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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675396 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2024 |
| NAME OF PROVIDER OR SUPPLIER Laredo South Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1100 Galveston Laredo, TX 78040 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748</p> <p>Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments, person-centered care plan to reflect the current condition for 1 of 11 residents (Residents #2) reviewed for care plan revisions.</p> <p>The facility failed to ensure Resident #2's care plan was comprehensive and updated to reflect Resident #2's fall preventions.</p> <p>This failure could place residents at risk of not receiving appropriate interventions meet their current needs.</p> <p>The findings include:</p> <p>Record review of Resident #2's admission records revealed an [AGE] year-old-female with an admitted [DATE] and re-admission on 02/09/24. Diagnoses included left femur (thigh)/hip fracture, heart failure, diabetes, osteoarthritis (severe bone degeneration), protein-calorie malnutrition, and muscle wasting.</p> <p>Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS of 6 indicating severe cognitive impairment. Resident #2 was dependent for chair/bed to chair transfers and toileting transfer. Picking up objects, sit to stand or walking 10 feet was not attempted due to medical or safety reasons. Resident #2 required supervision with toileting, substantial assistance with footwear and dressing, rolling left and right, sitting to lying, lying to sitting on the side of the bed, wheeling her wheelchair 50 feet. Resident #2 was incontinent of bladder and bowel. She had a manual wheelchair she could self-propel.</p> <p>Record review of Resident #2's care plans only had partial Low risk interventions when Resident #2 was rated at a high risk for falls since her admission on 07/28/22.</p> <p>Record review of Resident #2's comprehensive care plan dated 7/28/2022 indicated she was at risk for falls r/t Hx of falls: 8/16/22-witnessed fall/with skin tear to left side of lip/attempted unassisted transfer from bed to w/c Date Initiated: 07/28/2022 Revision on: 08/17/2022. Interventions were:</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Anticipate and meet Resident #2's needs. Date Initiated: 07/28/2022 Revision on: 08/17/2022 o Be sure Resident #2's call light is within reach and encourage to use it for assistance as needed. Date Initiated: 07/28/2022 Revision on: 08/17/2022 o Rehab referral related to 8/16/22 fall. Date Initiated: 08/16/2022. 8/16/22-staff to continue to anticipate and meet needs. Revision on: 10/02/2022.</p> <p>7/19/23-Resident sitting on bathroom doorway. Stated she slipped sitting down when she tried to self-transfer and forgot to lock her wheelchair and she was wearing socks. Date Initiated: 07/19/2023 o Resident #2 will have no major injuries from fall. Date Initiated: 07/19/2023 Target Date: 05/14/2024 o Call bell within reach to call for assistance. Date Initiated: 07/21/2023 o Perform frequent rounds to anticipate resident's needs. Date Initiated: 07/19/2023 o Therapy to evaluate and treat. Date Initiated: 07/19/2023 o 02/23/24-Resident found on floor in seated position: unwitnessed fall. 02/01/24-Resident voiced that she wanted to go to restroom. did not use call light. fell , c/o pain. Date Initiated: 02/23/2024 o Resident will have no major injuries from a fall. Date Initiated: 02/23/2024 Target Date: 05/14/2024 o Call bell within reach. Date Initiated: 02/23/2024 o Frequent rounds to anticipate resident's needs. Date Initiated: 02/23/2024 o Therapy to evaluate and treat. Date Initiated: 02/23/2024 o Resident #2 is High risk for falls r/t Hx of falls prior to admitted Initiated: 02/09/2024 Revision on: 02/14/2024 o The resident will be free of falls through the review date. Date Initiated: 02/09/2024 Target Date: 05/14/2024 o Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 02/09/2024 o Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. Date Initiated: 02/09/2024.</p> <p>Record review of Resident #2's Fall risk assessments dated 02/01/24 documented a score of 15 indicating a high risk for falls. Quarterly Fall risk assessments since 08/16/22 documented scores from 10-12, indicating a high risk for falls since her original admission on 07/28/22.</p> <p>Record reviews of Resident #2's initial baseline care plan dated 02/09/24, comprehensive care plans dated 02/09/24 and 02/14/24 revealed Resident #2's Care plan dated 02/14/24. Resident #2 has acute pain r/t recent ORIF (open reduction internal fixation=plates and screws).</p> <p>During an interview with the DON on 05/08/24 at 1:40 pm, he stated interventions for high risk fall scores should be care planned and in the physician orders.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview with the DON on 5/10/24 at 12:40 pm, he stated, Fall precautions should be in the care plan. Revisions were overlooked by the DON after Intra Disciplinary Team (IDT) daily morning meetings. The DON stated, Fall mats, call lights and low bed positioning should be in the interventions in the care plans. They (staff) need to keep the patients safe, so all staff should be very vigilant. If there was not something in the care plan that was suggested, it is rated by what the resident needs. The DON stated, Staff and the IDT review the fall prevention policy and go by that. The DON stated, The 02/09/24 care plan was after [Resident #2's] fall on 02/02/24 and again on 02/23/24. It had appropriate interventions, but there could have been more because she had broken her hip then fell again. The DON stated, The interventions in [Resident #2's] care plan were not adequate. The DON stated the fall interventions of call bell within reach and encourage to use it for assistance as needed, anticipate and meet Resident #2's needs were inadequate for Resident #2's current condition. The DON stated he did not see the interventions for a fall mat or low bed. The DON stated, There could be 15 of them (interventions), but if they weren't using them all, they tried to use the ones that were more useful. After reviewing the resident's Fall risk Evaluations, the DON stated, Some of the other interventions would have helped her and helpful in preventing a fall. The DON acknowledged Resident #2 was a high fall risk since 11/07/22 and more interventions would have been helpful. The DON stated he was not sure of what the facility's fall prevention program policy outlined. The DON was unable to show where fall interventions were located in Resident #2's electronic chart.</p> <p>Record review of facility policy titled, Fall Prevention Program dated 08/15/22 reflected-Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy explanation and compliance guidelines: 1. a. The risk assessment categorizes residents according to low or high risk. 3. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. 4. Low risk protocols: a. May implement universal environmental interventions, that decrease the risk of residents falling, including but not limited to: i. a clear pathway to the bathroom and bedroom doors. ii. Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. iii. Call light and frequently used items are within reach. iv. Adequate lighting. v. wheelchairs and assistive devices are in good repair. b. Implement routine rounding. c. Monitor for changes in resident's cognition, gait, ability to rise/sit and balance. d. encourage residents to wear shoes or slippers with non-slip soles when ambulating .g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. 5. High risk protocols: a. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. b. Provide additional interventions ass directed by the resident's assessment, including but not limited to ii. Increased frequency of rounds, v. Low bed, vii. Scheduled ambulation or toileting assistance. 8. When any resident experiences a fall, the facility will: e. Review the resident's care plan and update as indicated. f. Document all assessments and actions.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039</p> <p>Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 1 resident (Resident #1) of 8 residents reviewed for quality of care.</p> <p>The facility failed to follow the physicians order on 08/16/2022 in accordance with the care plan for Resident #1's Wanderguard bracelet (device designed to prevent elderly individuals with dementia from wandering outside a perimeter) to be placed on her right arm. The Wanderguard bracelet was instead placed around her right ankle.</p> <p>This failure could place residents requiring supervision who had a Wanderguard at risk for injury and accidents.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 05/08/2024 reflected an [AGE] year-old female with an original admitted [DATE]. Pertinent diagnoses includes dementia (mental decline that affects the quality of daily living) with exit seeking behaviors.</p> <p>Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 1 (Severe Cognitive Impairment).</p> <p>Record review of Resident #1's quarterly Wandering assessment dated [DATE] reflected Resident #1 was a moderate wandering risk.</p> <p>Record review of Resident #1's comprehensive care plan dated 01/28/2022 indicated a problem stating she was an elopement risk, wanderer, and disoriented to place. An intervention included for this problem was to check placement and function of safety monitoring device as per policy/orders.</p> <p>Record review of Resident #1's physician orders for Wanderguard dated 1/28/2022 and a revision physician order for Wanderguard to right arm on 8/16/22.</p> <p>In an interview with the DON on 05/08/2024 2:00 PM, it was revealed that on 10/17/2023, the day of an elopement by Resident #1, she had the Wanderguard bracelet on her right ankle making the Wanderguard system unable to detect the bracelet at floor level.</p> <p>In an interview with the MD on 05/08/2024 2:15 PM, it was revealed that as a resident with a Wanderguard device approaches a closed door equipped with the Wanderguard system, the door locks for 15 seconds. He further revealed that if the Wanderguard device crosses the threshold of an open door equipped with the Wanderguard system, an alarm sounds throughout the building.</p> <p>Observation on 05/08/2024 at 2:50 PM revealed that Resident #1 was wearing her Wanderguard bracelet on her right arm on. Resident #1 could not be interviewed due to history of dementia.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview with the ADON on 05/08/2024 3:04 PM, it was revealed Resident #1 was wearing her Wanderguard device around one of her ankles during the head-to-toe assessment of Resident #1 immediately following the elopement incident on 10/17/2023. The ADON stated a potential outcome of the incident was Resident #1 getting hit by a car.</p> <p>In an interview with LVN D on 05/10/2024 10:25 AM, LVN D stated that not following physician orders could lead to medical errors or poor patient outcomes. LVN D also stated that if she saw a resident wearing their Wanderguard bracelet in a different location from where it stated on the physician's order then she would inform the DON of the discrepancy and then get assistance to move it to the correct location based on the physician's order.</p> <p>Record review of a work order from a contractor dated 10/18/2023 8:42 AM revealed the following: WanderGuard at front door not alerting when tag is present. Requested by the Administrator for the front door WanderGuard system not working. The system was checked by tech and was adjusted to maximum coverage the system would allow. It was noted that the system has an external signal interference, that causes the bracelet, to not be picked up by sensor when close to the door. All adjustments were made and a resident was used to test door response. The resident had a tag applied to ankle. The nurse admin was notified that the tag was too close to the ground and was part of the reason the tag was not picked up by receiver. This person stated that it had been done that way and she would speak to Admin on his return. Job complete.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one resident (Resident #1) reviewed for supervision.</p> <p>The facility failed to ensure Resident #1 received adequate supervision while Resident #1 eloped from the facility during lunch time.</p> <p>This failure could place residents requiring supervision at risk for injury and accidents with potential for more than minimal harm.</p> <p>The noncompliance was identified as Past Non-Compliance. The IJ began on 10/17/23 and ended on 10/18/23. The facility had corrected the noncompliance before the investigation began.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 5/09/24 reflected an [AGE] year-old-female with an original admitted [DATE]. Diagnosis included type two diabetes (insufficient insulin production in the body), acute (sudden) kidney failure, and dementia (mental decline that affects the quality of daily living).</p> <p>Record review of Resident # 1's physician orders for Wanderguard (device designed to prevent elderly individuals with dementia from wandering outside a perimeter) dated 1/28/2022 and a revision physician order for Wanderguard to right arm on 8/16/22.</p> <p>Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 1 (Severe Cognitive Impairment).</p> <p>Record review of Resident #1's quarterly Wandering assessment dated [DATE] reflected Resident #1 was a moderate wandering risk.</p> <p>Record review of Resident #1's nursing documentation dated 10/17/2023 at 12:35 PM documented:</p> <p>Late Entry:</p> <p>Received call from concerned family member that had witness someone outside the building that she thought might be one of our residents. Staff searched premises and found resident outside building wheeling self-up the street. SN approached resident asking her where she was going and mentioned home. Resident redirected and brought back to nursing home. No distress or discomfort noted. No visible trauma. Resident outside the building for approximately 5-10 minutes. No missed medications or meals.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on 5/08/24 at 2:00 PM the DON stated on the day of the elopement, staff did not hear the Wanderguard alarm go off. The DON stated while staff were busy in the dining area, a concerned family member for another resident called the facility and stated Resident #1 was seen in the facility parking area in her wheelchair. The DON stated he and the ADON ran outside and found Resident #1 in the street by the stop sign on the opposite side of the facility parking area. The DON stated Resident #1 stated she was trying to go home.</p> <p>The DON stated Resident #1 was brought inside the facility and head to toe assessment was conducted with no injuries or distress noted. The DON stated a resident head count was conducted to make sure all residents were accounted for. The DON stated a facility walk around was conducted and during the walk around, that is when it was noticed the Wanderguard antenna was out of range since it had been moved to the ceiling. The DON stated at the time of the elopement, Resident #1 had the Wanderguard bracelet on her right ankle making the Wanderguard system unable to detect the bracelet at floor level. The DON stated Resident #1 was not in the intersection and did not consider the street Resident #1 was on to be a busy street.</p> <p>In an interview on 05/08/24 at 2:20 PM the Administrator stated the facility's front lobby area was going through a renovation and at that time the contracted construction company had put the Wanderguard antenna in the ceiling in an attempt to beautify the front lobby without his knowledge. The Administrator stated the antenna was still visible and the remodel was going on for about 6 months and Resident #1's elopement was the only elopement the facility had during that time and since then. The Administrator stated that all exit doors are checked daily by maintenance and on the day of Resident #1's elopement, the Wanderguard alarm system was working.</p> <p>Record review on 05/08/24 at 2:40pm of the Exit Door Logbook reflected on 10/16/23, and on 10/17/23, the day of Resident #1's elopement, the Wanderguard alarm system was working.</p> <p>In an interview on 5/8/24 at 3:04 PM the ADON stated she was in the office when the DON received a call from a concerned family member of another resident stating she saw a resident in a wheelchair out in the facility parking lot. The ADON stated she ran out the facility's front entrance while the DON ran out the facility's back entrance and at first, the ADON stated she couldn't see anything and kept going to the right of the facility and saw Resident #1 across the street up against the curb. The ADON stated the DON came around the back of the facility, ran to Resident #1 and took her inside the facility to get a head-to-toe assessment. The ADON stated the Wanderguard was on Resident #1's foot but was not sure which foot. The ADON stated she did not remember hearing the Wanderguard alarm go off as it can be heard throughout the building and her office. ADON stated Resident #1 could have gotten hit by a car and injured due to the elopement. The ADON stated nothing could have happened to Resident #1 as well.</p> <p>Interview beginning on 05/08/24 at 10:00am with 1 RN, 3 LVN's, 2 CNA's, 1 Business Office Manager, and 1 laundry aide from various shifts were all able to correctly identify the protocols for a resident elopement.</p> <p>Corrective action implemented by the facility beginning on 10/17/2023 included:</p> <p>Record review of the outside contractor invoice dated 10/18/23 revealed the alarm system was assessed and functional on door and was set at door alarm to maximum range.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Observation of Resident #1 on 05/08/24 revealed she had her wanderguard bracelet moved to right arm as indicated in physician order.</p> <p>Interview with the Administrator and DON on 05/08/24 at 3:04 PM revealed they both verified that R #1's wanderguard bracelet was moved to R #1's right arm.</p> <p>Record review of all sampled residents revealed they had a current wandering evaluation.</p> <p>Record review of facility in-services dated 10/17/23 included:</p> <ul style="list-style-type: none"> -Elopement and Wandering Residents -What to do when door alarm sounds, locate cause of alarm, locate person who went out or in the door. -Do not reset alarm without determining who entered or exited. -All new admissions will have wandering assessment completed. -All residents who are determined to be at risk of wandering will have care plan updated. -Daily exit door checks by maintenance, notify administrator and maintenance immediately if any of the doors appear to malfunction. -All residents have updated wandering assessments. -Daily Wanderguard bracelet checks by charge nurses and documented in computer system. -All residents who are determined to be at risk of wandering have an updated care plan. -All residents have an updated wandering assessment. -An electronic audit log for each exit door is kept and maintained by maintenance. -All staff have been educated on the definition of elopement, if an employee observes a resident leaving the premises, he/she should: <ul style="list-style-type: none"> -Attempt to prevent the resident from leaving in a courteous manner. -Get help from other staff members in the immediate vicinity if necessary. -Stay with the patient at all times. -Instruct another staff member to inform the charge nurse or Director of Nursing services that a resident is attempting to leave or has left the premises. Call local law enforcement if necessary. <p>In-services included staff signatures as evidence of receiving and understanding the in-service.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Interviews conducted on 05/08/24 revealed 1 RN, 3 LVN's, 2 CNA's, 1 Business Office Manager, and 1 laundry aide from various shifts were all able to correctly identify the protocols for a resident elopement.</p> <p>Record review of Elopements and Wandering Residents dated 11/21/22 stated:</p> <p>Policy:</p> <p>This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>Policy Explanation and Compliance Guidelines;</p> <p>2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.</p> <p>3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.</p> <p>Record review of Abuse, Neglect, and Exploitation dated 8/15/22 stated:</p> <p>Neglect means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>The noncompliance was identified as Past Non-Compliance. The IJ began on 10/17/23 and ended on 10/18/23. The facility had corrected the noncompliance before the investigation began.</p> | | |