

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  12/18/2024
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573</b></p> <p>Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 (Resident #1) of 3 residents reviewed for care plans.</p> <p>The facility failed to develop a comprehensive person-centered care plan for Resident #1 to address the risk for falls and the fall mat.</p> <p>This failure could place the residents at risk of not receiving appropriate interventions and care to meet their current needs.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 12/14/24 reflected a [AGE] year-old female with an original admitted [DATE]. Her diagnoses included: hydrocephalus (buildup of fluid in the brain ventricles), encephalopathy (brain dysfunction), muscle wasting and atrophy, dysphagia (difficulty swallowing), cognitive communication deficit, acquired absence of unspecified breast, and gastrostomy status (opening in the stomach for feeding).</p> <p>Record review of Resident #1's fall risk evaluation dated 11/15/24 reflected a score of 7 which indicated a low risk.</p> <p>Record review of Resident #1's initial baseline care plan dated 11/15/24 reflected Resident #1 was not at risk for falls.</p> <p>Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 did not have a BIMS conducted as she was never/rarely understood. Resident #1 was total dependence for bed mobility. Falls were not addressed on the MDS assessment.</p> <p>Record review of Resident #1's care plan dated 12/14/24 reflected risk for falls and the fall mat were not care planned.</p> <p>Interview and observation of Resident #1 on 12/14/24 at 12:00 PM revealed Resident #1 was non-interviewable. Resident #1 had a fall mat in place on the left side of her bed.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with CNA D on 12/14/24 at 12:50 PM revealed CNA D said Resident #1 had the fall mat in place, but she was not aware if Resident #1 had any falls. CNA D said maybe the fall mat was placed just as a precaution.</p> <p>Interview with LVN B on 12/14/24 at 1:10 PM revealed LVN B said Resident #1 had not fallen during her stay but she had a fall mat in place as a precaution.</p> <p>Interview with ADON P on 12/14/24 at 2:15 PM revealed ADON P said Resident #1 had not experienced any falls during her stay. ADON P said she was not sure why Resident #1 had a fall mat in place.</p> <p>Observation of Resident #1 on 12/18/24 at 11:20 AM revealed Resident #1 had a fall mat in place on the left side of her bed.</p> <p>Interview with MDS N on 12/18/24 at 1:10 PM revealed MDS N said Resident #1 did not trigger for risk of falls during the initial admission assessments. MDS N said the fall risk evaluation on 11/15/24 indicated Resident #1 was at low risk for falls. MDS N said the initial baseline care plan indicated that Resident #1 was not at risk for falls which would then not trigger the comprehensive care plan to include risk for falls. MDS N said the assessing nurse should have indicated Resident #1 was at risk for falls on the initial baseline care plan based on the fall risk evaluation, which would have triggered the risk for falls on the comprehensive care plan. MDS N said if there was a fall mat placed by the nurses, then the staff should have communicated that with the team so the care plan could be updated. MDS N said the team was not notified that the fall mat was implemented. MDS N said the nurses implemented interventions at times based on their nursing judgement. MDS N said she was not sure who placed the fall mat. MDS N said a fall mat would be considered an intervention and the fall mat would need to be care planned. MDS N verified the fall mat was not care planned for Resident #1 and a risk of falls was not care planned for Resident #1. MDS N said it was important for the fall mat and the risk for falls to be care planned so that staff were aware of the resident's needs, knew how to care for the resident, ensured the intervention was implemented, and to avoid any incident.</p> <p>Interview with the DON on 12/18/24 at 2:45 PM revealed the DON said Resident #1 had not experienced any falls. The DON said Resident #1 had the fall mat placed as a precaution. The DON said it had been brought to his attention that the care plan was not updated for Resident #1. The DON said the fall mat was implemented as a nursing judgment and should have been communicated to the team. The DON said the fall mat should have been care planned. The DON said Resident #1's initial fall risk assessment indicated she was at low risk for falls so the care plan should have included the risk for falls and the interventions which included the fall mat. The DON said although the risk was noted as low, the risk was still there and should have been care planned. The DON said Resident #1 was not negatively impacted by not having the risk for falls or the fall mat care planned. The DON said Resident #1 was at risk of the staff not knowing how to care for her. The DON said it was important for the fall mat and the risk for falls to be care planned to ensure the interventions were implemented and for the staff to know what to do for Resident #1 specific to her needs.</p> <p>Record review of Comprehensive Care Plans Policy date implemented: 10/24/22, reflected:</p> <p>Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.</p> <p>(continued on next page)</p>		

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