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	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	1100 Galveston Laredo, TX 78040

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's right to privacy for 1 (Resident #5) of 17 residents reviewed for privacy. The facility failed to ensure the WCN provided privacy for Resident #5 while performing his wound care. This failure could cause residents to feel uncomfortable, disrespected, and possibly a loss of dignity due to a lack of privacy. The findings include:Record review of Resident # 5's face sheet dated 07/21/25 reflected an [AGE] year-old-male with an original admission date of 09/09/24. Diagnoses included congestive heart failure, high blood pressure, type two diabetes (insufficient production of insulin in the body), and pressure ulcer (a localized injury to the skin and underlying tissue caused by prolonged pressure) at an unspecified site and location. Record review of Resident #5's physician orders dated 07/20/25 reflected: Cleanse Sacrum (triangular bone at the base of the spine. Upper cack part of the pelvic cavity) with normal saline, pat dry, pack with hydrofera blue (bacteriostatic foam dressing infused with a combination that provides powerful antibacterial effect while maintaining a moist wound environment), cover with dry gauze and secure every other day one time a day. During an observation of wound care on 07/21/2025 at 9:48 AM, the WCN began to provide wound care for Resident #5. The WCN left the door open, closed the left side of the privacy curtain but not the front side of the privacy curtain, leaving Resident #5 exposed to people who passed by in the hallway. In an interview on 07/21/2025 at 10:13 AM, the WCN stated it was important to provide privacy to all residents because it was part of their patient rights, their dignity and respect. The WCN stated she should have closed the door or the rest of the curtain but did not because she was unsure of how I would be able to observe the wound care process. The WCN stated she should have at least closed the door but just forgot. In an interview on 07/22/2025 at 9:56 AM, the DON stated Resident #5's door or curtain should have been closed to maintain the resident's privacy and dignity. The DON stated by not providing privacy, anyone walking past the door would be able to see Resident #5 exposed. Record review of the facility's policy of Promoting/Maintaining Resident Dignity dated 01/13/23 reflected: Policy: It is the practice of this facility to protect and promote resident rights and teat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 12. Maintain resident privacy.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one resident (Resident #7) of 17 residents whose care plans were reviewed. The facility failed to ensure Resident #7's comprehensive care plan was updated was developed and implemented after starting anticoagulant (blood thinner) medication on 04/26/25. The deficient practice could place residents in the facility at risk of not being provided with the necessary care or services, and the implementation of personalized plan of care developed to address their specific needs. Findings include:Record review of Resident #7's face sheet dating 07/20/25 reflected a [AGE] year-old-male with an original admission date of 1/07/20. Diagnoses included pulmonary fibrosis (lung disease characterized by the scarring and damage of lung tissue), congestive heart failure, high blood pressure, chronic kidney disease, and type two diabetes (insufficient production of insulin in the body). Record review of Resident #7's Physician orders dated 04/26/25 reflected: Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day related to chronic atrial fibrillation (type pf heart arrhythmia characterized by irregular and often rapid beating of the atria, upper chambers of the heart). Record review of Resident #7's care plan initiated on 01/07/2020 and revised on 06/02/2025 reflected no care plan for anticoagulants. In an interview on 07/22/2025 at 9:41 AM, the MDS Coordinator stated she was unable to find Resident #7's anticoagulant medication in the care plan. The MDS Coordinator stated it should be care planned to ensure the staff are aware of the signs and symptoms such as the risk of bleeding and bruising. The MDS stated it was an oversight, and there was no reason why Resident #7's care plan was not updated. In an interview on 07/22/2025 at 9:48 AM, the DON stated Resident #7's anticoagulants should have been care planned. The DON stated it was important to have any anticoagulants care planned so staff could be aware of what signs and symptoms to look for such as bleeding or bruising. The DON stated that whenever there is a change in condition or new medications for any resident, it would be discussed during morning meetings and the team would go over any revisions of care plans. The DON stated Resident #7's care plan was just overlooked. In an interview on 07/22/25 at 1:28 PM, the ADM stated Medical Records would do a lot of auditing and needed to get with her to see if she was responsible for conducting care plan audits. The ADM stated the facility had ensured Medical Records personnel were nurses so they would be able to assist with this kind of documentation. In an interview on 07/22/2025 at 1:47 PM, Medical Records stated she did not audit resident care plans and was not sure who did. Record review of the facility's Care Plan Revisions Upon Status Change dated 10/24/25 reflected: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 2 glucometers (device used to measure the amount of glucose in a resident's blood) reviewed for pharmacy services. The facility failed to ensure the glucometer in the nurse cart for halls 100, 200 and 400 were tested for accuracy and recorded in the glucometer logbook on 07/01/25, 07/02/25, 07/07/25, 07/08/25, and 07/21/25 in the month of July. These failures could place residents at risk of receiving either too much insulin or not enough. The findings included:Record review of the glucometer logbook on 07/22/25 at 10:37 AM revealed the test results for the glucometer in the nurse cart for halls 100, 200 and 400 were not recorded on 07/01/25, 07/02/25, 07/07/25, 07/08/25, and 07/21/25. In an interview with the DON on 07/22/25 at 1:11 PM, the DON stated the glucometers were supposed to be tested every day on the night shift by the nurses and the results recorded in the logbook. The DON stated night shift nurses were trained to test the glucometers every shift. The DON stated it was the DON and ADON's responsibility to check the logbooks and ensure the night shift nurses were recording the results of the tests. The DON stated he did not think there was an official policy on testing the glucometers every day, but that it was best practices for nursing. The DON stated it was important to test the glucometers to ensure they gave accurate readings. The DON stated if a glucometer gave inaccurate readings a resident may end up receiving insulin when they did not need it, or not receive insulin when they did need it. The DON stated this could impact any resident that received insulin. In an interview with LVN D on 07/22/25 at 2:06 PM, LVN D stated he did not work the night shift. LVN D stated it was the night shift nurse's responsibility to test the glucometers and record the results in the logbook every night. LVN D stated it was important to ensure the glucometers were working so there would not be any mistakes in administering insulin. LVN D stated an inaccurate glucose measurement may result in administering insulin to a resident that did not need it or vice versa. A phone interview was attempted with three different night shift nurses on 07/22/25 between 1:50 PM and 1:57 PM, but none answered the phone or called back. This stated surveyor requested a facility policy from the DON on 07/22/25 at 1:11 PM dictating how often to test the glucometers but none was provided prior to exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and record reviews, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of 1 medication rooms reviewed for medication storage. The facility failed to ensure the medication room was locked at 11:21 AM on 07/20/25 This failure could place residents in the facility at risk of drug diversion or misuse of medications leading to harm. The findings included:During an observation at 11:21 AM on 07/20/25, the medication room door was left slightly ajar, allowing this state surveyor to open the door and gain entrance without any key. No employees were in the medication room at that time. This state surveyor stayed by the entrance to the medication room until the ADM walked by at 11:50 AM and was informed the door was slightly ajar. In an interview with the ADM at 11:50 AM on 07/20/25, the ADM stated the medication room door was supposed to be closed and locked when no one was inside the room. The ADM stated the medication room should be closed and locked to prevent any unauthorized personnel from gaining access to residents' medications. The ADM stated LVN A, CMA C, and RN B all had keys to the medication room and had been working today from 6:00 AM to 2:00 PM. The ADM stated if the door was left open, residents or unauthorized staff could gain access to medications and ingest them or steal them. In an interview with RN B on 07/20/25 at 1:05 PM, RN B stated she had a key to the medication room, and the last time she was in the room today was around 9:30 AM. RN B stated she closed and locked the door behind her when she left. RN B stated it was important to keep the door to the medication room closed and locked, so unauthorized people did not gain access to medications. In an interview with CMA C on 07/20/25 at 1:20 PM, CMA C stated she had a key to the medication room, and the last time she was in the room was around 10:00 AM. CMA C stated she closed and locked the door behind her when she left. CMA C stated it was important to keep the door locked so residents or staff could not go in and out of the room and possible eat or steal medications. In an interview with LVN A on 07/20/25 at 1:35 PM, LVN A stated she had a key to the medication room, and the last time she was in the room was around 10:30 AM. LVN A stated she closed and locked the door behind her after she left. LVN A stated it was important to keep the door closed and locked to keep any unauthorized people from going into the medication room and taking things that did not belong to them. In an interview with the DON on 07/22/25 at 1:11 PM, the DON stated the medication room door should be closed and locked whenever no authorized staff were present in the room. The DON stated the room should be locked to prevent any unauthorized people from getting int the room and ingesting or stealing medications. The DON stated he liked to pull on the door handle whenever he walked by the room just to be sure it was closed. Record review of the facility policy titled Medication Carts and Supplies for Administering Meds revealed the following: .The following equipment and supplies are acquired and maintained by the facility for the proper storage, preparation, and administration of medications: 1. Lockable medication carts, cabinets, drawers, and/or rooms with well-lit medication preparation areas.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food per professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation, and sanitation.The facility failed to ensure dishes were cleaned after washing and not used for service.The facility failed to ensure the utensils were in good condition.The facility failed to ensure personal items were not in the prep areas.The facility failed to ensure a cabinet door was safe to open.The facility failed to ensure table scraps were disposed of properly.The facility failed to ensure personal items were separated from leftovers in refrigerator #D2.The facility failed to ensure food items in refrigerators #A1, and #D2, and freezers #B3, #C3, and #D2 were labeled, dated, and stored properly.The facility failed to ensure the dry storage area was free from fruit and dented cans.The facility failed to ensure food items in the dry storage area were properly sealed, labeled, and dated. The facility failed to properly maintain temperature logs in refrigerators #A1, and #D2, and freezers #B3, #C3, and #D2.The facility failed to maintain dishwasher temperature and sanitation logs. The facility failed to ensure all staff were properly trained in removing dishes from meal trays and serving residents seated at the same table at the same time. The facility failed to ensure all kitchen staff were using the designated handwashing sink and not the prep sink for handwashing.These failures could place residents who received meals and/or snacks from the kitchen and satellite kitchens at risk for food contamination and foodborne illness.Findings included:Observation and initial tour of the kitchen on 07/20/25 at 10:45 am revealed 13 of 26 coffee cups on the coffee cart were scratched and stained inside, and some had food stuck to the inside. The coffee maker on the coffee cart was leaking coffee. There were 20 of 78 juice glasses on the clean rack with a partially removable white substance in the bottoms and up the sides. There was a serving ladle stacked in another ladle in a clean drawer that had a sticky, red substance in it. When moved, the ladle beneath it had a sticky, red substance on its bottom, and inside the drawer. There was a large rubber spatula hanging from the pot rack with chips missing from the sides. There was a Styrofoam cup with foil over it and a personal cup next to the mixer on a prep table, both unlabeled and undated. There was a cabinet door above a prep area with an unscrewed hinge at the bottom that fell sharply when it opened. The DW was using an open trash bag on the floor to scrape food scraps into it. Refrigerator #D2 had a sign on the outside of the door that read, Kitchen Staff Only Refrigerator. One of the drawers inside refrigerator #D2 had a sign on it that read, This area is exclusive for employees and was full of what appeared to be jalapeno peppers. The peppers were loose in the drawer. Inside refrigerator #D2, there was an open Styrofoam cup without a lid that was 1/2 full of red liquid, unlabeled and undated. There were food items (later identified by the CK as leftovers for residents) stored in 5, 2-quart containers. Three of the containers were dated 07/16/25. There was a 1-gallon bag of what appeared to be 6 egg rolls unlabeled and undated; a partially empty 1-pint bottle of red liquid unlabeled and undated; 7 small sausages in a wrinkled, open piece of foil; a 1-gallon bag labeled turkey, but had no dates on it; a 1-gallon bag of a brown/red substance (later identified by the CK as left over beans) unlabeled and dated 07/16/25 inside refrigerator #D2. Refrigerator #A1 and freezer #s B3 and C3 had several unlabeled and undated trays of desserts inside. There was a 1/2-pint carton of milk open to air, unlabeled and undated in refrigerator #B3. There was a small juice glass filled with a white substance next to the open carton that was also not labeled or dated. There was a large bag of frozen ravioli in freezer #C3 dated 01/12/25. The ravioli was covered in frost and discolored. There were 3 resident pitchers open to air, 1/2 full of ice, undated and unlabeled in freezer #B3. There were 5, 6-pound dented cans on the use shelf in the dry storage room. The bin labeled Do Not Use Damaged Food Cans was empty. There was an uncut melon on the shelf in the dry storage room. There was a 1-gallon bag of bread and 8 slices of bread in a partially closed bag and a large, loosely closed bag of tortillas unlabeled and undated in the dry storage room. Refrigerator #A1 had an outer digital thermometer that read 36F even when the doors were opened for several minutes. The internal thermometers read 42F-45F with the doors open. The daily freezer and refrigerator temperature logs were missing data. The low-temp dishwasher temp and sanitation logs had the same numbers logged every day. There was one tray cart that had no covering on the sides or top. There were four regular push carts near the open tray cart.Observations and interview with the DW on 07/20/25 at 10:55 am, he said the low temp dishwasher temperature should be 120F, but it read 115F. He said he did not know how long the dishwasher water temperature had been low. He said he did not know what the sanitation level should be. [Chem strip container numbers and colors were scaled 0-light yellow, 100-light green, etc.] The DW demonstrated using