STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observation, interviews and record reviews, the facility failed to ensure the right to be free from abuse for one (Resident #1) of five residents reviewed for abuse. The facility failed to ensure Resident #1 was free from physical abuse on 01/13/25 when Resident #2 grabbed Resident #1 ' s head with both of his hands and hit Resident #1 ' s head against the wall several times then punched Resident #1 on the left side of his face with a closed fist. This failure could place residents at risk for physical, mental and psychosocial harm. Findings included: Record review of Resident #1's admission record on 05/14/25 reflected an [AGE] year-old male originally admitted to the facility on [DATE], with most recent admission on 08/26/21. Resident #1's diagnoses included hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction (stroke or brain injury) affecting left side, vascular dementia (problems with thought processes and memory caused by brain damage from impaired blood flow), cognitive communication deficit (difficulty with communication), generalized muscle weakness, Alzheimer ' s disease (progressive brain disorder that slowly destroys memory and thinking skills), reduced mobility, and need for assistance with personal care. Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 7, which indicated severe cognitive impairment, and Resident #1 used a wheelchair and required substantial assistance with transfers. (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
	675396	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 03/30/16 reflected on 12/12/24, Resident #1 had the potential to be physically and verbally aggressive, picked fights and struck at others due to dementia related poor impulse control. Resident #1's goal was to verbalize understanding of need to control physical and verbal aggressive behavior through the review date with interventions which included monitor and document observed behavior and attempted interventions in behavior log, monitor/ document/ report any s/sx (signs/symptoms) of resident posing danger to self or others, and when Resident #1 became agitated, intervene before agitation escalated, guide away from source of distress, engage calmly in conversation and if he responded aggressively, staff would walk calmly away and approach later. This care plan also reflected on 01/13/25, Resident #1 had an altercation with another resident (Resident #2). Resident #1's goal was to remain free of any altercations with other residents with interventions which included resident would be redirected to the living, dining, or his room if he engaged in discussion with other residents and he would be encouraged to participate in activities. Record review of Resident #1's progress notes reflected the following entry: Type: NURSING - Nurse Note Effective Date: 01/13/2025 at 9:24 am by GVN Resident (#1) physically assaulted by another resident (Resident #2); resident (#1) was at living room sitting on his wheelchair when another resident (Resident #2) approached him and started to smack him against the wall. When staff intervened to stop him, resident (#2) stuck him on the left eye. SN asked to resident (#1) what happened, and resident responded: I was here on the wheelchair when the other resident came to me and attack me.SN performed head to toe assessment and noted redness discoloration to his outer side of left eye and left cheek. No other observations noted at this time. Resident #1 denies pain or discomfort. Vital signs as follows: BP-157/87, P-76, O2-97@RA, RR-20, T-97.7. RP made aware of incident and stated to call on any updates of Resident #1. [Physician] made aware and gave order as follows: Xray of skull and facial bones. Record review of Resident #1's order summary report dated 05/14/25 reflected the following physician orders: 1. [Psychiatric services provider] may provide psychological services (ordered 01/13/25), 2. SN to monitor skin q shift for- Resident has mild swelling and bruising to left side of face (ordered 01/13/25), and 3. Facial 2V/ Skull 2V (2 view x-rays of the face and skull) one time only (ordered 01/13/25). Record review of Resident #1's radiology results dated 01/13/25 reflected, Multiple views of the skull/face demonstrate no overt fracture or dislocation. The nasal septum is midline. The soft tissues are unremarkable. Record review of Resident #1's skin and wound evaluation dated 01/14/25 at 3:25 pm reflected intact skin with a bruise to his left eye area that measured 1.5cm long by 1.9cm wide. Resident #1 denied any pain or discomfort. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's admission record on 05/13/25 reflected a [AGE] year-old male admitted to the facility on [DATE] and discharged to another facility on 01/24/25. Resident #2's diagnoses included frontal lobe and executive function deficit following cerebral infarction (difficulties with higher level cognitive processes such as planning, organization, and impulse control after a stroke or brain injury), conversion disorder (a condition in which emotional or psychological stress causes physical symptoms) with seizures (abnormal brain activity which affects muscle control, behavior, and awareness), schizoaffective disorder, depressive type (mental health problem characterized by thinking and behavior problems and sadness), dementia, mild, with psychotic disturbance (dementia with delusions or hallucinations), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), and cognitive communication deficit. Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 11 which indicated moderate cognitive impairment and Resident #2 did not exhibit physical or verbal behavioral symptoms directed toward others nor other behavioral symptoms not directed toward others. Resident #2 required minimal to no assistance with walking and transfers. Record review of Resident #2's care plan dated 08/21/24 reflected on 01/13/25, Resident #2 had an episode of aggression toward another resident (Resident #1). Resident #2's goal was to be free of confrontations with other residents with interventions which included keeping him occupied or interested in activities he enjoyed such as watching football, providing him snacks and treats of choice twice a day. Resident #2 was also placed on one-to-one observation until he was discharged to another facility on 01/24/25. This care plan also reflected on 01/13/25, Resident #2 had potential to be physically aggressive r/t (related to) poor impulse control. Resident #2's goal was to not harm self or others through the review date and interventions included analyze times of day, places, circumstances, triggers, and what deescalated behavior and document, assess and address contributing sensory deficits, assess Resident #2's needs: food, thirst, toileting, comfort level, pain, etc., monitor/document/report any s/sx of resident posing danger to self or others, psychiatric/ psychogeriatric consult as indicated, one to one monitor for behavior, and when Resident #2 became agitated, intervene before agitation escalated, guide away from source of distress, engage calmly in conversation and if he responded aggressively, staff would walk calmly away and approach later. Record review of Resident #2's progress notes reflected the following entries: Type: NURSING - Nurse Note Effective: 01/13/25 at 8:17 am by LVN A Resident #1 was sitting on his wheelchair in the lobby and Resident #2 approached other resident and banged his head against the wall then punched him on the face with closed fist. Resident #2 was instructed to go to his room. Notified RP and physician made aware. Type: SOCIAL SERVICES - Social Service Note Effective: 01/13/2025 at 1:03 pm by SW (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This morning [Resident #2] was involved in a physical altercation with another resident (Resident #1), he was the aggressor, he lashed out at another male resident (Resident #1) that male resident is in a wheelchair, [Resident #2] grabbed the other male resident (Resident #1) and was banging the head of that male resident against the wall. Staff intervened and managed to get Resident #2 away from the male resident, but as per staff when [Resident #2] released his hold on the other male resident, [Resident #2] punched the male resident on his eye.The D.O.N. stated that the psychiatrist from [Psychiatric Services Provider] was contacted, she is recommending inpatient psychiatric care. Record review of Resident #2's order summary report dated 01/24/25 reflected the following physician orders: 1, Resident placed on one-to-one monitoring pending transfer to another facility (ordered 01/13/25), 2. Resident to be placed in an inpatient psychiatric hospital (ordered 01/13/25), 3. Hydroxyzine Pamoate Oral Capsule 50mg. Give 1 capsule by mouth every 4 hours as needed for restlessness related to anxiety disorder due to known physiological condition until 01/27/25 at 11:59 pm (ordered 01/13/25). 4. Lorazepam Oral Tablet 0.5mg. Give 1 tablet by mouth every 6 hours as needed for anxiety until 01/27/25 at 11:59 pm (ordered 01/13/25), 5. Quetiapine Fumarate Tablet 50mg. Give 1 tablet by mouth at bedtime related to schizoaffective disorder (ordered 01/13/25), 6. Lab work: CBC (complete blood count) with auto diff (automatic differential), Comp. (Complete) Metabolic Panel, and Urinalysis with reflex (urine test with urine culture if needed to determine type of infection) (ordered 01/13/25). and 7. Bactrim DS (Double Strength) Oral Tablet 800- 160mg (Sulfamethoxazole- Trimethoprim, an antibiotic used to treat multiple infections including urinary tract infections). Give 1 tablet by mouth two times a day related to Escherichia coli (bacteria that can cause urinary tract infections) for 14 days (ordered 01/19/25). Record review of the facility's provider investigation report dated 01/17/25 reflected the facility notified the physician and the responsible parties for both residents as well as the local police department and the investigation findings were confirmed. The facility held an in-person in-service on abuse, neglect, and exploitation on 01/13/25 by the (previous) ADON and an in-person in-service on behavior chaining (the sequence of behaviors, events, situations, and interactions that led up to a particular event) by the (previous) ADON on 01/14/25. Observation and interview of Resident #1 on 5/14/25 at 10:43 am reflected Resident #1 was sitting in the dining room watching television with other residents. Resident #1 stated that he was doing good. Resident #1 did not recall the incident in January with Resident #2. Resident #1 stated he did not have issues with any other residents, and he liked living in this facility. Resident #1 stated he was not scared of any other residents or staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/14/25 at 11:49 am, the SW stated Resident #2 came to the facility from an out-of-town facility because he had family in this city. The SW stated she did a social history on Resident #2 and neither the transferring facility nor the RP gave any history of Resident #2 having aggressive behavior. The SW stated Resident #1 had a tendency to make gestures or say things to others. Resident #1 had bruising under his left eye, but not above it after the altercation with Resident #2. The SW stated witnesses said that Resident #1 said something or gestured something, and Resident #2 went at him and hit him. The SW stated Resident #2 was transferred to another facility shortly afterwards. In an interview on 05/14/25 at 12:30 pm, the DON stated Resident #1 said something to Resident #2 and Resident #2 was hitting Resident #1 ' s head on the wall then when the nurse stepped in and told him to stop, Resident #2 punched Resident #1 with a closed fist to the left side of his face. The DON stated Resident #1 initially had a quarter-sized bruise to his left cheek area. The DON further stated Resident #1 had no recollection of the incident after the day it occurred, and he was not fearful or withdrawn afterwards. The DON stated Resident #1 was evaluated by psychiatric services to determine if he had any distress from the incident and he did not. Resident #2 was transferred shortly after to another facility. The DON stated it was important for the facility to be free from abuse and neglect so the residents would feel safe because this is their home. The DON stated abuse or neglect could lead to physical, mental, or psychosocial harm, hospitalization , or even death. The DON stated abuse/neglect/exploitation was in-serviced every quarter and as needed as well as in the facility ' s online training every 2-3 months and the last abuse/neglect/exploitation in-service was in April. In an interview on 05/14/25 at 4:06 pm, LVN B stated on 01/13/25, she was walking past the nurse ' s station and heard a thumping sound. She stopped and looked around and realized it was coming from the front lobby area. She stated she looked in and saw Resident #2 had Resident #1 by the head and was banging his head against the wall and she said out loud, [Resident #2], Stop! LVN B stated, I told him to let him go and back away and that he could not do that and that was when he punched him and then walked away. He said, He [Resident #1] called me something, and I told him to just ignore it. Resident #2 then said he walked over to Resident #1 and told him that he (Resident #2) was a nice guy, and he should not talk to him like that. Resident #2 said Resident #1 raised his hand up and Resident #2 thought Resident #1 was going to hit him and that was why Resident #2 hit him. I told Resident #2 to go back to his room, and he walked to his room. LVN B stated she checked on Resident #1 and told him he had a little bruise, and she wanted to check him out and he said, No, I ' m OK in Spanish. LVN B stated Resident #1 had a small bruise near his eye, but he was not fearful, tearful, or withdrawn. LVN B stated she told Resident #1 she was going to call the doctor, and he told her he was fine and did not need the doctor called. LVN B stated LVN A had walked up at some point, and she told her she told Resident #2 to go to his room, and he went. LVN B stated LVN A took over from there. LVN B stated she had never seen Resident #2 do anything like that and afterwards he went back to being the same as before. LVN B stated Resident #2 had a lot of repetitive behaviors, like asking for chips and sodas, but never anything aggressive. LVN B stated, He was pretty chill. He could be a little intimidating at times because when he would talk to you, he would get really close, but he had never been violent. LVN B stated Resident #2 was put on one-to-one observation until he left. LVN B stated it was important that residents felt safe in this facility. LVN B named the abuse coordinator, stated the last abuse in-service was at the beginning of the year, and it was done quarterly in the facility ' s online training. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 05/14/25 at 4:30 pm, LVN A stated Resident #1 and Resident #2 were in the lobby. She heard screaming and ran to the lobby area where she saw Resident #2 punch Resident #1 in the face. LVN A stated she had never seen Resident #2 do anything like that before and to her knowledge Resident #2 did not have any issues with Resident #1 prior to that. LVN A stated Resident #2 was usually in his room watching tv and did not have any issues with any other residents. LVN A stated after Resident #2 hit Resident #1, he was taken back to his room and the RP and doctor were notified about the incident. Resident #2 was put on one-to-one observation. Resident #2 did not get into any other fights afterwards and he had never done that before. LVN A stated the last in-service on abuse was at the beginning of the year they were done quarterly and as needed. In an interview on 05/14/25 at 1:09 pm, the admin stated Resident #2 had behaviors, but it was nothing aggressive; he would ask for chips and sodas all the time then staff would go in his room and find opened but not consumed bags of chips and cans of soda. On 01/13/25, after Resident #2 hit Resident #1, he was placed on one-to-one monitoring. The admin stated, After speaking with psychiatric services, we began looking for an inpatient psychiatric facility to transfer him to. It took a couple of weeks to find a facility to transfer him to and he remained on one-to-one monitoring during that time. Resident #2 did not have any further aggressive behaviors prior to his transfer. The admin stated it was important for residents to be free from abuse because this was their home, and they had a right to feel safe in their home. The admin stated he felt the facility was not at fault for Resident #2 hitting Resident #1 because Resident #2 had not shown aggressive behavior prior to this incident and staff immediately intervened, removed Resident #2 from the situation, and put interventions in place to prevent it from happening again. The admin stated the facility had in-services on abuse every three months and as needed in person and it was also part of the facility ' s online training every quarter. Record review of the facility's Abuse, Neglect and Exploitation policy dated 08/15/22 reflected in part: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or others but has not yet been investigated and, if verified, could be an indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.