetings and it would show in the Direct Messages in the resident's chart. The RMDS stated the facility was one month late for the quarterly IDT/ care plan meeting that should have been done in February, but the facility was not late for the May IDT meeting because the last meeting was in March, so the next one was not due until June. Record review on 05/29/25 of the facility's Direct Messages for Resident #25 reflected the following messages: 01/27/25 Message from [nursing facility] would like to inform you dear family members we are keeping all our residents safe and warm during this winter freeze storm. Stay safe and warm. Thank you for your attention. God Bless you! (continued on next page)

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	675030	A. Building B. Wing	05/29/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/21/25 (4 messages in English) Good morning, dear family members, here at [nursing facility] we strive to keep our residents safe and happy as well as their personal belongings. However, we would like to recommend you take any jewelry or personal valuable belongings, if any, for safekeeping at your home. If there are any questions, please contact Social Services Director [name] at [phone number]. 03/03/25 (7 messages in Spanish) the same as the 4 valuables messages in English that were sent on 02/21/25. 05/01/25 (1 message in English, 1 message in Spanish) Dear Family, we would like to send this friendly reminder in case of any questions or concerns that you might have, please contact our community administrator [name] at [phone number], or Director of Nursing Services [name] at [phone number] to further assist you. Thank you for all your support and preference for your loved one's skilled nursing care. There were no messages to advise the RP of scheduled IDT/care plan meetings. In an interview on 05/29/25 at 4:18 PM, the DON stated he sometimes attended the IDT meetings and RPs/family members were notified of care plan meetings through the facility's Direct Message system that sent a text message to the RP/family. In an interview on 05/29/25 at 5:39 PM with the MDS nurse, DON and RMDS nurse, the MDS nurse stated it was important for all pertinent disciplines and the RP/resident to be present because it was an IDT meeting, and everyone needed to take part in the resident's [NAME] of care. The DON stated, If the disciplines and the RP/resident were not present for the meetings it could affect the resident's holistic care. The DON also stated they (the IDT team) were made aware of the resident's plan of care in morning meetings because all of the disciplines were in those meetings. The DON stated the SW emailed the department heads to inform them of upcoming IDT/Care plan meetings. The RMDS nurse stated, Even though we made not have the entire team there, we discuss all aspects of the resident's care as a whole. There are some meetings depending on the resident's needs, that the doctor or ombudsman have to be present. Record review of the facility's Care Plan Policy dated February 2017 and revised January 2023 reflected in part: Interdisciplinary means that professional disciplines work together to provide the greatest benefit to the resident. The care plan should be prepared, reviewed, and updated in accordance with the RAI guidance on a routine cadence (admission, quarterly, annually, and with significant change). Additionally, the care plan should be modified as appropriate and on an as needed basis as per the RAI instructions. The care plan should be reflective of resident's/representative's input, goals, and desired outcomes and should include the interdisciplinary team, to include but not limited to the attending physician, a registered nurse with responsibility for the resident, and other appropriate team members in disciplines as determined by the resident's needs. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 5 residents (Resident #9) reviewed for pharmacy services. 1. The facility failed to clarify the blood pressure parameters for Resident #9's Midodrine order. 2. The facility failed to administer Resident #9's order for Midodrine as prescribed in May of 2025 by administering Midodrine 8 times outside of physician ordered parameters. These failures could place residents at risk for complications, as well as jeopardize their health and safety. Findings included: Record review of Resident #9's face sheet, dated 05/28/25, revealed a [AGE] year-old male with an admission date of 04/06/2023. Resident #9's diagnoses included End Stage Renal Disease (an advanced stage of Chronic Kidney Disease when the kidneys can no longer filter waste or fluid from the blood), Dependence on Renal Dialysis, Type 2 Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), Hypertensive Heart and Chronic Kidney Disease without Heart Failure, Atherosclerotic Heart Disease (plaque build up in arterial walls), Peripheral Vascular Disease (disorder of the blood vessels that can involve narrowing, blockage or spasm of the vessel wall). Record review of Resident #9's MDS assessment, dated 03/11/25, revealed a BIMS score of 14, which revealed intact cognition. Record review of Resident #9's care plan initiated 09/18/24 revealed Resident #9 was at risk for cardiac complications such as chest pain, shortness of breath, fatigue, dizziness, poor endurance, poor activity tolerance, and edema. Interventions included administering medications as ordered by the physician and monitoring vital signs as indicated and reporting abnormal findings to the physician as indicated. Another care plan initiated 04/18/25 addressed Resident #9's End Stage Renal Disease and Heart Disease with interventions to administer medications as recommended by the physician and monitor vital signs as indicated. Record review of Resident #9's physician orders started 09/19/24 revealed an active order for Midodrine 5mg, take 4 tablets by mouth every Tuesday, Thursday, Saturday and hold for a SBP greater than 120, but, then, the directions for this same order revealed take 4 tablets by mouth every Tuesday, Thursday, and Saturday. Hold for SBP less than 120. Midodrine is a medication primarily used to treat low blood pressure. Record review of Resident #9's current, clarified physician order started 05/29/25 revealed a clarified order for Midodrine 10mg, give 2 tablets once a day on Tuesday, Thursday, and Saturday. Hold for a systolic blood pressure greater than 120. (continued on next page)

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	675030	A. Building B. Wing	05/29/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's MAR for May 2025 revealed Midodrine 5mg, give 4 tablets one time a day every Tuesday, Thursday and Saturday related to End Stage Renal Disease; hold for SBP greater than 120. May 2025 MAR revealed Midodrine was administered incorrectly 8 times. MAR for May 2025 revealed Midodrine was given as follows: 05/01/25 - b/p 160/64 - Midodrine administered by Med-Aide-A 05/03/25 - b/p 118/86 - Midodrine administered - not listed 05/06/25 - b/p 164/50 - Midodrine administered by Med-Aide-A 05/08/25 - b/p 141/53 - Midodrine administered - LVN-E 05/10/25 - b/p 159/72 - Midodrine administered by Med-Aide-A 05/13/25 - b/p 163/67 - Midodrine administered by Med-Aide-A 05/15/25 - b/p 126/55 - Midodrine administered by RN-B 05/17/25 - b/p 118/62 - Midodrine administered - not listed 05/20/26 - b/p 167/82 - Midodrine HELD 05/22/25 - b/p 150/61 - Midodrine Administered by Med-Aide-A 05/24/25 - b/p 120/68 - Midodrine Administered - not listed 05/27/25 - b/p 132/62 - Midodrine Administered by Med-Aide-A In an interview on 05/27/25 at 3:45 PM with Resident #9 he stated he felt good today. He was observed smiling, up in his wheelchair in his room. He was very talkative and stated how much he liked the facility and staff. He denied ever experiencing any type of abuse in the facility. He stated the nurses always checked his vital signs and gave him his medications when he was supposed to get them. In an interview on 05/28/25 at 3:20 PM with RN-B, he stated he knew Midodrine was used to increase the blood pressure for residents with hypotension (low blood pressure), and he gave it outside of the recommended or ordered parameters because he knew Resident #9 got hypotensive with dialysis. He stated he would not have given the Midodrine if the residents SBP was greater than 130. He stated if Resident #9's blood pressure became too elevated he could develop a stroke or hypertensive crisis. He stated going forward he would double check the physician orders, as well as the recommended and ordered parameters. In an interview on 05/28/25 at 3:30 PM with the DON, he stated Midodrine was used for hypotension, and if Resident #9's blood pressure had become too elevated he could have developed dizziness, headache, or even a stroke. He stated the nurses knew they were supposed to follow the ordered and recommended parameters for blood pressure medications. He stated he contacted the physician and clarified the order, and it was changed and added to Resident #9's MAR, as well as an in-service was started regarding checking blood pressures and administering medications appropriately and accurately. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/29/25 at 8:37 AM with Med Aide-A, she stated Midodrine was used to raise the blood pressure when someone had hypotension (a low blood pressure). She stated there was no excuse for why she gave the medication when she should not have. She stated sometimes she got in a rush and forgot to check the parameters of the order prior to administering. She stated she was already in-serviced yesterday regarding administering this medication wrong. She stated if Resident #9's blood pressure had become excessively elevated he could have experienced dizziness, headache, stroke, and/or ultimately death. She stated Resident #9 was cognitively alert and was always able to express when something was wrong, or he felt bad. Record review of the facility policy Pharmacy Services: Provision of Medication and Biologicals, implemented February 2017 and revised November 2023, revealed Team members will report drug errors and adverse drug reactions to the resident's physician in a timely manner. Record review of the facility policy Medication Administration, implemented March 2019 and revised January 2024, revealed a. The nurse/medication aide shall be responsible to read and follow precautionary or instructions on prescription labels. c. Report any discrepancies to the pharmacy. Do not administer the medication until the discrepancy is resolved.

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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 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, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation and sanitation. The facility failed to ensure the ice machine chute was free of scratches with removable black substances in the scratches and around them. The facility failed to ensure the meat slicer was covered properly when not in use and remained free of dust and debris. The facility failed to ensure hairnets were worn before entering the kitchen and made readily available. The facility failed to ensure the underside of the shelf directly above the steam table holding food was free of grime. The facility failed to ensure a pair of black plastic tongs were free of crevices and not melted. The facility failed to ensure an 18-quart container of rice did not have a scoop inside of it in the dry storage area. The facility failed to ensure proper scoops were used in the rice container instead of an ordinary cup. The facility failed to ensure the juice gun nozzle was clean. The facility failed to ensure the cleaning schedule was followed and monitored. The facility failed to ensure all left over items in the refrigerators had use-by dates. These failures could place residents who received meals and/or snacks from the kitchen and satellite kitchens at risk for food contamination and food borne illness. Findings included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial tour and observation of the kitchen on 05/27/25 at 12:30 pm revealed the chute inside the ice machine had a removable black-brown substance along the edge where the ice dumped out. The chute had multiple scratched areas on it with the same removable black-brown substance in the scratches. The cover on the meat slicer was askew and only partially covering the meat slicer. The cover had dust and other debris on it and the exposed areas of the meat slicer had dust and debris on it. Employees were seen entering the kitchen before putting on hairnets. There were no hairnets available near the two outer doors to the kitchen; one led outdoors toward an employee parking lot, the other led into the dining area. Hairnets were observed inside the kitchen on top of the ice machine near the door to the dining area. The underside of the shelf directly above food holding on the steam table had a removable gritty, brownish substance in clumps. There was a pair of black plastic tongs in a drawer with other utensils. The tongs were deformed in a way melted plastic looked, and the tongs had deep crevices in the pick-up end with a flakey, brownish substance in the crevices. The juice gun had a thick red substance stuck in the nozzle. Labeled items in the refrigerators did not have use-by dates. During a return visit and observations of the kitchen on 05/29/25 at 11:15 am revealed hairnets were not readily available outside the kitchen doors. The juice gun had a thick red substance in the nozzle. Labels in the refrigerator did not have use-by dates on the leftovers: multiple trays of beverages including tea, milk, and thickened liquids, potatoe salad, lunch meat, beans, multiple trays of desserts, and all other containers. In an interview with the DS on 05/27/25 at 12:40 pm, she said the inside of the ice machine was cleaned every four days and maintenance cleaned the filters monthly. She said the exterior of the ice machine was wiped down daily. She said the black-brown substance looked like mold and dirt. She said the meat slicer should have been covered properly to prevent dust and debris getting on the inside. She said the dust and debris could get into the food and make residents sick. She said she did not know who was responsible for the meat slicer. The DS said hairnets were used to cover hair to keep hair from getting into the food. She said hair in food was unsanitary and could make the residents sick because of cross contamination. She said the kitchen staff all had hairnets but would not say if they put them on before or after entering the kitchen. She said hairnets were available. She said she had to get them from her office (within the kitchen area). She said she was unaware of the removable gritty, brownish substance in clumps on the underside shelf directly above food holding on the steam table. She said the removable gritty, brownish substance in clumps could drop onto the food, contaminate it, and make residents sick. She said all food related items should be labeled and dated and did not know what use by dates meant. She said she was responsible for everything in the kitchen. In an interview with the RD on 05/27/25 at 12:45 pm, she said she did not know what the removable black-brown substance was on the ice chute in the ice machine, but it looked like dirt and guessed it could have been mold. She said the cover on the meat slicer was barely covering it and the meat slicer was dirty because the cover was more off than on. She said hairnets had to be worn at all times while in the kitchen. She said she did not know where the DS kept them or why they were not readily available. She said all food related items in the kitchen must be labeled and dated, including use-by dates. She said food that was past its use by date could make residents sick if consumed and should be discarded. She said the crevices in the black tongs could harbor bacteria, cross contaminate the food, and make residents sick. She said she needed to in-service the kitchen staff on cleaning and labeling. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DA on 05/29/25 at 11:25 am, she said the juice gun was cleaned every two days, the last cleaning being Tuesday, 05/27/25. She said they were told to only remove the outer nozzle and wipe the inner nozzle with a towel. She said the inner nozzle was not clean. She said she was not sure how long it had been since the juice gun had been cleaned. She said the dietary aides were supposed to be cleaning it. She said the red substance in the nozzle was because of the thickener. She said not cleaning the juice gun could make residents sick. In an interview with the DS on 05/29/25 at 11:30 am, she said the juice gun was cleaned every three days, the last cleaning Monday, 05/26/25. She said she was not sure why the juice gun was not clean if it was cleaned on Monday or Tuesday. She said she was responsible for monitoring the cleaning schedule. She said she was not monitoring the cleaning schedule. She said she was only looking at the cleaning schedule to see if the items were checked off. She said the daily cleaning schedule for 05/26/25 and 05/27/25 had been checked off as having been done for the juice gun. She said the juice gun was not clean. In an interview with the DA on 05/29/25 at 3:25 pm, she said her initials were on the daily cleaning schedule dated Monday 05/26/25 as having cleaned the juice gun. She said she could not remember if she had or had not done it. In an interview with the ADM on 05/29/25 at 4:25 pm, he said he would start conducting daily walking rounds with the DS in the kitchen from now, on. Record review of the facility's Daily kitchen 29-item cleaning checklists dated 01/06/25-05/26/25 revealed a total of 140 opportunities: #14. Food service employees wear hair restraints .that could spread into food, the task was not marked as done 42 times. 19. Clean .juice machine ., the task was not marked as done 42 times. 20. Clean and sanitize slicer. Cover. The task was not marked as done 79 times. The weeks of 02/17/25, 03/17/25, 04/07/25, 04/28/25, 05/05/25, and 05/19/25 were missing. Record review of the facility's Weekly kitchen 7-item cleaning checklists dated 01/06/25-05/26/25 revealed a total of 140 opportunities with 119 tasks not marked as having been done. There were 4 weeks missing for January, 3 weeks missing for February, 2 weeks missing for March, 1 week, 4 days missing for April, and 2 weeks missing for May. Record review of the facility's Monthly kitchen 6-item cleaning checklists dated 01/06/25-05/26/25 revealed a total of 28 opportunities with 23 tasks not marked as having been done. Record review of the facility's kitchen in-services revealed: 12/01/24 Sanitizing, Cleaning, 03/25/25 Kitchen Sanitation, 04/01/25 Services Management, 04/21/25 Adaptive Equipment, 05/08/25 Refrigeration Food Storage, 05/27/25 Carbon Build-up, Cleaning Schedules, Thermometers in fridge/freezer, and temp recording, Personal Hygiene, Cross-contamination, hair nets, wear and tear from cooking equipment. Record review of the RD's in-service dated 05/08/25, titled, Refrigeration Food Storage revealed under Date Marking, Food items must be labeled with dates if they are prepared and held for more than 24 hours .Under Refrigeration Storage Limits, use all leftovers within 72 hours. Discard items that are over 72 hours old. Immediately throw out any foods showing signs of spoilage or are past their expiration dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy dated 10/01/18, titled Cleaning Schedules revealed under Policy: The facility will maintain a cleaning schedule prepared by the Nutrition and Foodservice Manager and followed by employees as assigned in order to ensure that the kitchen is clean and free of hazards. 3.The Nutrition and Food Service Manager or designee will verify that the tasks were completed as assigned. The Daily, Monthly, and Weekly cleaning schedules within the policy listed juice machine was to be cleaned daily. Record review of the facility policy dated 10/01/18, titled, Food Storage revealed under Procedures: 1. Dry storage rooms, e. Provide scoops for items stored in bins, such as sugar, flour, rice, and other items. Store scoops covered in a protected area near the food containers .2. Refrigerators, e. Use all leftovers within 72 hours. Discard items that are over 72 hours old.